

Maine Barriers to Integration Study: Environmental Scan

October 2008

Authors

John A. Gale, MS

David Lambert, PhD

Muskie School of Public Service

Prepared for

The Maine Health Access Foundation

Contract no. 2007CON-0010



UNIVERSITY OF
SOUTHERN MAINE
Muskie School of
Public Service

**Maine Barriers to Integration Study:
Environmental Scan**

John A. Gale, MS
David Lambert, PhD

Muskie School of Public Service
University of Southern Maine

October 2008

Prepared for:

The Maine Health Access Foundation

Contract no. 2007CON-0010

Acknowledgements

We would like to thank the members of the Study Team and Advisory Committee for their assistance and guidance on this project. Their assistance was invaluable in undertaking this complex study. We also thank the following Muskie School staff for their assistance with this project: Karen Pearson, Kimberly Bird, and Melanie Race for their help in editing the final report; Lisa Marie Lindenschmidt and Tedda Yeo for their assistance in organizing the meetings of the Advisory Committee; and Jennifer Lenardson and Diane Friese for their assistance in organizing the models of care and in conducting stakeholder interviews. Finally, we would like to thank William Foster, Dean of the Muskie School and Wes Davidson, Executive Director of the Aroostook Mental Health Center, for serving as the Co-Chairs of the study's Advisory Committee.

Members of the Study Team and Advisory Committee (in alphabetical order)

| | |
|------------------------|---|
| Carol Carothers | NAMI Maine |
| Dawn Cook | Health Access Network |
| Wesley Davidson | Aroostook Mental Health Center |
| Ronald Deprez | Center for Health Policy, University of New England |
| Lynne Duby | Youth & Family Service, Inc. |
| William Foster | Muskie School of Public Service |
| Elsie Freeman, MD, MPH | Maine Department of Health and Human Services |
| John Gale | Muskie School of Public Service |
| Meg Haskell | Bangor Daily News |
| Jeffrey Holmstrom, DO | Anthem BC/BS of Maine/University Health Care |
| Neil Korsen, MD | MaineHealth |
| David Lambert | Muskie School of Public Service |
| Kevin Lewis | Maine Primary Care Association |
| Tom McAdam | Kennebec Behavioral Health |
| Lisa Miller | Representative, District 52 |
| David Moltz, MD | Consultation Project, Maine Association of Psychiatric Physicians |
| Mary Jean Mork, LCSW | MaineHealth |
| Nancy Morris | Maine Health Alliance |
| David Prescott, PhD | Acadia Hospital |
| Roderick Prior, MD | MaineCare |

Most importantly, we are grateful for the generous support of the Maine Health Access Foundation, which provided funding for this study and providing encouragement and advice. Dr. Wendy Wolf, President and CEO of the Foundation, and Barbara Leonard, Vice President for Programs, provided insightful comments on report drafts and materials. Ms. Leonard, Project Officer for this study, helped us to keep a steady eye on the goals of this study and engage all relevant stakeholders.

Table of Contents

| | |
|--|----|
| Executive Summary | i |
| Introduction..... | 1 |
| Overview of the Issues Related to Integration..... | 2 |
| Factors Driving the Interest in Integrated Care..... | 2 |
| Evolution of Integrated Care..... | 3 |
| Sentinel Reports..... | 6 |
| Barriers to Integration..... | 10 |
| National and System-Level Barriers..... | 10 |
| Regulatory Barriers..... | 12 |
| Reimbursement Barriers | 14 |
| Reimbursement Barriers: General Issues..... | 14 |
| General Coding Issues | 15 |
| Reimbursement Barriers: Medicare | 18 |
| Reimbursement Barriers: Commercial Payers..... | 21 |
| Reimbursement Barriers: Managed Care..... | 22 |
| Practice and Cultural Barriers..... | 23 |
| Patient-Level Barriers | 28 |
| State and Canadian Initiatives Supporting Integration | 29 |
| Minnesota..... | 29 |
| North Carolina | 31 |
| Oregon..... | 32 |
| Washington | 32 |
| Vermont | 32 |
| Connecticut | 33 |
| Canadian Collaborative Mental Health Initiative | 34 |
| Models of Integrated Care: From Structure to Function..... | 34 |
| Emerging Issues Related to Integration | 38 |
| Barriers to Integration: The View from Maine..... | 41 |
| Federally Qualified Health Centers Focus Group..... | 41 |
| Interviews with MeHAF Integration Initiative Grantees..... | 43 |
| Physician Surveys and Interviews Conducted by the Maine Center for Public Health..... | 45 |
| Maine Integrated Health Initiative: Maine People Speak About Health Care Integration | 46 |
| Discussion and Findings | 46 |
| Guiding Principles | 47 |
| Preliminary Findings from the Environmental Scan | 47 |
| Preliminary Recommendations..... | 49 |
| Endnotes..... | 51 |

Executive Summary

Maine Barriers to Integration Study: Environmental Scan

Introduction

Recognizing that our health care system lacks organization, integration, and coordination, the Maine Health Access Foundation (MeHAF) has adopted the promotion of patient- and family-centered care as a long-term funding priority. With the goals of encouraging patients to take an active role in their care and promoting integration of primary and specialty care with mental and behavioral health, dental care, and other services, MeHAF has funded several health care initiatives to improve the health of individuals and to improve the quality and cost-effectiveness of health care.

The *Maine Barriers to Integration Study* is one of these initiatives. MeHAF funded the Muskie School to identify barriers to integration of behavioral and physical health services and potential solutions to overcoming these barriers. This paper reports on the first phase of the study, which included an extensive literature review; an analysis of different approaches and models to integration; and a review of integration initiatives in Maine, other states, and Canada. Results from interviews and focus groups with Maine stakeholder organizations are also included.

Barriers to Integration in the Literature

We reviewed published and unpublished literature on integration including seminal reports and a broad range of academic, clinical, professional, and evaluation articles and reports. The literature suggests a number of barriers to integration.

- ***National and system-level barriers*** include the limited supply of specialty behavioral health providers; the maldistribution of behavioral health providers relative to need; the separation of funding streams for general and behavioral health care services; and the lack of parity between coverage for general medical and behavioral health conditions.
- ***Regulatory barriers*** to integration include state-level licensure laws governing the requirements for a professional title (e.g., psychologist, clinical counselor, marriage and family therapist), the scope of practice (e.g., the specific activities that persons meeting

these requirements are permitted to perform), and facility licensure governing the provision of services by behavioral health agencies.

- **Reimbursement barriers** include lack of reimbursement for integrative and preventive services, variation in reimbursement rules across third party payers, different coding and billing classifications by setting and payer, and use of mental health carve-outs.
- **Practice and cultural barriers** exist between primary and mental health practice, including different practice styles, culture, language, and administration; different techniques employed in reaching a diagnosis; different lengths and content of typical visits; the use of separate patient records; and different approaches to charting, record keeping, and communication between providers. An additional, increasingly important barrier at the practice level is the lack of information technology integration both within practices and across practices and provider organizations.
- **Patient-level barriers** include poor access to behavioral health services; limitations on coverage and reimbursement by third party payers; impact of high-deductibles and co-pays on utilization of services; complexity of authorization and utilization review processes; and patient perception of stigma in receiving behavioral health care.

State and Canadian Initiatives Supporting Integration

We identified a number of states and Canada that have undertaken initiatives to encourage the integration of behavioral and physical health services that are relevant to Maine. Within these initiatives, states may act as a facilitator; fund the development of demonstration projects; or make policy and reimbursement changes to support the integration of services.

- **Minnesota** has pursued a statewide effort to integrate mental and physical health and improve the mental health infrastructure. Projects include an initiative to screen primary care patients for depression, reimburse telehealth consultations between psychiatrists and primary care physicians, and pay bonus amounts to primary care physicians for providing quality depression care.
- **North Carolina** has established a statewide initiative to better manage and coordinate care for the Medicaid population. From 2005 through 2007, four pilot sites provided mental health care by co-locating mental health providers at each primary care site.

- **Oregon** has supported pilot projects that co-locate mental health specialists within Federally Qualified Health Centers. Mental health services are paid through the state's Medicaid mental health carve-out.
- **Washington** has blended funding from physical health, behavioral health, and long-term care to support integration services within one county's adult behavioral health system.
- **Vermont** has developed a coordinated system of care for people with co-occurring mental health, substance abuse, and primary care needs. The initiative includes state funding and local stakeholders and is based on a well-known model of chronic care.
- **Connecticut** has developed a reimbursement model for mental health and substance abuse clinics serving adults and/or children. These clinics provide therapy, medication management, and other services and receive enhanced Medicaid reimbursement to meet special requirements for enhanced access to care.
- The **Canadian** Collaborative Mental Health Initiative assembled a steering committee of consumers and providers to document the state of collaborative mental health, define its principles, and commit the participants to following those principles. Outcomes included the development of new alliances, practical tools, and a framework to carry the work forward and raise the profile of collaborative care among service funders and planners.

Models of Integrated Care: From Structure to Function

An extensive review of the various integration models reveals an evolution from structure to function as efforts to support integration have developed over time. Early demonstration programs often took the form of co-located providers, in which behavioral health specialists were placed in primary care settings. These models focused on location of care while more recent models have focused on what mid-level behavioral health providers may do and how they work with physical health care providers. For example, newer approaches that use behavioral health specialists to engage primary care patients through motivational interviewing focus on how care is provided rather than where it is provided.

Emerging Issues Related to Integration

Two emerging issues have the potential to alter the discussion about the integration of behavioral and physical health services. The first issue suggests the need to develop models and

tools to integrate primary care and physical health services into behavioral health settings based on the recognition that persons with severe mental illness do not receive adequate physical health services. The second issue involves the growing interest in the medical home concept. The term medical home refers to a partnership with families to provide primary health care that is accessible, family-centered, coordinated, comprehensive, continuous, compassionate, and culturally effective. Advocates for the medical home suggest that the adoption of the model has the potential to advance integration; however, most descriptions of the medical home do not include specific integration provisions and instead focus on the concept of care management and coordination.

Barriers to Integration: The View from Maine

To examine Maine-specific barriers to integration, we conducted a focus group with Federally Qualified Health Center staff, interviewed MeHAF integration grantees, and reviewed past efforts to identify barriers to integration in Maine through physician and consumer surveys.

- ***Federally Qualified Health Centers Focus Group:*** Identified barriers include staffing and credentialing barriers (e.g., the lack of specialty behavioral health providers); reimbursement barriers (e.g., limits on number of daily visits); community barriers (e.g., stigma against receipt of mental health care); facility issues (e.g., lack of appropriate space); training on behavioral health issues for primary care staff; and challenges related to the selection and implementation of the appropriate integration model.
- ***Interviews with MeHAF Integration Initiative Grantees:*** Identified barriers include the amount of time necessary to implement effective integrated programs; reimbursement barriers including limits on the number of daily visits; difficulties in finding appropriate staff and in sharing clinical and administrative information; and the need to develop different practice systems and protocols to support integrated care. A key finding is that no one model or approach is right for all settings; structural integration should be driven by resource availability, practice settings, and market context.
- ***Maine Center for Public Health Physician Surveys and Interviews:*** Identified barriers include language and cultural barriers between primary care and mental health providers; structural barriers that include regulatory requirements; ignorance of physical disorders by patients and mental health providers; inadequate mental health/substance abuse

assessment training of many primary care providers; lack of provider understanding/awareness of services; lack of ready access to child psychiatrists for consultation; difficulties in recruiting social workers, psychologists, and certified substance abuse professionals; and Office of Substance Abuse regulations that exacerbate the shortage of substance abuse providers in Aroostook County.

- ***MeHAF Consumer Survey on Integration:*** Consumers reported barriers to the use of integrated services including limited access to specialty mental health services; shortages of specialty mental health providers; and poor reimbursement for behavioral health services. Consumers reported that they prefer to receive behavioral health services in a primary care setting, which is perceived as less “stigmatizing” than a specialty health care setting.

Discussion and Findings

Interest in the integration of behavioral health and physical health services remains high nationally and in Maine. The discussion has evolved from earlier conceptions of integration to a more holistic focus on integration that allows for two-way integration between physical health and behavioral health settings and also focuses on the functional aspects of integration across provider organizations and agencies.

The environmental scan and input from our project Advisory Committee suggest that integrated health care initiatives should adhere to the following guiding principles: care should be patient-centered and should expand access; it should be delivered in settings preferred by patients; it should be evidence-based and driven by clinical issues and functions rather than practice and administrative issues; it should focus on integrating care within practices and facilities as well as across practices and care settings; and it should focus on both physical health and behavioral health settings.

The most significant barriers to integration in Maine involve licensure, reimbursement, and financial issues. Facility licensure rules often limit the ability of agencies to engage in integrated models of care, excluding providers who may not meet licensure standards and imposing administrative and clinical complexity on integration projects that may not be necessary. Third party payers including Medicare, MaineCare, managed behavioral health organizations, and commercial insurance carriers have different policies regarding the types of

behavioral health providers covered and the services they will reimburse. Providers need training and technical assistance on clinical, administrative, and operational issues related to integration including the identification and selection of integration models that are appropriate to their organizational settings and market contexts.

Preliminary Recommendations

A broad-based, transparent process is needed to discuss, reconcile, and formulate necessary changes to support integration. The following should be developed to support this work:

- An ongoing multi-disciplinary steering committee to address complex and potentially conflicting integration issues across settings. Members should include state policymakers, third party insurers, managed behavioral health organizations, physical health and behavioral health providers and practices, key stakeholders, and consumers of services.
- An information, education, and technical assistance resource center to address integration issues across practice settings and facility types.
- Outcome measurement tools and resources to monitor and evaluate the level of success of integration initiatives and their impact on expanding access, decreasing burden of illness, and optimizing care.

Finally, goals should be refined and clarified for the integration of behavioral and physical health services in Maine and to understand the implications of the different models of integration.

Introduction

The promotion of patient- and family-centered care is a long-term funding priority for the Maine Health Access Foundation (MeHAF). The Foundation's approach to patient-centered care recognizes that, from a patient's perspective, our health care system lacks organization, integration, and coordination. It also recognizes that our current system is difficult to navigate, particularly for people who are uninsured or low-income.¹ In response to these two issues, MeHAF has funded health care initiatives to improve the health of individuals and to improve the quality and cost-effectiveness of health care. The goals of these initiatives are to:

- Encourage patients to define and articulate their needs, participate with providers in health care decision making, and take an active role in guiding their own care; and
- Promote integration of primary and specialty care with mental and behavioral health, dental care, and other services.

As part of its efforts to promote patient- and family-centered care, MeHAF has funded a number of initiatives beginning with a day-long kickoff event for its integration initiative on April 27, 2006. Following this event, MeHAF convened a broad-based steering committee to assist in defining integration, articulating barriers and opportunities to advance integration, and to outline benchmarks to assess how Maine's health care system is moving toward improved integration. The steering committee developed a vision and goals for integration that are summarized in "*Integrated Health Care in Maine: Visions, Principles and Values, and Goals and Objectives.*"² This document is designed to serve as a general guide for integration in Maine and for MeHAF's grantmaking efforts in this area.

The visioning process was followed by grants to grassroots organizations to host discussion groups with Maine residents in 2006 to solicit input on what patient-centered care means to them. This effort was summarized in "*Maine Integrated Health Initiatives: Maine People Speak About Health Care Integration.*"³ In 2007, MeHAF funded 20 competitive grants to support patient-centered care in Maine through the integration of behavioral, primary, and specialty care. The foundation also commissioned the Muskie School to identify barriers to integration of behavioral and physical health services and potential solutions to overcoming these barriers. In 2008, MeHAF released a request for proposals for another round of integration grants to support patient-centered care.

Maine Barriers to Integration Study: As part of its portfolio of work on integration, MeHAF funded the Muskie School, working in collaboration with MaineHealth, Acadia Hospital, and the Health Access Network, to conduct a study on barriers to integration in Maine. We conducted this study in two phases. In phase one, we conducted a broad environmental scan, which included an extensive literature review of the clinical, administrative, and financial barriers to integration; an analysis of different approaches and models to integration across diverse types of practice; and a review of integration initiatives in Maine, other states, and Canada. To provide a local context, we interviewed stakeholder organizations funded by MeHAF under the first round of integration grants. We also conducted a focus group with administrators and board members of Maine Federally Qualified Health Centers, assembled by Kevin Lewis, Executive Director of the Maine Primary Care Association. The results of the environmental scan are presented in this paper.

Phase two involved interviews with a broad range of stakeholders in state government, the business community, third party payers, professional and trade associations, the legislature, advocacy organizations, and provider organizations. The goal of these interviews was to identify specific barriers to the integration of behavioral and physical health services in Maine, potential solutions to overcoming these barriers, and incentives that would encourage providers to integrate services.

To help guide the study, we assembled a multi-disciplinary advisory committee of key stakeholders representing the different sectors in Maine concerned with the integration of behavioral and physical health services. They have generously provided guidance on the scope and issues to be studied and provided timely, “on the ground” feedback to our findings.

Overview of the Issues Related to Integration

Factors Driving the Interest in Integrated Care

A number of factors have driven interest in integrated care, including:

- Limited access to behavioral health care in underserved areas including rural communities and inner city areas;
- Recognition that many persons with behavioral health issues are less likely to receive appropriate primary and physical health care;
- Studies that show that persons with serious mental illness die younger and suffer from higher rates of co-morbid physical illnesses;

- Financial, educational, and technical assistance support from the federal government including the Bureau of Primary Healthcare (Federally Qualified Health Center Program), Health Resources and Services Administration (Chronic Disease Collaboratives), and the Substance Abuse and Mental Health Services Administration;
- Support from national (Robert Wood Johnson Foundation, MacArthur Foundation, and others) and state (Maine Health Access Foundation and others) foundations;
- Recognition that many patients prefer to be seen in primary care settings for behavioral health issues, yet most primary care practices are not prepared to deliver evidence-based care for behavioral health issues;
- Increased reliance on medications as a primary intervention; and
- Recognition of the prevalence of behavioral health issues in primary care settings.

Evolution of Integrated Care

Interest in integrated behavioral and physical health services dates to the 1970s.^{4,5,6} These early discussions were concerned primarily with the integration of mental health services into primary care settings. Over time, policymakers, consumers, and providers have expanded the discussion to encompass the broader concept of the integration of behavioral and physical health services regardless of the setting of care. Integration is widely promoted as resulting in a more holistic, higher-quality, and more cost-effective approach to health care, particularly given substantial co-morbidity of physical and behavioral health problems. Integration is also touted as a way to reduce access barriers to behavioral health services arising from limited availability of specialty behavioral health providers and as a way to reduce the stigma attached to receiving behavioral health services by providing them in a less threatening and obvious setting. More recently, the Institute of Medicine has promoted the integration of services to develop a patient-centered, “no wrong door” approach to behavioral health care described in its *Crossing the Quality Chasm* series.⁷

The case for integration is compelling and has been advanced by policymakers and clinicians, in various forms, for several decades. Beginning in the late 1970s and extending through the 1990s, demonstration programs showed that mental health care could be delivered effectively in primary care settings. As a result of these demonstrations, the discussion of integration has focused primarily on the integration of mental health services into primary care settings and the development of approaches, models, and tools to help primary care practices implement and sustain mental health services. Belnap and colleagues⁸ note three waves of studies and initiatives aimed at overcoming the challenges of implementing effective depression

care in primary care settings. Beginning in the 1990s, the **first wave** provided guideline-based feedback to primary care physicians (PCPs) about patients requiring depression care. The Agency for Health Care Policy and Research (AHCPR) Depression in Primary Care Guidelines typified this approach.⁹ While improving the knowledge base of PCPs, the availability of guidelines did not result in improved recognition or treatment of depression in actual primary care settings.⁸ Implementation of patient screening and patient registries in primary care settings improved recognition but not treatment of depression.¹⁰⁻¹² These studies suggested that a narrow focus on increased recognition may not improve overall outcomes and that treatment resources might be best directed towards more intensive follow-up and relapse prevention among those already being treated. Subsequent studies found that multifaceted primary care intervention and stepped collaborative care for primary care patients improved adherence to antidepressant regimens and satisfaction with care in patients with major and minor depression.¹³⁻¹⁶ The studies also document more favorable depression outcomes among patients with major or persistent depression; outcome effects were ambiguous among patients with minor depression.¹³

A **second wave** of studies offered more sophisticated models of depression care based on various adaptations of Wagner's Chronic Care Model.⁸ These models included a chronic disease focus and incorporated patient education, patient self-management tools, and collaboration among clinicians, other healthcare professionals, and the patient. A rich empirical literature has emerged documenting the adaptation of this chronic care model to the treatment of depression.¹⁷⁻²⁰ The Health Resources and Services Administration (HRSA) incorporated this approach into its Health Disparities Collaboratives,²¹ which seek to improve the treatment of four chronic health conditions including depression.

A **third wave** of depression integration initiatives was sponsored by the Robert Wood Johnson Foundation (RWJF), which build on Wagner's Chronic Care model and the second wave studies adapting and assessing this model. RWJF's Depression in Primary Care Incentive Project developed a blueprint for implementing depression care management in eight demonstration sites.⁸ Sites were asked to develop a clinical model of depression care consistent with the chronic care model and to develop financial and system strategies to sustain these models. RWJF's focus on sustainability was a key difference of this demonstration project compared to previous efforts in that RWJF, unlike the funders of previous demonstration projects established expectations that grantees would develop and implement specific sustainability plans.

The clinical models and populations targeted varied widely across sites. The protocols developed by the sites generally incorporated some, but not necessarily all, of the following: systematic identification of patients at increased risk of depression; use of a structured assessment tool (preferably the PHQ-9); stratification of treatment intensity by episode, severity, and patient preference; monitoring of symptoms of depression and suicidality; routine follow-up; assistance with behavioral health referral and access; supervision of behavioral health consultation; and development of case management services. A key task for each site was to determine the role and scope of responsibilities of the care manager. Results from this initiative demonstrate the importance and benefit of care managers in enhancing ongoing, collaborative treatment for depression.²² The initiative appears to have achieved its primary goal of building systems of care that extend care beyond basic screening, identification, and initiation of treatment and documenting the utility of information technology and refinements in reimbursement to support this more comprehensive system of care.⁸

The experience of the eight demonstration sites also underscores the challenge of establishing care management over time when working within resources and relationships (although enhanced by demonstration funding). For example, not all participating organizations within a network or community may have, or can afford, the same level of information technology. A primary care practice may negotiate a change in reimbursement with a health care plan to support a primary care provider's time in collaterally treating depression with a behavioral health worker. However, in the throes and demands of everyday practice, it is difficult to change how one does business for some, but not all, patients based on a patient's insurance.²²

The **next stage** in the development of integrated care involves enhancing practice infrastructure and aligning systems to support the clinical and administrative functions necessary to provide integrated care. As experience with integration has grown, it has become less a question of where and how to provide integrated care (although challenges and questions remain) than of how to support and sustain the provision of integrated care to increasing numbers of patients over time.

Sentinel Reports

Major, sentinel reports have played an important role in encouraging the development of integration, both in directing the attention of stakeholders to the need for integration and in conceptualizing it (see Figure 1). In 1999, *Mental Health: A Report of the Surgeon General*²³ was issued, summarizing what was known about different types of mental illness and the most effective treatments, given the state of scientific knowledge and existing delivery and financing systems. Two key themes related to integration emerged from the report. The first is that mental health and mental illness are points on a continuum. The second is that the body and mind are inseparable. Reflecting these themes, the report strongly endorses the need to integrate general and mental health care. The Surgeon General's report was an important political as well as scientific document and its endorsement of integration was significant.

In 2003, the President's New Freedom Commission on Mental Health released *Achieving the Promise: Transforming Mental Health Care in America*.²⁴ The report identified our fragmented mental health system as a contributing factor to the substantial inefficiency and reduced effectiveness of our overall health care system. The report recommended the integration of primary care and mental health services, particularly in rural areas. More recently, the Institute of Medicine's report, *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*⁷ firmly endorsed integration as an essential strategy to improve access to and quality of treatment of mental health problems.

Over the last decade, a series of reports have introduced and refined the Four Quadrant Clinical Integration Model. The model was first introduced in 1998 in a joint report issued by the National Association of State Mental Health Program Directors (NASMHPD) and National Association of State Alcohol and Drug Abuse Directors (NASADAD). *A National Dialogue on Co-Occurring Mental Health and Substance Abuse Disorders*²⁵ focused on the treatment of co-occurring mental health and substance abuse disorders. The Four Quadrant model characterized clients by the severity of their mental health and substance abuse problems: i) less severe mental disorder and less severe substance disorder; ii) more severe mental disorder and less severe substance disorder; iii) less severe mental disorder and more severe substance disorder; and iv) more severe mental disorder and more severe substance disorder. The purpose of the model was to classify the client's clinical needs in a more integrated fashion to determine the most appropriate treatment setting in which to address their needs. The report recommended that states

use this framework to direct prevention and treatment services to settings where they might be more efficient and effective.

In 2003, the National Council for Community Behavioral Healthcare issued a background paper, *Behavioral Health/Primary Care Integration, Models, Competencies, and Infrastructure*. The paper reviewed the case for integration and the reasons why we have not made more system-level progress in this area. The report suggests that discussion has been “stuck” on the policy ideal of integration.²⁶ To make further progress, it was necessary to pursue integration at the policy, corporate/organizational, and practice levels and to maintain a focus on the needs and preferences of consumers. The report established a series of principles to further service integration:

- Focus on consumers and their families;
- Promote health, overcome disparities, and address chronic illness;
- Standardize quality and outcome disparities and address chronic illness;
- Promote collaboration and co-location;
- Redesign financing, the regulatory environment, and contracting methods;
- Develop best practice service models;
- Invest in training; and
- Assure development of appropriate health information technology.

The report adapted the Four Quadrant Model to classify the level of integration and clinician competencies needed to treat persons with differing behavioral health (BH) and physical health (PH) complexity and to organize the resources by treatment setting to best meet their needs. The Four Quadrant Model established the four following domains to organize treatment settings:

1. Low BH; low PH: Patient can be served in primary care setting with BH staff on site.
2. High BH; low PH: Patient can be served in a specialty BH system that coordinates with his/her primary care practitioner.
3. Low BH; high PH: Patient can be served in the primary care medical specialty system with BH staff or disease care managers on site coordinating with medical care system.
4. High BH; high PH: Patient can be served in specialty behavioral health and specialty health systems. Case management is highly recommended to coordinate services.

The Four Quadrant Model has been further promoted and adapted in subsequent reports. In the 2004 Report, *Get it Together: How to Integrate Physical and Mental Health Care for People With Serious Mental Disorders*²⁷, the Bazelon Center for Mental Health Law identified

the following barriers to integrated care: financing; cultural differences between mental health and primary providers including training, practice, and professional style; inadequate training to diagnose and treat disorders outside of their specialty; lack of access to needed mental and physical health services; difficulty in sharing information; and patient concerns about treatment sites. The report recommended that integration policy focus on encouraging clinical integration and developing the organizational structures and financing mechanisms to support it. Another 2005 report by NASMHPD²⁸ presented opportunities and challenges for state mental health authorities to promote the revised Four Quadrant Model. The National Council for Community Behavioral Healthcare has continued its support of the Four Quadrant Model in reports on the financing of integrated services²⁹ and the development of evidenced-based practices.³⁰

Interest in integration is not limited to the U.S. health care system. With funding from the Primary Health Transition Fund, the Canadian Collaborative Mental Health Initiative (CCMHI) undertook a major initiative on integrating primary care and mental health and developed a compelling case for improving mental health care in the primary health care setting through interdisciplinary collaboration among health care providers, consumers and caregivers. CCMHI produced a series of twelve papers and toolkits including *Collaborative Mental Health Care in Primary Health Care Across Canada: A Policy Review*³¹ and an *Annotated Bibliography of Collaborative Mental Health Care*.³² Despite differences in the organization and financing of services between Canada and the United States, the products from this initiative are very relevant to our system.

CCMHI identified opportunities to advance primary care and mental health integration and the concept of collaborative care including: i) primary health care and mental health policy frameworks; ii) reductions in legislative, service delivery and funding barriers to collaborative care; and iii) availability and use of health information technology supports. Challenges to the development of collaborative mental health care include: i) attitudes and awareness; ii) human resources including availability; iii) knowledge of collaborative models; iv) training of providers; and v) limited knowledge of information and tools for screening, treatment, referral, and support needs. CCMHI also tackled a topic not generally addressed in the integration literature in the United States by describing the political reform necessary to support integration. In general, CCMHI found that political reform initiatives needed to support integration were often relatively modest and were often hampered by lack of funding and resources.

Figure 1. Sentinel Reports Promoting Primary Care – Mental Health Integration

- 1998. National Dialogue on Co-Occurring Mental Health and Substance Abuse Disorders. NASMHPD and NASSAD.
- 1999. Mental Health: A Report of the Surgeon General.
- 2003. New Freedom Commission on Mental Health. Achieving the Promise: Transforming Mental Health Care in America.
- 2003. Behavioral Health/Primary Care Integration, Models, Competencies, and Infrastructure. Background Paper. National Council for Community Behavioral Healthcare.
- 2004. Get It Together: How to Integrate Physical and Mental Health Care for People With Serious Mental Disorders. Bazelon Center for Mental Health Law.
- 2004. Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities. NASPHPD.
- 2005. Integration of Primary Care and Behavioral Health: Report on a Roundtable Discussion of Strategies for Private Health Insurance. Bazelon Center for Mental Health Law.
- 2005. Canadian Collaborative Mental Health Initiative (CCMHI).
- 2006. Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Institute of Medicine.

While these reports have been important in cultivating support for integration and in providing broad frameworks for viewing integrated services, they generally focus at a high conceptual level and provide comparatively little practical information to those interested in developing integrated services. Demonstration projects, model programs, and ongoing policy initiatives are helpful in moving the discussion closer to ground level. Examples of demonstrations and “on the ground” projects include the Robert Wood Johnson Foundation/MacArthur Foundation demonstrations, the HRSA Health Disparities Collaboratives described earlier, and the Bureau of Primary Health Care’s Mental Health and Substance Abuse Service Expansion Grants for Federally Qualified Health Centers. Literature from these demonstrations and programs rounds out our understanding of the barriers to integration and highlights the challenge of developing sustainable integrated services.

Barriers to Integration

We reviewed published and unpublished literature on integration including the seminal reports described earlier as well as a broad range of academic, clinical, professional, and evaluation articles and reports. The literature suggests a number of barriers to integration. To analyze these barriers, we found it useful to categorize them in terms of the level at which they occur:

- National and system-level barriers;
- Regulatory barriers;
- Reimbursement barriers;
- Practice and cultural barriers; and
- Patient-level barriers.

National and System-Level Barriers

National and system-level barriers include: the chronic limited supply of specialty behavioral health providers; the maldistribution of behavioral health providers relative to need; the separation of funding streams for general and behavioral health care services; and the lack of parity between coverage for general medical and behavioral health conditions (Figure 2). Policymakers and advocates have focused on these barriers, which are usually included in state and community level-discussions of how to better meet behavioral health needs. Because these barriers are rooted in national policies and systems, they are not easily, or quickly, addressed by state and community policymakers and advocates. These barriers provide an important context for understanding the challenges and opportunities for integrating behavioral and physical health care in Maine and need to be addressed. However, it will be difficult in the short- and mid-term to make significant progress in resolving these barriers.

In Maine, and nationally, there are not enough behavioral health specialists (psychiatrists, psychologists, advanced practice nurses, clinical social workers, and substance abuse counselors) to provide all the care that is needed.³³ In 1978, a National Institute of Mental Health psychiatrist dubbed the general health care system, the “De Facto Mental Health System”³⁴ due to these shortages. In the three decades since, a number of initiatives have been undertaken to boost the supply of behavioral health providers, but shortages of many specialists, including psychiatrists and psychologists, appear to be growing.³⁵ These shortages are particularly pronounced for certain population groups such as children and adolescents³⁶ and for geographic

areas, particularly rural areas and inner city areas.²⁴ While integration has been promoted as one solution to these historic shortages, an adequate supply and distribution of behavioral health specialists is necessary to support the integration of these services.

Many behavioral health services at the state and community level are supported by federal funds available for individuals meeting certain eligibility criteria or categories (such funds are commonly referred to as “categorical”). These separate funding streams complicate the provision of integrated care for individual patients in multiple ways. First, these funds are often managed by separate state agencies and programs; each with their own standards, reporting requirements, and provider contracting policies. At the provider level, these funds are typically funded through specific provider agencies and do not typically follow the patient. It is not unusual for individual patients to receive services under multiple funding streams delivered by different providers. The extent to which multiple funding streams inhibit communication between providers; create additional reporting requirements; and require patients to receive services from different providers and agencies rather than through their provider of choice service to complicate the delivery of integrated and coordinated care at the practice level. This problem arising from categorical funding has proven difficult to resolve.

Historically, insurance coverage of behavioral health services has included significant benefit limits, in part because of concerns about adverse selection and moral hazard. Underlying this concern is the chronic nature of many mental illnesses and, in some areas, the lack of specificity about which treatments and approaches work best for different individuals and “how much” treatment is cost-effective. As a result of significant advances in the development of the evidence-base for mental health services, improved behavioral health insurance benefit designs have been developed (which better balance coverage and cost), and a number of states, including Maine, have passed mental health parity laws.^{37,38} The push for enhanced reimbursement through insurance parity at the federal level, which would help support integration, remains unresolved.

Figure 2: National and System-level Barriers

-
- Limited supply of specialty behavioral health providers
- Misalignment of supply relative to need
- Separation of funding streams for medical and behavioral health care
- Lack of parity for insurance coverage of medical and behavioral health care

Regulatory Barriers

Regulatory barriers to integration include state-level licensure laws governing the requirements for a professional title (e.g., psychologist, clinical counselor, licensed clinical social worker, marriage and family therapist), the scope of practice (e.g., the specific activities that persons meeting these requirements are permitted to perform), and facility licensure issues governing the provision of services by behavioral health agencies. To understand fully the ways in which regulatory issues may serve as barriers to integration, it is necessary to understand the ramification of individual regulatory issues as well as the ways in which they may intersect with one another to create additional barriers.

Licensure laws, including scope of practice, are established by each state for each major behavioral health profession (doctoral-level psychologists, social workers, professional counseling, and marriage and family therapists) as well as for psychiatric advanced practice nurses. In most states, licensure is governed by separate professional boards (e.g., psychology, social work, or nursing) with oversight by a state bureau of health professions. Traditionally, professional licensing boards have sought to maintain or enhance their members' competitive position. While reform of state licensure laws to increase the supply of qualified behavioral health providers is possible, it tends to be difficult to achieve in the short-run.³⁹

Another complication arises from state facility licensure laws. Many states, including Maine, have complex facility licensure laws that govern the services that can be delivered by a mental health agency. These laws also establish reporting and clinical requirements with which smaller organizations may find it difficult to comply. These regulations create barriers to integration by limiting the services that can be provided by different types of organizations, limiting Medicaid to licensed programs, creating administrative burdens, and limiting the flexibility of agencies to work across programs/agencies to integrate services. The facility licensure laws tend to perpetuate the historical separation of behavioral and physical health services.³⁹

Reform and revitalization of the behavioral health workforce remains an important priority and has received increasing policy attention at the national level. The Annapolis Coalition's study of the Behavioral Health Workforce³⁵ identified an aging workforce whose past and current training is out-of-date and often does not adequately reflect today's practice settings

and delivery systems, including the emerging and growing evidence-base and growing cultural diversity. Other major findings include:

- Varying growth trends among behavioral health professions: psychiatry has remained essentially static; psychology has doubled in the past 25 years; social work has increased 20% in the last 15 years; and the number of psychiatric nurses with graduate-level training has increased significantly but has been offset by high workforce attrition and the downsizing of graduate nursing programs.
- There is a notable lack of racial and cultural diversity in the behavioral health disciplines.
- The behavioral health workforce is geographically imbalanced, leaving many areas, particularly rural areas, underserved.
- Nationally, there are 145,000 members of the behavioral health workforce who have a bachelor's degree or less. This group receives significantly less ongoing training and support than higher-credentialed workforce members, even though they constitute 40 percent of the workforce in many public-sector service settings.

While the Annapolis Coalition offers broad recommendations to begin to remedy this situation³⁵, the well-publicized report has resulted in few concrete steps forward. It is important for training to reflect the reality that a significant amount of behavioral health care is provided in primary care settings and that behavioral health providers, particularly mid-level providers, are increasingly working there.

Complicating the workforce issue is the separation of reimbursement policies from licensure and scope of practice laws. Third party payers may limit reimbursement for specific services to certain types of behavioral health professionals in defined facility settings. For example, clinical social workers in many states have a similar scope of practice to marriage and family therapists. However, Medicare reimburses the services of clinical social workers and doctoral-level psychologists but not marriage and family therapists. In this way, reimbursement policies serve as a “de facto” form of regulation. This issue will be discussed in greater detail in the next section on reimbursement.

Rules governing clinical supervision of new behavioral health professionals may create barriers to integration of services. State licensure laws often require a new graduate to work under the supervision of another behavioral health professional for a set period of time (often

two years) before they can practice independently. Limitations on who may provide this supervision, particularly in areas with shortages of behavioral health professionals,³⁹ and denial of reimbursement for services provided by unsupervised new professionals hinder service integration.

Figure 3: Regulatory Barriers

- Professional licensure laws
- Scope of practice
- Facility licensure
- Interaction of regulatory standards and reimbursement policies

Reimbursement Barriers

Reimbursement issues are a primary barrier to the integration of services. Limitations and confusion over what providers and which services may be reimbursed within different care settings present very significant barriers to integration. It is useful to consider general reimbursement barriers (Figure 4), and then to consider reimbursement barriers in terms of specific payers, including Medicare (Figure 5), Medicaid (Figure 6) and managed care (Figure 7). Historically, third party payers have provided limited reimbursement for behavioral health and substance abuse services, in part because of the uncertainty of paying for what is often a chronic condition with difficult-to-measure outcomes. Although significant strides have been made in measuring behavioral health outcomes and developing evidence-based practices, payers generally continue to constrain behavioral health spending.^{40,41}

Reimbursement Barriers: General Issues

The delivery of behavioral health services in primary care settings involves two components of care—integrative activities and direct care services.⁴² Integrative services are usually performed by the behavioral health clinician and may include patient screening and engagement, interacting and consulting with the primary care staff, responding to questions from patients and staff, and maintaining “walk-in” slots to accept same-day referrals. These activities are important to integrating behavioral health services and reducing the time demands on primary care staff caring for patients with behavioral health problems. Integrative activities are typically not reimbursed by third party payers and their cost must often be treated as overhead for providing the service. Direct care services are the one-on-one services delivered by providers

to treat behavioral health conditions and are generally directly reimbursable by third party payers.

Coverage of behavioral health services in primary care settings varies significantly among third party payers. This variation adds complexity and administrative burden to primary care practices providing behavioral health services. Reimbursement policies vary by type of provider, licensure and certification requirements, services rendered, and practice setting. Adding to the complexity is the growth of managed behavioral health care programs that set their own reimbursement policies and credentialing standards, within the context of state laws and the contracts under which they operate. It is very challenging for providers to stay on top of these varying and often changing policies for the large number of third party payers with which they interact.

Reimbursement issues pose significant barriers to the integration of services. Reimbursement policies and licensure/scope of practice laws may bear little relationship to one another. For example, Medicare as well as other third party payers do not reimburse for the services of marriage and family therapists even though they are master's-prepared and have a similar scope of practice to clinical social workers.³⁹ This arbitrarily limits the available workforce and may restrain recruitment of specialty behavioral health professionals in integrated settings.

General Coding Issues

Confusion over reimbursement for integrated care often starts with the different coding and billing systems typically used by primary care and behavioral health clinicians.⁴³ Primary care clinicians typically classify illnesses and conditions using the *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)*, which classifies diseases and conditions based on a wide variety of signs, symptoms, abnormal findings, and complaints. Behavioral health clinicians typically classify psychiatric and social disorders using the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*, which is used to determine a diagnosis based on detailed psychiatric assessment and testing. The DSM-IV also uses a multi-axial or multidimensional approach to reaching a diagnosis because other factors in a person's life typically impact their mental health. The DSM-IV assesses mental illness on five dimensions: 1) Axis I: Clinical Syndromes (e.g., the primary diagnosis); 2) Axis II:

Developmental Disorders and Personality Disorders; 3) Axis III: Physical Conditions (which play a role in the development, continuance, or exacerbation of Axis I and II Disorders); 4) Axis IV: Severity of Psychosocial Stressors (events in a person's life that can impact the disorders listed in Axis I and II); and 5) Axis V: Highest Level of Functioning (a rating of the person's level of functioning both at the present time and the highest level within the previous year).

While the correspondence between the DSM-IV and the mental health disorders section of the ICD-9-CM has been refined and improved over time, the two classification systems reflect the different diagnostic and practice styles of primary care and behavioral health clinicians. Primary care clinicians and their administrative and billing staff typically use the ICD-9-CM diagnostics codes and may not be familiar with the DSM-IV system. Conversely, behavioral health providers typically use the DSM-IV system and not the ICD-9-CM.

Clinicians and providers typically bill for behavioral health services, using the Current Procedural Terminology (CPT) codes, developed and maintained by the American Medical Association. While the CPT manual contains all procedure codes that physicians and providers may use to bill for behavioral health services, the use of specific codes are limited to certain types of providers when billing for behavioral health services.⁴¹

For example, primary care physicians, nurse practitioners, and physician assistants typically bill for services using the evaluation and management code series, which are based on service location (e.g., outpatient, inpatient); type of service (e.g., consult or problem-oriented); components of history taken; extent of physical exam performed; and complexity of medical decision-making. Depending on the type of service delivered, clinicians may use one of the codes from the psychiatric services (e.g., initial evaluation, individual therapy, medication management).

Psychiatrists, psychologists, social workers, and other behavioral health professionals typically use the codes from the psychiatric series. Which codes they use depends on: 1) the services delivered; 2) their licensure and scope of practice; and 3) specific reimbursement policies of third party payers. Psychiatrists may use the medication management code while social workers or psychologists, who do not have prescriptive rights, may not.

The challenge is selecting the appropriate code that enables the provider to maximize reimbursement, within appropriate reimbursement policies, or to be paid at all for their services. Selecting the proper code is a complex issue further complicated by the varying coding policies

developed by individual third party payers. Not all codes are reimbursed consistently across third party payers, complicating the ability to obtain payment for services. Using the wrong codes may result in lower reimbursement, denials of submitted claims, and exposure to claims audits and recovery actions from Medicare, Medicaid, and commercial insurers.

Coding has been made more complicated by the implementation of a series of codes known as the Health and Behavioral Assessment codes that were included in the CPT manual and the Medicare Fee Schedule in 2002.^{44,45} These codes are designed to be used by non-physician providers (e.g., advanced practice nurses, psychologists, clinical social workers, and other health care providers) to bill for services provided to patients who are **not** diagnosed with a psychiatric problem, but whose cognitive, emotional, or behavioral functioning affect prevention, treatment, or management of a physical health problem. When using these codes, the assessment, reassessment, or treatment provided by the behavioral health professional is not for the diagnosis or treatment of behavioral illness, but for behavioral, social, or bio-psychosocial factors or issues that may significantly affect the underlying physical illness or injury. Under Medicare, each code requires an ICD-9-CM physical health diagnosis. The advantage of using the Health and Behavioral Assessment codes is that they preclude the inappropriate labeling of a patient as having a behavioral health disorder when the problem may be related to a physical illness.

Although there is much interest in using these codes, important issues are still being sorted out. Some, but not all, private insurers and Medicaid programs will reimburse for the services provided under these codes, although coverage may differ from Medicare.^{44,45} Other insurers limit their use to certain types of behavioral health professionals. It is important for providers, advocates, and policymakers to clarify how these services differ from more traditional behavioral health services. Although these codes appear to benefit integrated practices seeking to develop self-sustaining services, it is important to be very clear about the services being offered. Although these codes address a very specific need, they do not necessarily improve access to service for individuals needing care for depression, anxiety, and other conditions that may not be related to an underlying physical health problem.

Another barrier to the provision of integrated services involves historical limitations on the reimbursement of two services delivered by a practice on the same day.⁴¹ Typically, policies limit reimbursement to a practice to one visit per day unless the second diagnosis is emergent and substantially different from the first diagnosis. Medicare has resolved this issue and allows

for the billing of a medical service and a behavioral health service by a practice on the same day. The Centers for Medicare and Medicaid Services (CMS) have issued a Provider Information Notice clarifying that Federally Qualified Health Centers and Rural Health Clinics may bill for both a medical and a behavioral health services on the same day under both Medicare and Medicaid. Policies regarding same-day billing limits vary across commercial insurers. Providers have raised concerns that using a Health and Behavioral Assessment code on the same day as a traditional medical visit may trigger limitations on same-day billings because both services carry a medical diagnosis rather than a medical diagnosis and a separate behavioral health diagnosis.

Limited reimbursement for telemental health services is an important barrier to integration. Tele-mental health services may boost integration by providing consultative and supervisory support to providers located in remote areas with significant specialty mental health shortages. Telehealth technology may help to maximize the use of the limited supply of specialty mental health providers and limit lost productivity for patient and clinician resulting from travel to and from distant on-site clinical venues. Reimbursement of telemental health services tends to be limited, varies among payers, and does not pay for many infrastructure and technology costs.⁴¹ Relatively few Medicaid programs and third party payers reimburse for telemental health services. Medicare provides limited telemental health coverage.⁴¹

Figure 4: Reimbursement Barriers: General Issues

- No reimbursement for integrative (e.g., collaborative care and team approaches) and preventive services
- Reimbursement rules vary across third party payers
- Cost of credentialing providers across multiple payers
- High administrative costs to cope with complexity
- Primary care and behavioral health providers use different coding and billing classifications
- Confusion over the use of evaluation and management, psychiatric, and health and behavioral assessment and intervention codes by different types of providers
- Restrictions on same-day billing
- Limited reimbursement for telehealth and telemental health services

Reimbursement Barriers: Medicare

One in five persons 65 years of age or older has a diagnosable behavioral health illness, and the prevalence of behavioral illness among older persons is higher for those with a chronic physical health illness (e.g., diabetes, cardiovascular disease). Despite the high prevalence of

behavioral health problems among older primary care patients, behavioral health screening, treatment, and referral of behavioral health problems lags behind those for young persons.⁴⁶ Stigma and co-morbidity of physical and mental health problems (in which symptoms overlap and may mask each other) are major barriers. Another significant barrier is the significant limitation on Medicare reimbursement for behavioral health care (See Figure 5).

Medicare imposes the highest co-payment on outpatient mental health care of any major payer, effectively 50 percent, and also imposes an annual cap and lifetime limits on the number of allowable visits. Medicare limits reimbursement of mid-level behavioral health providers to licensed clinical social workers and doctoral-level psychologists.⁴⁷ The growth of Medicare managed care plans and implementation of Medicare Part D (prescription drug coverage) have increased uncertainty about what services are reimbursable by Medicare, as individual managed care and prescription drug plans may have different levels of coverage. In the case of Medicare Part D, providers must now assume the burden of knowing what plans cover which medications. And manage the pressure from the plans to shift Medicare patients to less expensive medications.

Figure 5. Reimbursement Barriers: Medicare

- High level of co-morbidity of physical and mental health issues among Medicare population
- High co-payments (effectively 50%), visit limits, and lifetime caps on services
- Outpatient MH treatment limitations
- Coverage limited to clinical social workers and doctoral-level psychologists
- Growth of Medicare managed care plans
- Medicare Part D plans
 - Create prescribing issues for providers who need to be familiar with medications covered by individual plans
 - May shift patients to less-expensive drugs

Reimbursement Barriers: Medicaid

Medicaid is the major payer for mental health services to persons with serious mental illness (SMI) who qualify based on a disability, and for the mental health care of low-income persons. As a result, these expenditures have placed a substantial demand on state Medicaid budgets. As states face budgetary pressures from rising health care and other costs, there has been significant pressure to reduce the increase in behavioral health expenditures under Medicaid.⁴⁸ This has resulted in widespread reductions in behavioral health services covered

under Medicaid, particularly for intensive care services for persons with SMI. States are also reluctant to expand services, extend coverage to new populations, or expand the types of clinicians eligible for reimbursement under Medicaid.

In addition to these more recent global pressures on Medicaid budgets, Medicaid behavioral health coverage has historically included significant coverage limitations and low reimbursement rates. Until recently, behavioral health coverage was optional under state Medicaid plans. While nearly all states include behavioral health coverage, significant limitations are common, including restrictions on same-day service billing, limited reimbursement for care and case management, confusion over use of Level II and Level III (also known as local codes) Healthcare Common Procedure Coding System codes (which represent *ad hoc* agreements with particular providers)^a, co-payments for Medicaid beneficiaries, and variations in coverage and eligibility across different practice settings including school-based clinics and hospital-based outpatient services.

Another factor impeding integration involves the individual state regulations and reimbursement policies related to the delivery of services by licensed mental health agencies. Many states have implemented preferential payment policies for licensed mental health agencies. These licensure policies limit the flexibility of agencies to engage in the development of innovative models and, in some cases, provide incentives to provide care in a non-integrated way. In addition, Maine and other states have explored reimbursement changes that would expand the ability of private practices and other provider types to deliver behavioral health

^a Services delivered by health care providers and facilities are billed to Medicare, Medicaid, and other third party carriers using the Healthcare Common Procedure Coding System (HCPS) codes (Smith 2007). These codes are divided into three levels. Level I codes are made up of Current Procedural Terminology (CPT-4) codes devised by the American Medical Association. Level II codes are used to bill Medicare and Medicaid for products, materials, and services not covered in the CPT-4 coding system (e.g., ambulance services, prosthetics, and medical equipment and supplies used outside of a medical office) and by states to bill for mental health and substance abuse screening and treatment services using the series H and T codes. Level II codes in the A through V series are standardized nationally. Codes in the W through Z series vary from state to state. Maine, for example, uses the Z series codes to bill for mental health services. Local codes fall into the category of Level III codes which are developed by state Medicaid agencies and private insurers for use in specific programs and jurisdictions. The Health Insurance and Portability and Accountability Act of 1996 requires the Level II and III codes to be standardized nationally, however, this process is not complete. The difficulty for providers is that the use of the state and local codes vary across provider and facility types which may limit their use by primary care practices.

services but would pay for them by reducing reimbursement to licensed mental health agencies. Not surprisingly, the licensed mental health agencies oppose these changes.

Finally, most states have turned to managed care companies to manage behavioral health services under Medicaid. In the 1990s and early 2000s, these programs included capitated carve-outs. Recently, there has been a shift to managed care plans that employ contracted prior authorization and utilization review, but do not include explicit capitation. Currently, Maine is operating under a prior authorization/utilization review arrangement for behavioral health services provided under the MaineCare program under a contract with APS Healthcare.

One last Medicaid reimbursement barrier involves the limited reimbursement for care and case management services required by Medicaid recipients with complex health and mental health needs. These services are essential to help these individuals access the full range of services they need. The limited reimbursement for this service is a major barrier to providers developing and offering care and case management services.

Figure 6. Reimbursement Barriers: Medicaid

- State fiscal budget crises
- Limited Medicaid reimbursement rates
- Coding issues including the use of local codes
- Complex licensure issues (licensed clinics, hospital-based, etc.)
- Variation in policies across settings and licensure types
- Medicaid managed care practices
- Limited reimbursement for care and case managers

Reimbursement Barriers: Commercial Payers

Many of the reimbursement barriers to integration already described apply to commercial payers as well. These barriers involve the variation in use of codes, payment limitations to one service per day, and the high use of managed behavioral health vendors to manage the delivery of services. The particular challenge presented by commercial payers is their variation in policies and procedures and their internal variation in coverage across policies and contracts. Most providers deal with a large number of different commercial payers as well as with differing coverage provision across the employer contracts offered by individual carriers. This presents a growing administrative difficulty for practices and high levels of administrative costs as providers are required comply with these demands. Small practices have limited ability to

negotiate with large commercial carriers to address these concerns. They also incur substantial administrative costs to enroll their providers in a large number of commercial plans, many of which require their own unique forms and documentation. Many managed behavioral health care programs perpetuate the separation of behavioral health and physical health by carving out responsibility for the management and reimbursement of behavioral health from physical health services. This adds administrative complexity, and limits the ability of primary care practices to enroll providers in behavioral health panels.

Figure 7. Reimbursement Barriers: Commercial Payers

- Variation in use of codes across third party payers
- Dependence on MBHOs and carve-out arrangements to manage behavioral health services
- Complexity of dealing with policies and procedures that vary across payers
- Variation in coverage levels across employers and contracts
- Limited ability for smaller providers to negotiate with commercial payers
- Complexity and cost of credentialing providers with multiple commercial payers
- Carve-out managed care plans perpetuate the separation of physical and behavioral health services by excluding primary care providers from behavioral health panels

Reimbursement Barriers: Managed Care

The development and growth of managed care in both general and behavioral health care over the past two decades have transformed the environment in which all providers practice and pose specific challenges for providing integrated care.⁴⁹ At the same time that primary care providers have assumed an important role in diagnosing, treating, and referring behavioral health problems, two-thirds of Americans with health insurance have their behavioral health benefits managed by behavioral health plans that effectively carve out, or separate, financing and organization of these services.⁴⁹

Common to all forms of managed behavioral health care is the need to review/approve entry to and utilization of covered behavioral health services (“prior authorization”), as well as to control reimbursement levels. The separation of behavioral and physical health services through carve-outs creates a barrier to the integration of services by adding another, complex, administrative layer. A common feature of carve-out programs are provider panels and networks that accept the managed care plan’s reimbursement schedule and its process for authorization and utilization review. Applying to and maintaining standing in multiple panels may be

burdensome, as is obtaining authorization to provide services to an enrollee and meeting ongoing utilization review requirements. Collectively, these issues provide a disincentive to treat behavioral health problems in physical health settings.

A final managed care reimbursement barrier is the complexity of reimbursement rules and practices within and across managed care organizations. The cost and administrative burden of tracking and complying with differing contracting, credentialing, prior-authorization and utilization review, billing, and reimbursement policies are substantial for providers.

Figure 8. Reimbursement Barriers: Managed Care

- Separation of behavioral and physical health services through carve-out programs
- Administrative complexity related to managed care practices (e.g., obtaining prior authorizations, utilization review, etc.)
- Provider panels/networks composition
- Disincentive to identify and treat behavioral health problems in physical health settings
- Complex reimbursement rules and practices

Practice and Cultural Barriers

Primary care and behavioral health clinicians have very different practice styles, which creates an ongoing challenge to integrating care (See Figure 9). These practice and cultural barriers persist, in part because of differences in medical training, day-to-day responsibility for care of patients, and the way practices are organized and reimbursed for this care. The U.S. Air Force Medical Operations Agency summarized the cultural difference between primary care and specialty mental health by describing primary care as largely an action environment in which patients expect to be advised what to do.⁵⁰ In contrast, specialty mental health was described as largely a reflective environment characterized by a focus on therapist/patient fit, rapport building, and the verbal analysis of problems and potential solutions.

At a very basic level, primary care and behavioral health clinicians use different systems and conventions to code procedures, which reinforce different practice and diagnostic styles. Psychiatric diagnostic categories are often unsuitable for patients in a general medical practice as they assume that a patient has passed through a series of diagnostic screenings before arriving at the psychiatric clinic.⁵¹ Many patients seen in a general practice simply do not fit into the mental health nomenclature; mixed states of depression and anxiety are common.⁵² In addition, many primary care physicians are not conversant with the multi-axial evaluation system inherent in the

DSM-IV. Asking them to provide “Axis I through V” diagnoses on a patient referral form may not be appropriate or necessary. Many primary care providers are unlikely to diagnose with the same level of specificity as specialty behavioral health providers and are more likely to diagnose symptoms affecting the patient’s daily functioning rather than render specific behavioral diagnoses.⁴³ Agreeing to a common language and the type of required information (e.g., a description of the problems affecting the patient’s functioning rather than a formal diagnosis) may simplify the transfer of patients between primary care and behavioral health.

Primary care providers and behavioral health clinicians have very different work (e.g., practice and productivity) styles. Primary care providers typically see four to five patients per hour and acknowledge the need for walk-in appointments for patients with emergent issues. Behavioral health providers typically see patients in 20-30 minute or 45-50 minute appointments and are less likely to alter their schedules for walk-in patients. The typical primary care practice is more fluid based on patient needs. It is common for primary care providers to be interrupted to take calls from other physicians or answer questions while with patients; behavioral health providers are typically less comfortable in doing so. Behavioral health providers in primary care settings may also be asked to see patients in shorter time increments and for fewer sessions than they would in a specialty behavioral health setting. It may take behavioral health clinicians some time to adjust to the faster pace in primary care and general medical settings. Some may not be able to make the transition as few clinicians are trained to practice in these settings.

There is an ongoing tension between direct service (billable) activities and the integrative (non-billable) activities in integrated practices. One of the major advantages cited by primary care practitioners to an integrated model is the ability to initiate a “warm hand-off” of a patient from the physician to a behavioral health clinician with the goal being to engage the patient and maximize the physician’s productivity. They also describe the importance of access to “hallway behavioral health consults” and care coordination activities provided by behavioral health staff. While important to the practice, these activities are typically not reimbursable and may impair the behavioral health clinician’s production of billable services. As mentioned above, some behavioral health clinicians may be uncomfortable with these unscheduled, non-reimbursable services.

The provision of behavioral health services in a primary care setting requires a different model of intervention that generally used in specialty mental health settings.²⁶ The practice culture of primary care requires:

- Consultative behavioral interventions;
- Fast pace of brief interactions;
- High volumes of persons seen (an average PCP sees 130 patients per week);
- Immediate access, visibility, and availability, where interruptions are acceptable;
- New vocabulary; and
- Different documentation and tracking systems.

Documentation in the primary care setting also requires a different set of skills for the traditionally trained behavioral health specialist to learn. Documentation requirements for specialty behavioral health settings are generally more extensive in response to public funding requirements and the greater range of services provided in these settings.²⁶ In comparison, the documentation in primary care settings tends towards brief, immediate, problem-focused documentation.

In its Primary Behavioral Health Care Services Practice Manual⁵⁰, the Air Force Medical Operations Agency advised behavioral health providers on how to establish practices in primary care practice settings. This advice nicely illustrates the practice and cultural differences between the two styles of practice:

- Learn to address medication issues;
- Get your foot in the door to demonstrate the long-term value of the service;
- Act like a guest in order to fit into the flow of the practice;
- Be flexible in terms of how and when you see patients and work with other providers;
- See all comers and give feedback later on the appropriateness of the referral;
- Eliminate guesswork by helping the primary care team to understand how and when to refer;
- Get used to the lack of privacy;
- “Schmooze” the staff (clinical and administrative) to become a member of the team;
- Be responsive to the doctors and accommodate their schedules;
- Be proactive, but not pushy, to sell your services;
- Relentlessly follow-up as primary care providers are very busy (take advantage of the rhythm of their practice schedules);
- Mimic the work pace of the primary care providers;
- Be available at all times; and
- Be a visitor and a peer to become a trusted member of the team.

In many ways, it is contingent upon the behavioral health staff to learn to become a member of the primary care team. This takes a certain adaptive skill that not all clinicians may

have. When recruiting behavioral health clinicians to practice in primary care settings, primary care providers must consider the personality characteristics of the candidates as well as their ability to understand and adapt to this different practice style. Failure to do so may lead to frustration and dissatisfaction on the part of the clinicians and the practices and perpetuate these cultural barriers. At the same time, primary care clinicians must be aware of the different nature of behavioral health practice to avoid unnecessary conflict and develop realistic expectations.

With the growing emphasis on the integration of care both within practices as well as across practices and provider organizations, one increasingly important and substantial barrier is the lack of information technology integration within and across organizations. An effectively integrated information system supports the integration of behavioral and physical health services by:

- Tracking patients and their appointments, follow-up sessions, referrals, test results, and assessments;
- Facilitates communication between patients, primary care providers, clinicians, specialists, and care managers;
- Helps patients and clinicians determine treatment preferences;
- Assist patients to establish realistic self-management goals;
- Connects patients and families to community resources; and tracks both clinical and financial outcomes.⁵³

Effective integration of services depends on the ability of providers to share information and communicate effectively. This becomes increasingly important patients are being treated by multiple providers and very difficult to do when relying on paper records or when information systems cannot “talk” to one another. A national study of integration in leading integrated delivery networks found that information systems continue to be inadequate in the critical function of physician and clinical information.⁵⁴ Similarly, Khoubati, Themistocleous, and Irani reported that the cost of health care integration is high and the level of interoperability between information systems remains low.⁵⁵

Although focused on the information management problems that plagued Kaiser Permanente’s San Francisco kidney transplant program, a Baselinemag.com article by Kim Nash⁵⁶ is relevant to the discussion of the integration of behavioral and physical health services.

In that article, the author described a number of information management problems that contributed to the closure of the facility. These problems included:

- A lack of specific procedures to transfer data on the initial 1,500 treated by the Center after its opening in 2004;
- A reliance on paper patient records that delayed the discovery and collection of missing clinical data points or patient information;
- No master database of patient names to be used to verify that full medical records have been received on all patients in the program;
- No systematic system to track and analyze patient complaints; and
- Inadequate systems to track and collect critical patient information.

One of the consequences of this inadequate approach to information technology was that patients were not registered with the national transplant list in a timely fashion and that registrations were delayed due to missing or incorrect clinical and patient information such as missing test results or erroneous social security information. Although an extreme example of the problems caused by the failure to integrate information technology, these issues are not uncommon within and across health systems nationally and in Maine.

Figure 9. Practice and Cultural Differences between PCP and MH Providers

- Action orientation of primary care verses reflective orientation of mental health
- Psychiatric diagnostic categories are often unsuitable for use in general medical settings
- Specialty behavioral health providers generally reach diagnoses based on detailed psychological testing and evaluation
- PCPs typically diagnose symptoms or problems affecting daily functioning
- Fundamental differences in working styles
- 15 minute PCP visit vs. 50 minute therapy session
- Tensions between direct care services (reimbursable) and integrative (non-reimbursable) services
- Behavioral health providers may be uncomfortable with the unscheduled nature of these integrative activities desired by primary care practices
- Differing documentation requirements
- Specialty behavioral health providers must become a member of the primary care team
- Lack of information technology integration within and between practices and provider organizations

Patient-Level Barriers

Relatively little research focuses on patient-level barriers to integration. However, a number of key patient-level barriers to integration have been identified, if not fully studied, including access to care, payment issues, staffing shortages, and public attitudes towards persons receiving behavioral health services resulting in stigma that prevents persons from using these services. Issues in accessing care arise from the limited supply of behavioral health services and shortages of specialty behavioral health providers. Payment issues include low reimbursement levels, high deductibles and co-payments, limits on services, and a complex set of service authorization and utilization review requirements to receive and continue services. Despite improved public understanding of mental illness, stigma remains a barrier to persons accessing care, particularly when stigma originating from others is internalized and results in self-stigma.⁵⁷

As part of its Maine Integrated Health Integration Initiative, MeHAF, with the assistance of John Snow, Inc. surveyed Maine people about their perspectives on health care integration.³ This report corroborated the patient-level barriers to the use of integrated services listed in Figure 10. Many consumers report that they prefer to receive behavioral health services in a primary care setting in that they find the receipt of services in those settings to be less “stigmatizing.” Consumers have low expectations for the integration of care and they are unsure of the patient’s role in maintaining and coordinating health care.³ On a positive note, behavioral health patients report that they are more likely to have integrated care than other patients; that non-medical resources are an important part of the health care system; and that a consistent relationship with a primary care provider and co-location of primary care and behavioral health services make integrated care more likely. These perspectives suggest that we need to continue to incorporate consumer perspective in the development of integrated services to ensure services best meet their needs.

Figure 10. Patient-Level Barriers

- Poor access to behavioral health services
- Limitations on coverage and reimbursement for third party payers
- Impact of high-deductibles and co-pays on utilization of services
- Complexity of authorization and utilization review process
- Stigma
- Lack of understanding of the need for integration of services

State and Canadian Initiatives Supporting Integration

We identified a number of states that have undertaken initiatives to encourage the integration of behavioral and physical health services. These initiatives vary in the role the state plays. States may provide related education and convene/facilitate discussions of the issues related to integration among key stakeholders and providers. States may also facilitate and fund the development of demonstration projects to integrate behavioral health and physical health services. Finally, states may make specific policy and reimbursement changes to support the integration of services. States may undertake one or more of these roles as they gain comfort and familiarity with the issues related to integration.

There are both opportunities and challenges for states seeking to promote integration. On one hand, state government is in an excellent strategic position to promote integration, since it oversees the specialty mental health and substance abuse service systems, controls the state share of Medicaid funding, and is responsible for professional regulation (licensure and certification). State regulations and policies may be changed and used to influence important practice-level venues including school-based services, Federally Qualified Health Centers, Rural Health Clinics, private practices, hospital-based practices, and mental health agencies. On the other hand, it may be difficult for states to exercise this authority fully, since each public system tends to pursue its specialized role and seeks to serve its traditional client/patient populations. States may find it difficult to change the way that “business is done” without committing new resources to the task. The current fiscal problems that most states face make committing new resources difficult. Below, we review a select number of key states with initiatives relevant to Maine.

Minnesota

Minnesota has systematically worked to transform its behavioral health system since the early part of this decade. Taking up the President’s New Freedom Commission’s call to reform fragmented mental health service systems, Minnesota targeted improving access to and the quality of care to adults with serious mental illness and to children with serious emotional disorders. In 2003, The Minnesota Council of Health Plans and the Minnesota Department of Human Services created the Minnesota Mental Health Action Group (MMHAG) to develop and implement a plan to transform the state’s mental health system. The MMHAG included health professionals, mental health centers, medical clinics, health plans, hospitals, schools, county and

state agencies, and consumers and advocates. Major problems identified were provider shortages, stigma, lack of equitable services statewide, insufficient and dysfunctional financing, payments connected to programs but not people, cost shifting, limited accountability, complex and fragmented systems, and lack of coordination between public and private systems. The MMHAG recommended developing a fiscal framework that included public and private funding at sufficient levels to support needed changes; developing public and private partnerships; coordination of care and services; enhanced quality of care; earlier recognition of and intervention in problems; and developing workforce solutions to increase the supply of mental health professionals. The MMHAG initially focused on steps that did not require legislative action, so that the initiative would not bog down, and then sought legislative action when greater consensus had been reached. Guiding principles were adopted to help develop the plan. A 65-member mental health caucus of state legislators was created to help pass legislation to reform Minnesota's mental health system.

In 2005, Minnesota established reimbursement under Medicaid for telemental health services to support access of primary care providers to consultations with a psychiatrist and to connect patients with behavioral health specialists using telehealth equipment located in a clinic or hospital. By 2006, two priority areas had emerged: 1) creating a funding model that is consistent and easily accessible across the state; and 2) addressing accountability and quality issues.

In 2007, the work of the MMHAG was taken up and advanced under the "Governor's Mental Health Initiative",⁵⁸ which included three key components:

- Adoption of a comprehensive mental health benefit for proven treatment across all publicly funded health care programs;
- Integration of mental health and physical health care and the effective coordination of health care with social services and education; and
- Targeting significant investments to support an effective mental health infrastructure.

The primary strategies for integration are to integrate payment for mental and physical health services and to develop integrated service networks that would receive enhanced reimbursement for providing integrated care under a "preferred integrated network" status. Based on this effort, the *DIAMOND Initiative* (Depression Improvement Across Minnesota Offering a New Direction) was implemented in Spring 2008, in which ten primary care clinics across the

state screen (using the PHQ-9) adult primary care patients for depression under a care management model. The integrative function provided by the care manager is paid for by a periodic fee from the health plan to the primary care medical groups. Thus, support of the care manager is not time limited as it was under earlier demonstrations. Specific payment details are made between each health plan and medical group.⁵⁹ The care manager model may be sustainable under the DIAMOND Initiative, since reimbursement is built into the payment structure. However, it remains to be seen what volume and intensity of care management can be supported over time.

Minnesota has also announced plans to pay primary care physicians a bonus for providing quality depression care under a pilot program supported by the Buyers Health Care Action Group, a coalition of Minnesota's 40 largest employers. This pilot will be the first time a depression component is included under the Bridges to Excellence Initiative, a national effort to reward clinicians for providing effective, patient-centered care. The depression pilot resembles ongoing efforts in Minnesota to reward optimal care for diabetes and for cardio-vascular disease. The pilot is scheduled to be operational by summer 2009.⁶⁰ The State has played an active role in facilitating interest and collaboration in this effort and in seeking funding to support it.

Minnesota stands out as a state that has taken a deliberative and strategic path to integrating primary care and behavioral health services. It started with a convener/facilitator role, added regulatory and reimbursement changes, and supported demonstration projects. It has sought to develop integration within the context of mental health transformation and general health improvement and has developed viable public-private partnerships. It has kept sight of the importance of engaging and empowering health plans, providers, and consumers.

North Carolina

North Carolina has established the Community Care of North Carolina Program (CCNC), a statewide initiative of 15 provider networks with 1,000 providers serving 600,000 Medicaid enrollees. CCNC was created to better manage and coordinate care and provide higher-quality services to the Medicaid population. From 2005 through 2007, four pilot sites across eight counties implemented the program and provided mental health care by co-locating mental health providers at each primary care site. Using the Four Quadrant Model as a guide, there was a

concerted effort to screen and triage patients by using age-appropriate screening tools.^{61b} Primary care clinicians received incentives to screen for depression, anxiety, attention deficit disorder, and bipolar disorder. Clinical pathways were to be developed to support chronic care management of identified problems. The results from these pilots are expected to inform efforts to better meet the mental health needs of North Carolina's Medicaid population.

Oregon

Oregon has supported pilot projects focused on the co-location of mental health specialists in FQHCs. The model used to achieve co-location involves a mix of employed and contracted specialty providers. Core FQHC services using employed staff are covered under the Oregon Health Plan (Oregon's Medicaid program), with these costs built into the FQHC's cost reports. Contracted mental health services in FQHCs are covered under the Oregon Health Plan's mental health carve-out. Oregon has been flexible in working with providers to ensure reimbursement for integrated services.

Washington

Washington has supported the integration of primary, behavioral health, and long-term care services within its county-based adult behavioral health system in Snohomish County. This demonstration includes 5,000 enrollees. The State is establishing another demonstration covering 13,000 enrollees in eastern Washington. Washington has blended funding from physical health, behavioral health, and long-term care to support these demonstrations. Early results have shown that the level integration of the services has been less than expected at the practice level.⁶² The lesson learned from the Washington demonstration is that the blending of funding does not automatically lead to the desired levels of functional integration at the practice level.

Vermont

The Vermont Integrated Services Initiative seeks to develop a coordinated system of care for people with co-occurring mental health, substance abuse, and primary care needs. The State's vision is to "build a client-centered, recovery-oriented system of care" organized at every level to

^b For children and their parents, the Ages and Stages Questionnaire, Parents Evaluation of Developmental Status, and Pediatric Symptom Checklist were used. The PHQ-9 was used for adults.

serve people and families with complex needs. Collaborating partners, including the Bi-State Primary Care Association, have been recruited and Vermont has committed state funds to support the initiative. The initiative includes primary care settings and has adopted the chronic care model with a regional approach. As part of this process, Vermont is working to modify the Dual Diagnosis Capability in Addiction Treatment standards for primary health care settings. They are also supporting provider participation in the Network for the Improvement of Addiction Treatment.

Connecticut

Connecticut has developed a reimbursement model for mental health services that may be applicable to integrated services. This approach creates a category of specially designated Connecticut-based mental health and substance abuse clinics that serve adults and/or children.^{63,64} These clinics—named Enhanced Care Clinics (ECCs)—provide routine outpatient services including individual therapy, group therapy, family therapy, medication management, and other special services for Connecticut Behavioral Health Plan members. ECCs receive enhanced reimbursement (on average 25% higher than the normal Connecticut Medicaid fee schedule) in exchange for agreeing to meet special requirements concerning access and the ability to see clients in a timely fashion depending on their level of urgency. Enhanced capabilities include extending coverage outside of normal business hours and seeing clients with:

- Emergent needs within two hours;
- Urgent needs within two days; and
- Routine needs within two weeks.

In the future, ECCs will be required to meet other special requirements and standards, including coordination of care with primary care physicians; member services and support; quality of care; and cultural competence. To become designated as an ECC, clinics must submit an application documenting their ability and willingness to meet the established standards. The ECC program provides a model that may have applicability to the concept of pay-for-performance to encourage the integration of services.

Canadian Collaborative Mental Health Initiative

Although not a state-based model of integration, the Canadian Collaborative Mental Health Initiative (CCMHI) is relevant to efforts to support and enhance integration of services in Maine. Funded by Canada's Primary Health Care Transition Fund, the initiative seeks to make collaborative mental health work in Canada. CCMHI assembled a 21-member Steering Committee of consumers, families, PCPs, nurses, OTs, psychiatrists, psychologists, social workers, and pharmacists. Products included a paper documenting the state of collaborative mental health in Canada, a charter expressing the willingness of the Steering Committee and the 12 sponsoring organizations to continue to work together, and a set of 12 targeted tools covering issues related to integration for different populations including indigenous Canadians, rural residents, children, and the elderly.

The Canadian Collaborative Mental Health Charter was crafted to keep the momentum of collaborative mental health care going after the initiative formally ended in May 2006 and may be the most enduring benefit of the initiative. The ideas behind collaborative mental health care were defined in a set of principles, and the commitments of the partner organizations to follow through on those principles were confirmed. Significant outcomes included the development of new alliances, practical tools, and a framework to carry on the work and raise the profile of collaborative care among the public and the people who fund and plan services. The key message of the Charter, and of the entire two-year project, is that the work is really just getting started.

Models of Integrated Care: From Structure to Function

We undertook an extensive review of the various models of integration that have been tested and implemented across the country. Models for integrating care have played a prominent role as efforts to support integration have developed over time. Primarily, these models have taken the form of vertical integration of behavioral health services into primary care practices and have evolved over time from co-location demonstrations (in which behavioral health providers were placed in primary care settings).⁶⁵ Many early demonstration programs were conducted in rural areas in response to the lack of availability of mental health specialists. Over time, they have evolved to more formal integration models.

Based on a 1994 national survey of rural primary care sites providing mental health care, the Maine Rural Health Research Center identified four approaches, or models, used to integrate

care^{66,65}: *diversification* (providing on-site staff directly with a center's own mental health staff; *linkage/co-location* (providing mental health care on-site by a non-center staff); *referral* (mental health care provided off-site by non-center staff under a formal agreement; and *enhancement* (training primary care practitioners to provide mental health care on-site). In a more recent study of rural community health centers, Lambert and Gale⁴² found that more rural community health centers provided mental health care than a decade earlier and that they were more likely to do so using their own staff. Referral was still an important option for patients with complex problems.

As discussed earlier, the Four Quadrant Model was first introduced in 1998, depicting logical treatment venues for persons with different levels of severity of mental health and substance abuse problems. This model was refined in 2003 to classify the level of integration and clinician competencies needed to treat persons with different (low, high) behavioral health (BH) and physical health (PH) needs.²⁶ The Four Quadrant Model is widely cited within the literature and by policymakers.

Depictions of integration models have evolved from the question of where care is provided (general health care or specialty mental health) to how care is provided. Approaches such as the Chronic Care Model, anchored by a care manager, and Kirk Stroschal's model in which mid-level behavioral health specialists help engage and treat primary care patients have gained significant attention.⁶⁷ Similarly, the approaches to integrating care by the Intermountain Health Group in Utah⁶⁸ and integration experts such as Alexander Blount⁶⁹ have gained wide attention.

Stepping back from the details of each of these "models," it is apparent that they depict somewhat different aspects of integrating physical and behavioral health care. These depictions are not "models" of exactly the same thing. Earlier models focused on location of care while later models have focused on what mid-level behavioral health providers may do and how they work with physical health care providers. One assumption running through the integration literature is that more comprehensively integrated models are preferable to less integrated models. Rarely do these models acknowledge the resources necessary to implement these models in different practice settings and how resource limitations may constrain the use of these models in private and rural practice settings. Much of the literature is focused on the development of integrated behavioral health services in FQHCs without explicitly acknowledging the advantages (e.g., preferential reimbursement under Medicare and Medicaid, 330 grant funds to support care

to low-income and uninsured patients, and access to expansion grant funds through the Bureau of Primary Health Care) these entities have in developing integrated services.

Similarly, the literature does not acknowledge that ostensibly lesser forms of integration (i.e., those that do not meet the standard of a fully integrated model) may be appropriate and functional in settings where the complexity of patient need and availability of resources are lower and that the choice of model is most likely driven by available resources and the practice’s competitive environment. Finally, these models should be viewed as evolutionary in that practices may choose a relatively simple model of integration such as co-location of services and evolve to more integrated models with time and experience.

Doherty, McDaniel, and Baird⁷⁰ captured these issues in their five-level classification of integration (see Figure 11). Practices interested in integrating behavioral health and physical health services should carefully consider their market context, available resources, and the needs of their patient populations (as described in Figure 11) before selecting a model of integration.

Figure 11. Levels of Integration (Doherty, McDaniel, and Baird)

| |
|--|
| <p>Level 1: Separate systems and facilities</p> <ul style="list-style-type: none"> • Minimal communication • Minimal collaboration • Adequate for simple problems |
| <p>Level 2: Basic collaboration from a distance</p> <ul style="list-style-type: none"> • Separate systems and facilities • Periodic communication, no awareness of “cultures” • Adequate for moderate problems |
| <p>Level 3: Basic collaboration on site</p> <ul style="list-style-type: none"> • Shared facility but separate systems • Regular communication • Appreciation of roles but with a power imbalance • Adequate for moderate problems requiring some treatment coordination |
| <p>Level 4: Close collaboration in a partially integrated system</p> <ul style="list-style-type: none"> • Shared site and some shared systems • Regular communication with coordinated treatment plans and models • Some tensions systemically and with role influence • Adequate for more complex problems or complicated management |
| <p>Level 5: Fully integrated system</p> |

- Shared site and systems
- Regular face to face communication
- Shared treatment plans and models
- In-depth understanding of roles and culture
- Adequate for difficult, complex, and challenging problems

Earlier models of integration, such as the Four Quadrant Model, were useful in conceptualizing the need and rationale for integrating care, and models distinguishing location of care (e.g., co-location, referral, on-site with own staff) were useful for showing where care could be provided. As integration efforts continue to develop and grow, we believe the emphasis should shift from the structure of integration (location) to how key functional activities of integration are organized and performed.

Figure 12 presents key functional elements of integration performed under 11 well-known approaches and practice sites. These functions include outreach, assessment processes (to screen patients and evaluate patients), treatment in the primary care setting, consultation with the primary care practitioner, care management of patient, primary care practice management of patients with mental health problems (risk stratification, psychiatric consultations, referral to specialty care, and patient education and shared decision-making.

Figure 12. Functional Elements of Integration

| | | Functional Elements of Integrated Models | | | | | | | | | | | | | | | | | | | | | |
|---|---|--|-------------------------|-------------------------|--------------------------------|-----------------|---------------------------------|-----------------|--|--------------------|--|---------------------|------------------------|-----------------|---------------------|---------------------|--------------------------|----------------------------|--------------------|----------|-------------------|------------------------|------------------|
| | | Initial Assessment | Standardized Assessment | Standardized Assessment | BH/MHP on-site in Primary Care | "Warm Hand-off" | Brief Intervention and Duration | Group Treatment | Relapse Prevention/Periodic Maintenance TX | Dual Interventions | Integrated Treatment with BH/MHP and PCP | Consultation to PCP | Curb-side Consultation | Care Management | Telephone follow-up | Risk Stratification | Psychiatric Consultation | Referral to Specialty Care | Early Intervention | Outreach | Patient Education | Shared Decision-making | Combined Records |
| Depression Care Process Model | x | | | | | | | | | | | | | | | | | | | | | | |
| Intermountain Health Care | x | x | | x | x | x | | | | x | x | x | x | x | x | x | x | | | | x | | x |
| Mountainview** | x | | | x | x | x | x | x | x | x | x | x | x | x | x | | | | | | x | | x |
| Strosahl** Behavioral Health Care | x | | | x | x | x | x | | | x | x | | | x | | x | | | | | x | | x |
| MHPC - VA | | | | | | | | | | | | | | | | | | | x | | | | |
| Air Force | x | | | | | x | | | | x | | | | | | | | | | x | | x | |
| Care Integra | | | | | | x | | | | x | | | x | x | | x | | | | | x | | |
| Four Quadrant | x | | | | | | | | | x | | | | x | | x | | | | | | | |
| Dept of Family Medicine & Community Health/U. MA. | | | | x | x | x | x | x | x | x | x | | | x | x | x | x | x | | | x | | x |
| Cherokee Health Systems | | | | x | x | | x | | | x | | | | x | | x | x | x | | | x | | x |
| DIAMOND Depression Care Mgt Program - ICSI | | | | x | | | | | | | | | x | x | | x | | | | | x | | |

None of the 11 programs/approaches listed in Figure 12 performs all these functions, nor should they be expected to. No model or approach is right for all settings. Structural integration (location, staffing) is driven by resource availability, practice settings, and market context. The key focus should be on functional integration (what is done clinically and administratively in support of providing integrated health services) with the goal of best meeting the needs of patients served by a practice in a particular area. Consideration of the functional elements of integration will help practices to select an appropriate model based on the needs of their practice and patients.

Emerging Issues Related to Integration

Two emerging issues have the potential to alter the discussion related to the integration of behavioral and physical health services. The first involves the recognition that persons with severe mental illness do not receive adequate primary care and physical health services and suffer from higher rates of chronic illness and avoidable hospitalizations.⁷¹ They tend to suffer greater levels of physical disability and higher mortality rates at younger ages. This issue

suggests the need to develop models and tools to integrate primary care and physical health services into behavioral health settings.

The second emerging issue involves the growing interest in the concept of the medical home which has captured the attention of policymakers and other stakeholders as a potential foundation for healthcare reform.⁷² The medical home concept is a mix of older and recent approaches to health care designed to address the fragmentation in and gaps of our health care system.⁷²

The American Academy of Pediatrics (AAP) introduced the term “medical home” in 1967 and within a decade it was adopted as AAP policy.⁷³ Initially, it was used to describe a single source of medical information about a patient but gradually was expanded to include a partnership with families to provide primary health care that is accessible, family-centered, coordinated, comprehensive, continuous, compassionate, and culturally effective—themes that have been echoed by the Institute of Medicine in its *Quality Chasm* series. In 2002, AAP added an operational definition that lists 37 specific activities that should occur within a medical home. In 1978, the World Health Organization met at Alma Ata and laid down some of the basic tenets of the medical home and the important role of primary care in it. The Alma Ata declaration specifically states that primary care “is the key” to attaining “adequate health,” which they further defined as “a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity,” adding that adequate health “is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal.”

The American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association have agreed on seven core features of the medical home:

- Personal physician;
- Physician-directed medical practice;
- Whole person orientation;
- Care is coordinated and/or integrated;
- Quality and safety;
- Enhanced access; and
- Payment reform.

Admittedly, this model is an aspiration that is not currently found in most clinical practices and is not available to most people in the U.S.⁷³ In reality, the resources necessary to implement the medical home model may exclude many small primary care practices.

Despite agreement by these key primary care stakeholders, no one single prominent definition of the medical home has emerged. Rather, each group promoting the medical home has its own variation of what they mean by it. At the risk of oversimplifying the discussion, the medical home appears to be a return to the values typically espoused by primary care physicians and their professional organizations overlaid with care or case management framework and incorporating the Institute of Medicine's language of "patient-centeredness."

Key advocates for the medical home include the previously mentioned key primary care medical societies, the National Committee for Quality Assurance (NCQA), large employers, and third party carriers. In collaboration with primary care medical societies, NCQA has developed criteria that practices must meet to be recognized as a medical home under the Physician Practice Connections/Patient Centered Medical Home Program.⁷⁴

As evidence of the interest in the medical home concept, Backer reports that 77 bills containing medical home language had been introduced in 20 states during 2007. A substantial number of medical home demonstration/pilot programs are under development including a Maine demonstration that is being jointly developed by Quality Counts, the Maine Quality Forum, the Maine Health Management Coalition, Maine MaineCare, Cigna, Anthem BlueCross BlueShield of Maine, and Harvard Pilgrim Healthcare.⁷⁵

Advocates for the medical home suggest that the adoption of the model has the potential to advance integration of behavioral health and physical health services, primarily due to the fourth of the seven core concepts, that care will be coordinated and/or integrated. Some in particular, have argued that there "must be room for mental health in the medical home" and that mental health should be included if the medical home is to succeed in improving care and reducing costs.⁷⁶ As written, most descriptions of the medical home do not include specific provisions to integrate behavioral health services and instead focus on the concept of care management and coordination. In reviewing the literature, it becomes clear that many advocates for the medical home do not distinguish between the concepts of integration and care management. In these demonstrations, the payment reform necessary to support the medical

home model typically focuses on the former concept of care management/coordination rather than the latter concept of integration.

In reality, efforts to integrate behavioral and physical health services must proceed separately from efforts to implement the concept of the medical home as they are two separate activities. As efforts to implement the medical home concept evolve in Maine, it will be important to clarify goals and expectations for these demonstrations to avoid the mistaken belief that the medical home will automatically advance the concept of integration in Maine.

Barriers to Integration: The View from Maine

As part of the environmental scan, we conducted a focus group with administrators, staff, and board members from FQHCs at a monthly meeting of the board of the Maine Primary Care Association, interviewed 20 grantees from the first round of Health Integration Grants funded by MeHAF, and reviewed past efforts to identify barriers to integration in Maine including provider surveys conducted by the Maine Center for Public Health in 2003 and the survey of consumers commissioned by MeHAF.

Federally Qualified Health Centers Focus Group

We conducted a focus group of FQHC administrators, staff, and board members prior to a monthly board meeting of the Maine Primary Care Association using semi-structured interview protocols to identify the barriers to integration. The focus group identified the following broad categories:

- Staffing and credentialing barriers;
- Reimbursement barriers;
- Community barriers;
- Facility issues;
- Training issues; and
- Challenges related to the selection and implementation of the appropriate integration model.

Staffing and credentialing barriers identified by the focus group participants were consistent with those identified by our literature review. Small health centers have difficulty supporting full-time behavioral health staff and often employ part-time staff. The participants felt that integration works best with regular access to full-time behavioral health staff. The participants identified administrative burdens related to differing credentialing standards across

third party payers and variations in the types of behavioral health providers covered by payer type. They described barriers created by the scarcity of specialty behavioral health providers, particularly child and pediatric specialists, which limit access to services and the ability to refer complex patients that cannot be appropriately cared for in primary care settings. They also identified a shortage of advanced practice nurses with prescriptive rights. Finally, they mentioned the challenge of getting physicians to participate in meetings on behavioral health care due to the demands of the physicians' schedules.

Reimbursement barriers include Medicaid limits on the number of daily visits allowed (one medical and one mental health visit are allowed per day). They also identified high outpatient co-payments under Medicare (effectively 50%) as a major barrier to the use of integrated behavioral health services by these beneficiaries. They noted that reimbursement policies across payers and a provider's legally defined scope of practice may not always be in alignment. They further noted that Medicare's health and behavioral assessment codes are considered medical services since they use a medical diagnosis related to a patient's physical health issues (rather than a mental health diagnosis). As a result, they worried that they may not be reimbursed if a health and behavioral health service was rendered on the same day as another medical service. Finally, they noted that licensed mental health agencies are paid at a higher rate than FQHCs, making it more difficult for FQHCs to sustain integrated services.

The participants identified stigma as an ongoing community-level issue, even in primary care settings. They felt that stigma keeps residents from accessing behavioral health services, even if delivered in primary care settings.

Facility issues were a significant barrier to the development and delivery of integrated services, primarily due to the fact that appropriate space is hard to find and may need re-configuring. In particular, participants noted that behavioral health providers should be located in space adjoining the primary care exam rooms to facilitate access and interaction with primary care providers. The cost of re-configuring existing clinic buildings to make these changes can be expensive. They suggested that placing behavioral health providers in basements or remote offices is not ideal. Finally, they noted that behavioral health patients need to use the same entrances and common areas (e.g., reception and waiting areas) as other patients to reduce stigma. They did highlight the need to preserve confidentiality and anonymity when sharing space and waiting areas.

An additional barrier identified by focus group participants involved the training needs of both clinical and administrative staff. Participants noted that primary care providers varied in their comfort and familiarity with behavioral health issues and that training was necessary to bring them up to speed. They also felt that all staff may need assistance in dealing with behavioral health issues. On the opposite side of the integration equation, they also felt that behavioral health staff needed support in understanding how to work in a primary care setting. Administrative staff needed assistance in understanding the different diagnostic coding systems for behavioral health (DSM-IV) and physical health services (ICD-9-CM) and the challenges of procedural coding for behavioral health services. Clinical staff also need assistance and support in understanding and selecting appropriate procedure codes. They also acknowledge the administrative burden imposed on practices undertaking the delivery of integrated care.

The final barrier to integration identified by focus group participants involved the assistance needed by FQHCs in determining and implementing the appropriate integrative model. This advice may be difficult to find. Finally, they noted that many began their first integrated programs by contracting with part-time outside staff to deliver behavioral health services and that it was more difficult to have contracted staff serve as members of an integrated team (e.g., consulting with primary care staff, participating in staff meetings, etc.), particularly if those staff have commitments to other practices or organizations. Ideally, they would prefer to hire staff but noted that recruiting and retaining behavioral health staff is a challenge.

Interviews with MeHAF Integration Initiative Grantees

Using semi-structured interview protocols, we conducted interviews with each of the 20 Health Integration grantees funded by MeHAF in the fall of 2007. The purpose of the interviews was to identify the approach to integration adopted by each grantee, the barriers to implementing their projects, and the technical assistance and support needed. The 20 grantees represent a diverse selection of practices and organizations as well as integration activities and partners.

Based on our interviews, it is clear that no one model or approach is right for all settings and that structural integration is driven by resource availability, practice settings, and market context. We observed a mix of grantees focused on integration within their organizations (vertical integration) compared to those focused on integration and coordination across organizations (horizontal integration).

As a result of the diversity and complexity of this group of grantees, a key focus should be on identifying the functional aspects of integration necessary to best meet patients' needs within and across practices and agencies. These functional elements of integration include patient identification and assessment processes, the ways in which patients are connected with behavioral health services, use of treatment protocols, internal and external care coordination, internal teambuilding, internal consultation support, patient record keeping, coordination with external providers and referral services, availability of external consultative support, internal and external communications, patient education, and engagement of patients in decision-making related to their care.

Barriers identified by the grantees include the amount of time necessary to implement effective integrated programs and the difficulty in finding appropriate staff. Participants also recognized the need to develop different practice systems and protocols to support integrated care. Communication barriers (e.g., paper charts and lack of electronic health records) within and across organizations can inhibit integration by making it difficult to share clinical and administrative information. Paperwork related to informed consent also serves as a barrier to integration across organizations as each individual organization needs to be identified in the informed consent along with the scope of information covered. Collecting and updating the necessary informed consents can be time consuming and administratively difficult. Differing practice cultures of physical and behavioral health organizations was also identified as a barrier to integration, particularly for those organizations attempting to integrate services across facilities. Finally, some respondents were concerned that practices and organizations might not see behavioral health services as a benefit given the level of effort and work involved, thereby eroding support for continuation of integration activities.

The grantees identified technical assistance needs in a number of areas to help support their projects, including:

- Coding and reimbursement for integration services;
- Sustainability of services;
- Care coordination for complex patients;
- Development of outcome measures for their projects;
- Evaluation planning;
- Assessment tools; and
- Licensing issues.

They were also interested in opportunities to work with other grantees undertaking similar work. They sought information on examples of integration that are not hierarchically structured.

Physician Surveys and Interviews Conducted by the Maine Center for Public Health

As part of its Integrated Primary Care and Mental Health Project, the Maine Center for Public Health collaborated with the Bureau of Medical Services and the Bureau of Health (with funding from MeHAF) to design and conduct a needs assessment using both quantitative and qualitative data strategies. The goal of the survey was to identify the key needs of practices throughout Maine to inform the development of models to be tested.^{77,78} Following the surveys, twelve primary care clinicians across the state were interviewed, primarily by telephone to obtain more detailed information on issues related to integration.

Financing was a central concern for all providers given that critical aspects of care for children with mental illness were not reimbursed. These services include care management, consultation, and referral. Other issues include refusal among many behavioral health and psychiatric providers to accept Medicaid reimbursement. The authorization and approval process implemented by commercial insurance programs is also a challenge and can delay treatment for substantial periods.

A number of access barriers were identified including the shortage of specialty mental health providers; long waiting lists and delays in accessing services; a lack of knowledge of community/family-based services available either locally or statewide; and the large number of mental health providers that do not take Medicaid or are uninterested in children's issues. Primary care providers coped with these barriers by cobbling together resources to provide a minimal level of assistance to patients. Others developed their own diagnosis and treatment plans to cope with the lack of specialized resources. Others said that they attempted to diagnosis as much as they could in the absence of resources while others limited their self-developed expertise to one or two areas.

In developing models to integrate services, providers were enthusiastic about the potential for enhanced consultation with a child psychiatrist and a practice care manager who would be familiar with local resources. Providers were interested in reimbursement for referral, consultation, and case management. Providers were generally interested in fully integrated

practice models but were concerned about time, energy, disruption, and the monetary commitment involved in implementing these models. Providers tended to think of the co-location of a mental health provider in a practice for a specific period of time as a more “doable” model. Primary care providers also wanted mental health providers to better understand their needs and existing arrangements, but were unsure of how this might be done.

In 2004, the Maine Center for Public Health conducted a follow-up to their earlier study by creating a template to provide basic information about integration projects that had sprung up across the state and to assess structural barriers from the perspective of mental health providers. Identified barriers included:

- Language and cultural barriers between primary care and mental health providers;
- Cultural barriers that are structural, clinical, and financial in nature;
- Structural barriers including regulatory requirements;
- Ignorance of physical disorders by patients and mental health providers;
- Inadequate training in assessment on the part of many primary care providers;
- Lack of provider understanding/awareness of services;
- Lack of ready access to child psychiatrists for consultation;
- Difficulties in recruiting social workers, psychologists, and certified substance abuse professionals; and
- Office of Substance Abuse regulations that have exacerbated the shortage of substance abuse providers in Aroostook County.

Maine Integrated Health Initiative: Maine People Speak About Health Care Integration

As described earlier, MeHAF, with the assistance of John Snow, Inc. surveyed Maine people about their perspectives on health care integration.³ This report corroborated the patient-level barriers to the use of integrated services as described earlier in this report.

Discussion and Findings

Interest in the integration of behavioral health and physical health services remains high nationally and in Maine. MeHAF’s continued funding of integration activities reflects that interest. The discussion, however, has evolved from earlier conceptions of integration. Typically, the discussion of integration focused on the incorporation of behavioral health services into primary care settings. That discussion has shaped our approach to integration in that we seek to identify and implement the proper integration model, typically a vertically integrated model of integrated practice, without clearly understanding the underlying clinical, administrative, and

organizational dynamics that influence integration and without explicitly addressing the functional aspects of integration.

MeHAF's current approach to integration takes a more holistic view in that it focuses on the overall integration of behavioral health and physical health services and allows for two-way integration in both physical health and behavioral health settings. It also encourages us to think about the functional aspects of integration across provider organizations and agencies, rather than the more limited site-specific approach to integration inherent in earlier discussions. Finally, it encourages linking the concept of integration with patient and family-centered care.

Guiding Principles

Emerging from the environmental scan and our work with the Advisory Committee for this study, we prepared a set of principles to help guide the development of integrated health care models. Integrated health care initiatives should be:

- Patient-centered (e.g., address the needs of the patient; respond to patient preferences, needs, and values; and ensure that patient values guide all clinical decisions);
- Designed to expand access to care, decrease burden of illness, and optimize care;
- Delivered in settings preferred by patients;
- Evidence-based;
- Driven by clinical and care issues and functions, not practice and administrative issues;
- Focused not only on integrating care within practices/facilities but also across practices and care settings; and
- Focused on both physical health and behavioral health settings.

These principles have been reviewed and accepted by members of the advisory committee. They can be used to guide and assess the development of models of integrated behavioral health and physical health services.

Preliminary Findings from the Environmental Scan

The most significant barriers to integration in Maine primarily involve licensure, reimbursement, and financial issues. Larger system issues such as the overall shortages of specialty behavioral health providers and the maldistribution of these providers in relation to

need are also at work in Maine; but it is unlikely that we will be able to resolve these issues locally in the short run. Rather than worry about these system-level problems, we should focus on making our existing system work as well as it can and address those issues that are within our power to resolve.

Scope of practice issues are often cited as major barriers to integration in the national literature; however, it appears to be less of an issue in Maine based on our preliminary discussions with providers. The problem is less what certain types of providers are able to do under the scope of their license and more directly related to the varying coverage decisions (e.g., the types of behavioral health providers covered and the services that will be paid for) by third party payers including Medicare, MaineCare, managed behavioral health organizations, and commercial insurance carriers. Complicating this issue are the barriers created by facility licensure regulations for mental health agencies. Facility licensure issues are complex and may constrain the ability to integrate across settings (e.g., they limit the ability of licensed agencies to engage in integrated models of care; they exclude other types of providers who may not meet licensure standards; and they impose administrative and clinical complexity on integrated projects that may not be necessary).

Providers need training and technical assistance on clinical, administrative, and operational issues related to integration including the identification and selection of integration models that are appropriate to their organizational settings and market context. The information needs of practice and providers will vary by provider type and setting. The information and technical assistance needs of primary care providers interested in integrating behavioral health services are likely to be very different from those of behavioral health providers interested in integrating primary and physical health services into their settings. No single source of information and technical assistance exists to support integration across settings and practices.

It is also important to recognize that the environment in which these integration discussions are taking place is very complex and that regulatory, reimbursement, and facility licensing changes to enhance integration may benefit some providers at the expense of others. It is critical that we be aware of the trade offs and be alert for unintended consequences of policy, regulatory, and budgetary changes. Discussions of these issues must include as many key stakeholders as possible and be open to all that are interested. The potential political and

budgetary implications of these decisions must be considered and reconciled across practice settings. The watchword for this process should be transparency.

Preliminary Recommendations

While it is too early in the process to recommend specific regulatory and reimbursement changes to support integration, we can make recommendations to address the need for a broad-based, transparent process in which to discuss, reconcile, and formulate necessary changes to support integration; to support the information and technical assistance needs of providers; and to develop tools and resources to support the establishment and evaluation of integrated services. Therefore, we recommend the development of:

- An ongoing multi-disciplinary advisory or steering committee to provide leadership in addressing the complex and potentially conflicting integration issues across settings. Members should include state policymakers, third party payers, managed behavioral health organizations, physical health and behavioral health providers and practices, key stakeholders, and consumers of services.
- An information, education, and technical assistance resource center to address integration issues across practice settings and facility types.
- Outcome measurement tools and resources to monitor and evaluate the levels of success of integration initiatives and their impact on expanding access, decreasing burden of illness, and optimizing care.

Finally, we recommend that an effort be made to establish and clarify the goals for the integration of behavioral and physical health services in Maine and to understand the implications of the different models of integration. As we expand the discussion to look at the implication of services across settings of care and the growing complexity of the models and reimbursement patterns, it is important that we understand the implication of the implementation of any specific model on the expansion of access, reductions in the burden of illness, and optimization of care. Integration models are not inter-changeable nor are they all likely to achieve the same goals.

An example of this issue is Kirk Strosahl's model of integration that focuses on the use of health and behavioral assessment codes for patients with behavioral needs related to physical or chronic illnesses (e.g., the physical health issue is the patient's primary problem for which

treatment is being sought). Although an important and useful service, it does not necessarily expand access to traditional behavioral health services for individuals with depression, anxiety, or other issues that are their primary reason for seeking treatment at the time of the encounter.

Another example would be the growing interest in the medical home concept. Some proponents have suggested that medical home will advance the integration of services in Maine and elsewhere. It certainly has the potential to support the integration of behavioral and physical health services but will not automatically do so for multiple reasons. First, as typically conceptualized, the medical home model does not necessarily speak to integration *per se*, but rather focuses on the issue of care coordination and management. Second, as defined by groups such as the American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics, the American Osteopathic Association, and the National Committee for Quality Assurance (NCQA), the key feature in the definition of the medical home is that it is a model of care where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care (NCQA 2008). The scoring system developed by NCQA to recognize primary care medical homes focus on issues related to access and communication, patient tracking and registry functions, care management, patient self-management support, electronic prescribing, test tracking, referral tracking, performance reporting and improvement, and advanced electronic communication. Among some of the measures of a medical home are that patients have a regular physician, easy access to that provider by phone, availability on evenings and weekends, and office visits that are well organized and on schedule. None of these groups have spoken directly to the integration of behavioral health services into these settings as part of their definitions of the medical home. Finally, as typically conceptualized, most medical home demonstrations do not address the barriers to the integration of behavioral and physical health services as identified in this environmental scan.

This suggests the need for specific goals for integration; a clear understanding of the various models and the ways in which they impact integration; and tools to evaluate the impact of integration initiatives on the expansion of access to services, reductions in the burden of illness, and the optimization of care. These recommendations will provide important information and support for policymakers, regulators, and other stakeholders interested in promoting the effective integration of behavioral health and physical health services.

Endnotes

1. Maine Health Access Foundation. *Promoting Patient and Family-Centered Care*. [Web Page]. Available at: <http://www.mehaf.org/promote-patient-centered-care.aspx>. Accessed October 6, 2008.
2. Maine Health Access Foundation, Integration Initiative Steering Committee & Advisory Group. *Integrated Health Care in Maine: Vision, Principles and Values, and Goals and Objectives*. Augusta, ME: Maine Health Access Foundation; March 2007a. http://www.mehaf.org/pictures/integration_vision.pdf
3. Maine Health Access Foundation. *Maine Integrated Health Initiatives: Maine People Speak About Health Care Integration*. Augusta, ME: Maine Health Access Foundation; 2007b. <http://208.106.187.202/pictures/grassroots-feedback-2007.pdf>
4. Borus JF. Neighborhood health centers as providers of primary mental-health care. *New England Journal of Medicine*. July 1976; 295:140-5.
5. Ozarin LD, Samuels ME, and Biedenkapp J. Need for mental health services in federally funded rural primary health care systems. *Public Health Reports*. July-August 1978; 93:351-5.
6. Broskowski, A. *Evaluation of the Primary Health Care--Community Mental Health Center Linkage Initiative*. Rockville, MD: Alcohol, Drug Abuse, and Mental Health Administration; 1980.
7. Institute of Medicine, Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*. Washington, DC: National Academies Press; 2006.
8. Belnap BH, Kuebler J, Upshur C, et al. Challenges of implementing depression care management in the primary care setting. *Administration and Policy in Mental Health and Mental Health Services Research*. January 2006; 33:65-75.
9. Agency for Health Care Policy and Research. *Depression in Primary Care. Clinical Practice Guidelines. Volume 1: Detection and Diagnosis. Volume 2: Treatment of Major Depression*. (AHCPR Publication No. 93-0551). Rockville, MD: U.S. Department of Health and Human Services, Public Health Service; 1993.
10. Simon GE, VonKorff M. Recognition, management, and outcomes of depression in primary care. *Archives of Family Medicine*. February 1995; 4:99-105.
11. Wells KB, Schoenbaum M, Unutzer J, Lagomasino IT, and Rubenstein LV. Quality of care for primary care patients with depression in managed care. *Archives of Family Medicine*. November-December 1999; 8:529-36.

12. Gilbody SM, Whitty PM, Grimshaw JM, and Thomas RE. Improving the detection and management of depression in primary care. *Quality and Safety in Health Care*. 2003; 12:149-155.
13. Katon W, Robinson P, VonKorff M, et al. A multifaceted intervention to improve treatment of depression in primary care. *Archives of General Psychiatry*. October 1996; 53:924-32.
14. Katon W, Von Korff M, Lin E, et al. Stepped collaborative care for primary care patients with persistent symptoms of depression: a randomized trial. *Archives of General Psychiatry*. December 1999; 56:1109-15.
15. Katon W, Russo J, Von Korff M, et al. Long-term effects of a collaborative care intervention in persistently depressed primary care patients. *Journal of General Internal Medicine*. October 2002; 17:741-8.
16. Simon GE, Katon WJ, VonKorff M, et al. Cost-effectiveness of a collaborative care program for primary care patients with persistent depression. *American Journal of Psychiatry*. October 2001; 158:1638-44.
17. Oxman TE, Dietrich AJ, and Schulberg HC. The depression care manager and mental health specialist as collaborators within primary care. *American Journal of Geriatric Psychiatry*. September 2003-October 2003; 11:507-16.
18. Simon G, VonKorff M, Rutter C, and Wagner E. Randomized trial of monitoring, feedback, and management of care by telephone to improve treatment of depression in primary care. *British Medical Journal*. 2000; 320: 550-554.
19. Rost K, Nutting PA, Smith J, and Werner JJ. Designing and implementing a primary care intervention trial to improve the quality and outcome of care for major depression. *General Hospital Psychiatry*. March-April 2000; 22:66-77.
20. Unutzer J, Katon W, Callahan CM, et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *Journal of the American Medical Association*. December 2002; 288:2836-45.
21. Health Resources and Services Administration. *Health Disparities Collaboratives*. [Web Page]. n.d. Available at: <http://www.healthdisparities.net/hdc/html/home.aspx>. Accessed December 13, 2007.
22. Pincus HA, Pechura C, Keyser D, Bachman J, and Houtsinger JK. Depression in primary care: learning lessons in a national quality improvement program. *Administration and Policy in Mental Health and Mental Health Services Research*. January 2006; 33:2-15.
23. U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Mental Health; 1999.

24. New Freedom Commission on Mental Health. *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* (DHHS Pub. No. SMA-03-3832). Rockville, MD: U.S. Department of Health and Human Services; 2003.
25. National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors. *National Dialogue on Co-Occurring Mental Health and Substance Abuse Disorders.* Alexandria, VA: NASMHPD; 1998.
26. Mauer, BJ. *Behavioral Health / Primary Care Integration, Models, Competencies, and Infrastructure: Background Paper.* Rockville, MD: National Council for Community Behavioral Healthcare; 2003.
27. Bazelon Center for Mental Health Law. *Get it Together: How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders.* Washington, DC: Bazelon Center for Mental Health Law; 2004.
28. Parks, J, Pollack, D, Bartels, S, and Mauer, B. *Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities.* Alexandria, VA: National Association of State Mental Health Program Directors; January 2005.
29. National Council for Community Behavioral Healthcare. *Behavioral health / primary care integration: Finance, Policy and Integration of Services.* Rockville, MD: National Council for Community Behavioral Healthcare; July 2006.
30. National Council for Community Behavioral Healthcare. *Behavioral health / primary care integration: The four quadrant model and evidence-based practices.* Rockville, MD: National Council for Community Behavioral Healthcare; February 2006.
31. Pawlenko, N. *Collaborative Mental Health Care in Primary Health Care Across Canada: A Policy Review.* Missussauga, ON: Canadian Collaborative Mental Health Initiative; 2005.
http://www.ccmhi.ca/en/products/documents/06_PolicyReview_EN.pdf
32. Pawlenko, N. *Annotated Bibliography of Collaborative Mental Health Care.* Missussauga, ON: Canadian Collaborative Mental Health Initiative; 2005.
http://www.ccmhi.ca/en/products/documents/03_AnnotatedBibliography_EN.pdf
33. Lambert, D, Brennan, M. *Mental Health and Substance Abuse in Maine: Building a Community-Based System.* (Issue brief). Portland, ME: Muskie School of Public Service, University of Southern Maine and Margaret Chase Smith Policy Center, University of Maine; 2007.
<http://muskie.usm.maine.edu/Publications/PLA/mentalhealth.pdf>

34. Regier DA, Goldberg ID, and Taube CA. The de facto US mental health services system: a public health perspective. *Archives of General Psychiatry*. June 1978; 35:685-93.
35. The Annapolis Coalition on the Behavioral Health Workforce. *An Action Plan on Behavioral Health Workforce Development*. Cincinnati, OH: The Annapolis Coalition on the Behavioral Health Workforce; 2007.
36. Koppelman J. The provider system for children's mental health: Workforce capacity and effective treatment. *National Health Policy Forum Issue Brief (No. 801)*. October 2004; 1-18.
37. Frank RG, Glied SA; *Better But Not Well: Mental Health Policy in the United States Since 1950*. Baltimore, MD: Johns Hopkins University Press; 2006.
38. National Conference of State Legislatures. *State Laws Mandating or Regulating Mental Health Benefits*. [Web Page]. 2007, July 1. Available at: <http://www.ncsl.org/programs/health/mentalben.htm>. Accessed September 16, 2007.
39. Hartley, D, Ziller, E, Lambert, D, Loux, S, and Bird, D. *State Licensure Laws and the Mental Health Professions: Implications for the Rural Mental Health Workforce*. (Working paper #29). Portland, ME: Maine Rural Health Research Center, Muskie School of Public Service, University of Southern Maine; 2002.
40. Barry CL, Frank RG. Commentary: an economic perspective on implementing evidence-based depression care. *Administration and Policy in Mental Health and Mental Health Services Research*. January 2006; 33:21-5.
41. Mauch, D, Kautz, C, and Smith, S. *Reimbursement of mental health services in primary care settings*. (HHS Pub. No. SMA-08-4324). Rockville, MD: U.S. DHHS, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services; February 2008.
42. Lambert, D, Gale, J. *Integrating Primary Care and Mental Health Services in Rural Community Health Centers*. Kansas City, MO and Washington, DC: National Rural Health Association; 2006.
43. Gale JA, Deprez RD. A Public Health Approach to the Challenges of Rural Mental Health Service Integration. In: Stamm BH, Ed. *Rural Behavioral Health Care: An Interdisciplinary Guide*. Washington, DC: American Psychological Association; 2003:95-108.
44. Noll RB, Fischer S. Commentary. Health and behavior CPT codes: an opportunity to revolutionize reimbursement in pediatric psychology. *Journal of Pediatric Psychology*. October 2004; 29:571-8.

45. Kessler R. Integration of care is about money too: The health and behavior codes as an element of a new financial paradigm. *Families, Systems, & Health*. 2008; 26:207-216.
46. Lambert D. Meeting the mental health needs of rural older people. In: *Caring for the older person in rural communities*. Kansas City, MO: National Rural Health Association; 2008:28-35.
47. Loftis, CW, Salinsky, E. Medicare and Mental Health: The Fundamentals *National Health Policy Forum Background Paper*. Washington, DC: George Washington University; November 2006.
48. Frank RG, Goldman HH, and Hogan M. Medicaid and mental health: be careful what you ask for. *Health Affairs (Millwood)*. January 2003-February 2003; 22:101-13.
49. Mauer, BJ, Druss, BG. *Mind and body reunited: Improving care at the behavioral and primary healthcare interface*. American College of Mental Health Administration, National Council for Community Behavioral Healthcare, Carter Center Mental Health Program; March 2007. http://www.public-health.uiowa.edu/icmha/outreach/documents/MindandBodyCollaborativeCare_000.PDF
50. U.S. Air Force Medical Operations Agency, Behavioral Health Optimization Project. *Primary Behavioral Health Services: Practice Manual*. Brooks AFB, TX: AFMOA Population Health Support Division; March 2002.
51. Eisenberg L. Treating depression and anxiety in the primary care setting. *Health Affairs (Millwood)*. Fall 1992; 11:149-56.
52. Barrett JE, Barrett JA, Oxman TE, and Gerber PD. The prevalence of psychiatric disorders in a primary care practice. *Archives of General Psychiatry*. December 1988; 45:1100-6.
53. Kilbourne AM, McGinnis GF, Belnap BH, Klinkman M, and Thomas M. The role of clinical information technology in depression care management. *Administration and Policy in Mental Health and Mental Health Services Research*. January 2006; 33:54-64.
54. Sensmeier J. Advancing the state of data integration in healthcare. *Journal of Healthcare Information Management*. 2003; 17:58-61.
55. Khoubati, K. et al. Integration technology adoption in healthcare organizations: A case for enterprise application integration. Paper presented at the *38th Hawaii International Conference on System Sciences*. IEEE Computer Society; 2005.

56. Nash KS. *We really did screw up*. [Web Page]. 2007, May 14. Available at: <http://www.baselinemag.com/c/a/Intelligence/QTEWe-Really-Did-Screw-UpQTE/8/>. Accessed October 31, 2008.
57. Watson, A, Corrigan, P. *The Impact of Stigma on Service Access and Participation: A Guideline Developed for the Behavioral Health Recovery Management Project*. Peoria, IL: Behavioral Health Recovery Management Project; 2001. <http://bhrm.org/guidelines/mhguidelines.htm>
58. Minnesota Department of Human Services. *Governor's Mental Health Initiative: Fast Facts. 2007 Legislative Session*. St. Paul, MN: Minnesota Department of Human Services; 2007. <http://www/mhcsn.net/DHS.pdf>
59. Mental Health Weekly. Groundbreaking depression initiative expands to 10 Minnesota clinics. *Mental Health Weekly*. 2 June 2008; 18.
60. Mental Health Weekly. Minnesota doctors will be eligible for bonuses tied to depression care. *Mental Health Weekly*. 9 June 2008; 18.
61. Levis D. Piloting Mental Health Integration in the Community Care of North Carolina Program. *North Carolina Medical Journal*. 2006; 67:68.
62. Mauer, B, Jarvis, D. *Washington Medicaid Integration Partnership. Snohomish County Pilot White Paper. Executive Summary*. (Prepared for North Sound Mental Health Administration). Seattle, WA: MCPP Healthcare Consulting Inc.; January 2004.
63. State of Connecticut, Department of Children and Families, Department of Social Services. *Enhanced Care Clinics: Request for Applications*. Hartford, CT: Connecticut Department of Children and Families; June 2006.
64. Ford, J, Steinberg, K, Pidano, A, Honigfeld, L, and Meyers, J. *Behavioral Health Services in Pediatric Primary Care: Meeting the Needs in Connecticut*. Farmington, CT: Child Health and Development Institute of Connecticut; 2006.
65. Bird DC, Lambert D, Hartley D, Beeson PG, and Coburn AF. Rural models for integrating primary care and mental health services. *Administration and Policy in Mental Health and Mental Health Services Research*. January 1998; 25:287-308.
66. Lambert, D, Bird, D, Hartley, D, and Genova, N. *Integrating Primary Care and Mental Health Services: Current Practices in Rural Areas*. Kansas City, MO and Washington, DC: National Rural Health Association; 1996.
67. Strosahl K. Integrating Behavioral Health and Primary Care Services: The Primary Mental Health Model. In: Blount A, ed. *Integrated Primary Care: The Future of Medical and Social Mental Health Collaboration*. New York, NY: W.W. Norton & Company; 1998.

68. Intermountain Healthcare. *IHC mental health integration: Primary care clinical programs*. [Web Page]. 2004. Available at: <http://intermountainhealthcare.org/alumniprojectfiles/2004-029.pdf>. Accessed December 4, 2007.
69. Blount A, Ed. *Integrated Primary Care: The Future of Medical and Social Mental Health Collaboration*. New York, NY: W.W. Norton & Company; 1998.
70. Doherty WJ, McDaniel SH, and Baird MA. Five levels of primary care/behavioral healthcare collaboration. *Behavioral Healthcare Tomorrow*. October 1996; 5:25-7.
71. Parks, J, Svendsen, D, Singer, P, Foti, ME, and Mauer, B. *Morbidity and Mortality in People with Serious Mental Illness*. Alexandria, VA: National Association of State Mental Health Program Directors, Medical Directors Council; October 2006.
http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Technical%20Report%20on%20Morbidity%20and%20Mortality%20-%20Final%2011-06.pdf
72. Backer LA. The medical home: an idea whose time has come ... again. *Family Practice Management*. September 2007; 14:38-41.
73. Robert Graham Center. *The Patient Centered Medical Home: History, Seven Core Features, Evidence and Transformational Change*. Washington, DC: Robert Graham Center; November 2007.
74. National Committee for Quality Assurance (NCQA). *Standards and guidelines for Physician Practice Connections--Patient-Centered Medical Home (PPC-PCMH)*. Washington, DC: NCQA; 2008.
75. Quality Counts, Maine Quality Forum, and Maine Health Management Coalition. *Maine Multi-Payer Pilot of the Patient Centered Medical Home: Proposal for Planning Process*: unpublished; April 2008.
76. Petterson S, Phillips B, Bazemore A, Doodoo M, Zhang X, and Green L. *Why there must be room for mental health in the medical home*. [Web Page]. 2008, March. Available at: <http://www.graham-center.org/x1001.xml>. Accessed September 22, 2008.
77. Maine Center for Public Health. *Integrated Primary Care and Mental Health Project Needs Assessment: Results of Physician Surveys and Interviews*. 2003.
http://www.mcph.org/Major_Activities/Primary_Care_Mental_Health/Maine%20Practitioner%20Survey.pdf

78. Maine Center for Public Health. *Integrated Primary Care and Mental Health Project: Results of Structural Survey, Results of Template Inquiry*. December 2004.
http://www.mcph.org/Major_Activities/Primary_Care_Mental_Health/surveys.pdf

Appendix A
Review of Integrated Primary Care and Mental Health Service Models

| Model / Approach | Purpose | Target Population | Types of Services | Clinical Integration | Financial Integration | Structural Integration | Barriers / Opportunities |
|--|---|---|--|--|--|--|---|
| <p>Primary Mental Health Care Model</p> <p>Developed by Kirk Strosahl</p> <ul style="list-style-type: none"> <i>Focuses on the general primary care population</i> | <p>A consultative, time limited approach to the provision of BH services in PC, with the goal of increasing the impact of the PCP’s ongoing psychosocial interventions. The model maintains that behavioral health care must have goals, strategies and culture consistent with that of primary care. The BH provider may engage in temporary co-management with the PCP of patients who require more concentrated services. Triaging into more intensive care as needed.</p> | <p>BH services are available to all PC patients for any reason. The model aims to improve recognition of BH needs, collaboration and management of patients with BH issues in PC, provide PCP with internal resource for BH issues, immediate access to BH consultants, improved fit between care patients seek and what is offered, and to promote early recognition and intervention.</p> | <p>Initial 30 minute screen to determine appropriate level of intervention and/or intake evaluation for diagnostic and functional evaluation, making recommendations for Rx and forming limited behavior change goals. Consultation visits are brief (15-30 minutes), limited (1-3 visits) and provided in the PC practice area as a form of primary care service.</p> | <p>The BH consultant supports the behavioral health interventions of the primary care provider, focusing on resolving problems within the normal primary care service structure as well as to engage in health promotion and monitoring at-risk patients. PCP is the chief customer of the service and remains in charge of patient care at all times. The specialty consultation level pertains to patients with chronic psychosocial and/or physical problems that need management over time in the PC setting. The integrated care level is for high frequency and/or high cost PC populations, such as major depression or panic disorder.</p> | <p>The model includes evaluation of benefit design and identifying payment mechanisms for BH providers, developing a sustainable budget strategy, methods for risk sharing with partners, and agreements for distribution of cost savings.</p> | <p>Includes training programs for increasing organizational readiness for integrated care.</p> | <p>This model appears to be the most well-developed and mature of all the models.</p> |
| <p>Integrating Primary Care and Behavioral Health Services</p> <p>Developed by Mountainview</p> | <p>This approach is based in public health and epidemiology and includes: a focus on raising population health; emphasis on early identification and prevention; triage and clinical services in</p> | <p>The approach targets patients seen at community health centers and aims to serve a high percentage of this population.</p> | <p>The BH provider acts as consultant and health team member, supporting PCP decision making. This provider builds on PCP interventions; teaches the PCP “core” behavioral health skills;</p> | <p>Patients are typically seen by the BH provider for 1-3 visits of 15-30 minutes in duration. Care provided may follow critical pathway programs or use classes and group clinics. Intervention is informal, and revolves around PCP assessment and goals, with visits timed around PCP visits. Patients are referred by the</p> | | | <p>This approach is specifically designed for community health centers, a type of provider common throughout Maine.</p> |

| Model / Approach | Purpose | Target Population | Types of Services | Clinical Integration | Financial Integration | Structural Integration | Barriers / Opportunities |
|--|---|--|--|---|---|---|---|
| <p>Consulting Group</p> <ul style="list-style-type: none"> <i>Focuses on the general primary care population</i> | <p>stepped care fashion; a “panel” instead of “clinical case” model; and an evidence based medicine model.</p> | | <p>educates patient in self-management skills; improves PCP-patient working relationship; and monitors at risk patients with PCP.</p> | <p>PCP only, could be a “warm handoff” on same day as PC appointment, and BH provider may screen PCP appointment schedule to “leverage” medical visits.</p> | | | |
| <p>Air Force Behavioral Health Optimization Project</p> <p>Developed by the Air Force Medical Service</p> <ul style="list-style-type: none"> <i>Focuses on the general primary care population</i> | <p>This project aims to increase access to BH care within AF facilities, provide options to patients and encourage shared-decision making, early identification of BH conditions, break down communication barriers among medical providers, offer services along the continuum of health, and offer acceptable and effective services.</p> | <p>Air Force Medical Services enrollees and dependents in 30 primary care settings.</p> | <p>Typically one to four BH visits in most cases of 15-30 minutes. Brief assessment focused on presenting problem, emphasis on functional status. Simple, specific behavioral or cognitive interventions, supported by PC clinic in ongoing care. Patient education and self-management used frequently.</p> | <p>BH providers are shifted from specialty mental health clinics to primary care clinics and are trained in the behavioral health consultation model of care, rooted in population health and consistent with project goals. Focus is on brief, functionally based assessment with recommendations and delivery interventions designed to improve the patients’ functioning and QOL. BH provider focuses on increasing PCPs ability to address BH problems as part of PC Rx, without increasing the PCP’s time or care burden. Program expands the BH options available to AFMS beneficiaries at an early point on the health care continuum.</p> | <p>AFMS functions as 78 distinct staff model HMOs, so there was no need to negotiate a financial arrangement for BH services delivered in a PC setting.</p> | <p>Variety of informal communications used to gain support from local decision makers including a 2-day meeting to review evidence, address local concerns, and develop a systematic plan.</p> | <p>Emphasis on addressing BH issues without adding to PCP burden may make it easier for physicians to buy into integration.</p> |
| <p>CareIntegra</p> <p>Developed by Cummings and O’Donahue</p> <ul style="list-style-type: none"> <i>Focuses on the general primary care population</i> | <p>The model aims to improve clinical outcomes for acute conditions, use wellness techniques to prevent mental disorder or recurrence, provide consultation and education for PC team. Manage high using patients with chronic health and</p> | <p>Open door service philosophy to encourage broad referral pattern from within PC practice.</p> | <p>The BCP’s role: identify, consult, treat, triage, and manage primary care patients with medical and/or behavioral health problems.</p> | <p>Uses short term collaborative care intervention model, implement best practice guidelines for high frequency conditions such as depression, build on existing PC interventions and suggest new ones, coordinate acute care management with primary care team. Employ collaborative treatment model emphasizing co-management of patient care; offer basic consultation to address care management issues;</p> | <p>Evaluate benefit design and identify payment mechanisms for behavioral health providers; develop a sustainable budget strategy; identify methods for risk sharing with partners; and develop</p> | <p>Involve senior level management and staff, key internal stakeholders, key external stakeholders in the change process; provide preparatory workshops and training to increase understanding of</p> | <p>In systems used by Cummings et al, integrated care extends into and encompasses at least 50% of what is customarily specialty psychiatry and psychology. This could serve as a way to extend health care workforce in rural areas.</p> |

| Model / Approach | Purpose | Target Population | Types of Services | Clinical Integration | Financial Integration | Structural Integration | Barriers / Opportunities |
|--|---|--|--------------------------|---|---|---|---------------------------------|
| | behavioral health concerns, manage behavioral sequelae of medical conditions, identify and place patients requiring specialized mental health Rx, make behavioral care provider (BCP) services available to all within the PC team. | | | develop interventions tailored to the 15 minute hour. Longer term BCP case management reserved for patients with numerous medical and/or psychosocial concerns. Patient education in individual and group formats. Develop and use referral criteria for triaging patients to specialty care. Provide limited number of brief visits using scheduled time and on demand crisis appointments. Use telephone screening and follow-up strategies. | agreements for distribution of cost savings | the integration process; base the system of care in a well-documented administrative process and structure; design a service perceived as feasible to implement and operate by participants; create a service manual, determine reporting and supervisory relationships, charting and documentation requirements, and develop schedule templates. | |
| The Four Quadrant Clinical Integration Model Developed by the National Council for Community Behavioral Healthcare | This conceptual model describes physical and behavioral health integration and clinician competencies based on four levels of combined behavioral health risk / status and physical health risk / status. | Considers persons with co-occurring mental health and substance abuse needs. | | Quadrant I: Low behavioral health and physical health complexity/risk. Served by primary care practitioner using standard BH screening tools and practice guidelines. Quadrant II: High behavioral and low physical health complexity/risk. PC services in collaboration with specialty BH providers. Quadrant III: Low behavioral and high physical health complexity/risk. PCP works with specialists and disease managers, using standard BH screening tools and practice guidelines. Quadrant IV: High behavioral and high physical health complexity/risk. Served by | Not included. | Not included. | |

| Model / Approach | Purpose | Target Population | Types of Services | Clinical Integration | Financial Integration | Structural Integration | Barriers / Opportunities |
|--|---|---|--|--|------------------------------|---|---|
| <ul style="list-style-type: none"> <i>Focuses on a specific population within the primary care setting</i> | | | | specialty BH and primary/specialty medical systems. | | | |
| <p>The Chronic Care Model (CCM)</p> <p>Developed by Ed Wagner et al under the <i>Improving Chronic Illness Care Program</i></p> <ul style="list-style-type: none"> <i>Focuses on a specific population within the primary care setting</i> | CCM identifies essential elements of a health care system that encourage high-quality chronic disease care, including self-management support, clinical information systems, delivery system redesign, decision support, health care organization, and community resources. | CCM can be applied to a variety of chronic illnesses, health care settings and target populations. It has been used for patients with diabetes, cardiovascular disease, asthma, and depression. | | CCM seeks to assure the delivery of effective, efficient clinical care and self-management support through defined team member roles and tasks; planned interactions to support evidence-based care; clinical case management services for complex patients; regular follow-up by the care team; and care that patients understand and that fits with their cultural background. Additionally, CCM promotes clinical care consistent with scientific evidence and patient preferences, empowering patients to manage their health and health care, mobilization of community resources to meet patients' needs, and a comprehensive clinical information system that supports patient care and performance monitoring. | | CCM promotes comprehensive system-wide improvement, beginning with the senior leader and encourages open and systematic handling of errors and quality problems to improve care, incentives based on quality, agreements that facilitate care coordination within and across organizations. | CCM includes a focus on mobilizing community resources and on empowering patients in their own care. |
| <p>Health Disparities Collaborative in Depression (HDC)</p> <p>Developed by the Health</p> | The HDC is a federal program aimed at eliminating racial, ethnic, and socioeconomic disparities. | Targets patients with depression (over age 16) within the community health center system. Each center should decide which patients with clinical depression | The HDC borrows from the Chronic Care Model, including key change concepts of health care organization / leadership, decision support, delivery system design, self-management, and community. | The HDC includes the implementation of a Care Model and the Model for Improvement in CHCs. | | The program seeks to improve its systematic tracking and reporting of quality improvements and to develop improved community organizational | CHC have any budget shortfalls absorbed by the government at the end of each year, so they may not be interested in retooling for integration if they don't get to keep the cost savings. (Cummings 2003) |

| Model / Approach | Purpose | Target Population | Types of Services | Clinical Integration | Financial Integration | Structural Integration | Barriers / Opportunities |
|---|--|---|---|--|------------------------------|---|---|
| Resources and Services Administration and the Institute for Healthcare Improvement <ul style="list-style-type: none"> <i>Focuses on a specific population within the primary care setting</i> | | and other co-occurring mental disorders will be included in the registry. | | | | resources and alignment of community activities of relevance to the CHCs. | CMHCs are opposed to BH/PC integration in CHCs because they fear reduction in their referrals. |
| Depression Care Process Model Developed by Intermountain Health Care <ul style="list-style-type: none"> <i>Focuses on a specific population within the primary care setting</i> | The model aims to increase identification and treatment of depression within primary care, improve patient treatment compliance, increase number patients that get well and stay well, increase referrals to and consultation with mental health providers, and improve overall quality and decrease medical costs in patients with severe medical problems and significant untreated/undertreated depression. | The model focuses on identifying and treating major depression in the primary care setting. | The model provides a practice guideline for depressed patients, including identification, treatment and treatment response, relapse, referral guidelines, and guidelines on emergent psychiatric situations. The treatment algorithm is adapted from national guidelines, including AHRQ's Treatment of Major Depression in Primary Care and is primarily based on pharmaceuticals. | The model screens selected patient populations with the highest prevalence of depression and significant medical comorbidity, a strategy to address the needs of the most seriously ill with the available resources. Regular contact with the provider (typically every two weeks during the acute phase of illness) and specific educational tools and mailers are used to promote compliance. | Not included. | Not included | Compared to usual care, patients treated under the model had improved mental health outcomes, better employment retention, and improved quality of life. This was all accomplished without a significant increase in overall cost. The model relies solely on the PCP; no behavioral health provider is involved except by referral. |

| Model / Approach | Purpose | Target Population | Types of Services | Clinical Integration | Financial Integration | Structural Integration | Barriers / Opportunities |
|--|--|---|--------------------------|--|---|--|---|
| <p>Mental Health / Primary Care Integration</p> <p>Department of Veterans Affairs</p> <ul style="list-style-type: none"> <i>Focuses on a specific population within the primary care setting</i> | <p>This program fosters integration of mental health and primary care in medical facility clinics and in the care of home-bound veterans served by VA's Home Based Primary Care program.</p> | <p>Appears to focus on patients with diagnoses frequently made in primary care settings or high users of PC, such as diabetes, cardiac issues, depression, PTSD, or alcohol-related disorder.</p> | | <p>Mental health care is currently provided at each of VA's 153 medical centers and 882 outpatient clinics. As of 7/07, the VA expanded its mental health services to include: greater availability of "telemental health" programs, which treated about 20,000 patients last year; integrating mental health services into geriatric programs; adding psychologists and social workers to the staffs of VA's polytrauma centers; increasing the number of Vet Centers from 209 to 232, and adding 100 new combat veterans to run outreach programs to their former comrades.</p> | | | <p>The VA has data that show that when primary care services are integrated with mental health services, clinical outcomes and patient satisfaction are improved.</p> |
| <p>Minnesota Integration Complexity Assessment Method</p> <p>Developed by Macaran Baird MD and colleagues</p> <ul style="list-style-type: none"> <i>Target population is unclear in available literature</i> | | | | <p>Five levels of PC/BH collaboration: 1) minimal collaboration: separate facilities, charts, and mgmt systems, rarely communicate about patients, able to manage routine cases; 2) basic collaboration at a distance: separate sites, charts, and mgmt, periodic communication, little shared responsibilities, able to manage somewhat complex cases; 3) basic on-site collaboration: shared facility, regular communication, increased shared responsibility; vague but shared sense of tem; more frequent interactions; can manage moderately complex cases; 4) partially integrated close collaboration: shared facility, scheduling, charts, mgmt, regular interaction, shared model of bio-</p> | <p>Pilot program is negotiating with payment changes being for shared visits for MD/MH consult (pending); team consultations on "complex" patients (pending); for phone consultations or care shared between MD and MH (achieved 2007); and for care coordinators for complex patients (achieved 2007).</p> | <p>This approach involves a self-inventory to determine the best level of collaborative care for the providers' needs.</p> | <p>This approach offers a continuum of integration based on the preferences and needs of the provider.</p> |

| Model / Approach | Purpose | Target Population | Types of Services | Clinical Integration | Financial Integration | Structural Integration | Barriers / Opportunities |
|------------------|---------|-------------------|-------------------|--|-----------------------|------------------------|--------------------------|
| | | | | psycho-social care; shared appreciation of value of other professionals; able to handle many complex cases; 5) fully integrated close collaboration: shared facility, scheduling, charts, clinical vision, values, regular collaborative team meetings, seamless services, conscious efforts to balance power, able to managed most complex cases. | | | |

Sources

CareIntegra. *Integrated Behavioral Healthcare: Basic Principles*. (Presentation). Reno, NV: CareIntegra Behavioral Healthcare Solutions; 2005.

Department of Veterans Affairs. *VA Brings Mental Health Programs to Primary Care Settings*. Washington, DC: Department of Veterans Affairs; July 2007.

Health Resources and Services Administration. *Health Disparities Collaboratives*. [Web Page]. n.d. Available at: <http://www.healthdisparities.net/hdc/html/home.aspx>. Accessed December 13, 2007.

Mauer, BJ. *Behavioral health / primary care integration: The four quadrant model and evidence-based practices*. Rockville, MD: National Council for Community Behavioral Healthcare; February 2006.

Parks, J, Pollack, D, Bartels, S, and Mauer, B. *Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities*. Alexandria, VA: National Association of State Mental Health Program Directors; January 2005.

Mountainview Consulting Group, Inc. *Integrating Primary Care and Behavioral Health Services: A Compass and a Horizon. A curriculum for community health centers developed for the Bureau of Primary Health Care Managed Care Technical Assistance Program*. [Web Page]. 2004.

Mulligan K. VA Promotes Simple Idea: Integrate Primary, MH Care. *Psychiatric News*. November 2002; 37:8-9.

The Primary Care Clinical Program and The Depression Management Team at Intermountain Healthcare. *Management of Depression*. Salt Lake City, UT: Intermountain Healthcare; 2000.

Runyan CN, Fonseca VP, Hunter C. Integrating Consultative Behavioral Healthcare into the Air Force Medical System. In: Cummings NA, O'Donohue WT, & Ferguson KE, Eds. *Behavioral Health as Primary Care: Beyond Efficacy to Effectiveness*. Reno, NV: Context Press; 2003.

Strosahl K. Integrating Behavioral Health and Primary Care Services: The Primary Mental Health Model. In: Blount A, Ed. *Integrated Primary Care: The Future of Medical and Social Mental Health Collaboration*. New York, NY: W.W. Norton & Company; 1998.

Wagner EH, Austin BT, Davis C, et al. Improving chronic illness care: Translating evidence into action. *Health Affairs (Millwood)*. 2001; 20:64-78.