

CROSSING THE DIVIDE: PRIMARY CARE AND MENTAL HEALTH INTEGRATION

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ABSTRACT: This paper describes the views of primary care providers about treating depression among adult Medicaid patients and their experiences with managed behavioral health care. It also shows the outcomes of an intervention project that provides a care manager to facilitate connections among PCPs, patients, and behavioral health providers. Despite widespread initiatives to improve depression management in primary care and to manage behavioral health services, it appears that links between the two systems and the use of evidence-based approaches to managing patients are rare. A pilot project to initiate practice redesign, the use of a care manager to assist in patient support, and compliance with both medical and behavioral health treatment has been shown to improve communication and results in positive patient outcomes. Managed behavioral health care can result in incentive structures that create gaps between primary care and behavioral health systems. This project illustrates an initiative co-sponsored by the Massachusetts behavioral health program designed to strengthen links between behavioral health and primary care, and increase rates and effectiveness of depression treatment.

KEY WORDS: depression; managed behavioral health; Medicaid; primary health care.

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This paper discusses the experiences of a primary care depression treatment project, and what has been learned about the interface between primary care and managed behavioral health care in the mental health treatment of Medicaid patients. We chose to focus on depression as the primary diagnosis for identifying patients in primary care who may need behavioral health services because of its high prevalence. Depression has recently been acknowledged as a major health risk both in the U.S. and worldwide. Within the U.S., AHCPR indicates a major depressive disorder (MDD) prevalence of 4.8% to 8.6% in the adult primary care population (AHCPR, 1993), while others have found ranges as high as 18.9% in an urban, low-income population (Olfson et al., 2000). Depression was ranked in 1990 as the fourth highest cause of disability internationally (Murray & Lopez, 1996). However, there is widespread evidence that depression and other mental disorders frequently remain undiagnosed and untreated (Jackson, Houston, Hanling, Terhaar, & Yun, 2001). At the same time, patients with depression receive more care in primary care settings than from mental health specialists (Regier et al., 1993). In general, patients with chronic conditions prefer to receive services in primary care (Wagner, Austin, & VonKorff, 1996). However, patients in primary care with depression and other mental health disorders are more likely to have unmet expectations about their medical care, and providers are more likely to find them frustrating patients to care for (Kroenke, Jackson, & Chamberlin, 1997).

In response to the growing evidence of this highly prevalent yet underdiagnosed and under-treated illness, a variety of studies have been undertaken to improve screening and identification of depression in primary care settings, and to implement guideline-based psychotherapy and/or pharmacotherapy for depression, complemented by mental health consultations, physician education, and standardized treatment protocols (Pigone et al., 1992; Schulberg, Katon, Simon, & Rush, 1998; Simon, 2002). These studies have shown better patient adherence to medication, better clinical outcomes on depression and functional status measures, and higher patient satisfaction as compared to usual care, placebo, or no treatment (Katon et al., 1995; Katzelnick et al., 2000; Wells et al., 2000). However, a major barrier to successful guideline implementation in primary care is the comprehensiveness of the intervention. Regardless of the use of various elements, including depression screening and identification, physician education, standardized treatment protocols, academic detailing, or mental health specialist support, the most important factor in improved patient outcomes appears to be a structured patient follow-up program sustained by some type of data system (Simon, Von Korff, Rutter, & Wagner, 2000; Wagner et al., 1996). Increasingly, this approach, often called case management, is utilized in managed behav-

ioral health care as well as primary care to wrap services and support around patients with chronic conditions, resulting in more effective care and decreases in inappropriate utilization (Inglehart, 1992; Lane, 2004; Shueman, Troy, & Mayhugh, 1994).

Massachusetts was the first state to implement a statewide Medicaid behavioral health carve-out contract to a private vendor for the Commonwealth's Primary Care Clinician (PCC) Plan, following in the footsteps of many private health care insurers (Patullo & Malpiede, 1996). Driven by concerns about the quality of public mental health care, other states have followed (Ogles, Trout, Gillespie, & Penkart, 1998). This movement has been accompanied by widespread criticism and concern on the part of some clients and behavioral health providers, who argue that managed behavioral health reduces quality in service to save costs, creates barriers to obtaining service, and poorly manages the more sick or difficult clients (Dorwart, 1990; Eckert, 1994; Karon, 1995). However, others argue that the business practices inherent to public managed care adopted from the private sector also involve the management of quality. Along with this comes the potential to develop better cross-system integration to provide comprehensive services to clients that require multiservice interventions, especially children and low-income Medicaid recipients (Ogles et al., 1998; Shueman et al., 1994).

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Nevertheless, there remain substantial challenges to providing appropriately managed behavioral healthcare to populations with multiple needs, a remaining stigma about mental illness, and an imperfect relationship with health care in general, such as found in the Medicaid population. The Massachusetts Medicaid program (MassHealth) in conjunction with the University of Massachusetts Medical School Department of Family Medicine and Community Health (UMMS/DFM) undertook such challenges when it became part of the Robert Wood Johnson Foundation Depression in Primary Care: Linking Clinical and Systems Strategies project (Kilbourne, Rollman, Schulberg, Herbeck-Belnap, & Pincus, 2002). This project was premised on the assumption that while positive outcomes have been documented as part of clinical trials and specific quality improvement (QI) initiatives to treat depression in primary care, the real challenge is how to implement the same approach and guidelines in entire health care delivery systems, and with disadvantaged and racially and ethnically diverse populations, with enough rigor

to produce similar patient outcomes (Schulberg, 2001). This paper reports the results of conducting pre-implementation focus groups and interviews with primary care clinicians to determine current issues and concerns faced by providers at the practice level. It then describes how the project has been implemented, and will end with implications for managed behavioral health care.

METHODS

Prior to recruitment of participants (both providers and patients), study methods were reviewed and approved by the academic medical center's Institutional Review Board. For the provider focus groups, primary care providers were recruited based on letters, email lists, word of mouth, and nominations from MassHealth-contracted health plans to participate in a group discussion about treatment of adults with depression, based on two criteria: (1) treating a large number of MassHealth-insured adults in their practice, and (2) having an interest in depression treatment. All providers recruited served a substantial number of MassHealth patients ($n = 75\text{--}250+$). The discussion was oriented to uncovering issues and concerns of providers and had five major questions:

- How do you identify your Medicaid patients that you suspect may have depression?
- What are some of your major concerns about treating your patients with depression?
- Are there particular groups of patients that you have special concerns about?
- If available, how would you use a care manager to assist you with your patients with depression?
- What types of information, guidelines, and decision support would be most useful to you in treating patients with depression, and in what form would you like the information?

We sought providers who represented different types of practice sites (small solo or group practices, outpatient clinics, community health centers), and different geographic locations in Massachusetts. A total of three groups were held with a total of 15 providers, one in the Western part of the state, one in central Massachusetts, and one in the Boston area. Three additional individual interviews were conducted with providers who had planned to attend a group but were unable to do so. There were a total of 15 physicians and 3 nurses (representing 13 different practice sites). Of

this 15, nine were family practitioners, six were internists, two were family nurse practitioners, and one was an internal medicine nurse specialist.

These groups were part of the planning activities to determine how to structure physician training, care management, and behavioral health support for primary care physicians to appropriately treat adult depression among the Medicaid population. Subsequently, using the information drawn from these groups, patient groups, and prior studies of the chronic illness model applied to depression care (Kilbourne et al., 2002), a depression care project was implemented at seven primary care sites, which enrolled approximately 5,000 MassHealth adult members. The results include preliminary data from the first six months of project implementation based on patient enrollment and outcome data.

RESULTS

Primary care provider views of treating adult depression prior to project implementation are as follows.

Identifying Patients. Providers unanimously agreed that depression was high among their Medicaid patient population, and that they struggled with providing appropriate treatment to these patients. One provider noted, "I wasn't interested in mental health when I started to practice, but that's what most people come to me for." All indicate depression prevalence rates for the Medicaid patients in their practices as 21% or over, with 26–30% being the modal range. However, only one regularly and two sometimes reported using a standardized depression assessment instrument to confirm the diagnosis. Most used informal methods, or targeted patients with other symptoms such as sleep disturbance, chronic pain, or anxiety. They appeared to be comfortable with their informal methods. One provider reported, "Every time we use a tool, depression is off the charts." Another reported, "We may be over-identifying." It was acknowledged that for this low income, diverse, and highly-stressed group of patients, almost all had a level of dysthymia and complaints of a non-specific nature that mimicked major depression, but may have related more to their life circumstances than to clinical criteria. The unstable and difficult lives many of the patients experienced, along with multiple chronic physical problems, was also noted as making diagnosis difficult. One provider said, "We see patients who have a ton of social issues and never fit just one diagnosis." While the providers' reported approach to diagnosing depression was in almost all cases based on clinical judgment rather than clinically-validated criteria, most did not readily agree that a systematic protocol for screening and assessment would be useful to them and their patients.

Major Concerns. For patients with depression, providers reported a range of treatments, including medication, office visit support, referral to behavioral health, and watchful waiting. The majority of practitioners reported using medication for over 51% of their patients suspected of depression, and about half accommodated regular office visits. While some providers noted that they referred large percentages of patients for behavioral health services, many reported that access to behavioral health in a timely and appropriate manner was extremely difficult, so difficult in some cases that they would only refer and push hard for services for the most at-risk or difficult-to-treat patients. One provider commented, “I better do all I can as a PCP so I can call in a favor to get [more severe] patients bumped up on behavioral health lists.” Other providers reported that their patient population resisted seeing behavioral health specialists. “They’ll come to us, but they absolutely won’t go to behavioral health.” Other issues with behavioral health included lack of bilingual/bicultural practitioners, and concerns about the quality and appropriateness of traditional “50-minute hours” for this patient population, instead citing the need for emotional support and crisis intervention, and lack of communication with the primary care physician once a referral has been successfully made. Several providers felt that because of the lack of a system of care for mental health issues, and the difficulty in billing for ancillary [non-medical] services that help keep people out of crisis, the current system is wasteful, and many unnecessary hospital admissions occur.

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These comments point to the perception of the primary care providers that the behavioral health system did not manage patients well, even when patients found their way to behavioral health. Many providers noted that they “picked up the pieces.” Finally, a number of providers also reported that they “were not paid” from many health plans for an office visit if they coded depression as the primary diagnostic code, or that for some health plans, when a medical provider used a behavioral health procedure code, this meant that a behavioral health visit was “used up” and deducted from the total eligible visits to which a patient was entitled. (The payment restrictions seemed to be one way some health plans have to control behavioral health costs and shift care to behavioral health carve-outs. However, most health plans in Massachusetts at the time of data collection, including MassHealth, did not have these rules, despite provider belief that they were in effect.) Thus, patients with

depression were identified in medical records and claims by somatic symptoms only (e.g., chronic pain, insomnia), and the true prevalence of depression in the population was masked.

Particular Risk Groups. When asked if there were particularly high-risk groups for obtaining appropriate treatment among their patients, the most common group mentioned was linguistic and cultural minorities: “You can’t help a population without knowing the culture.” Providers were also concerned with how to handle those with more severe mental health comorbidities, suicide risk, and substance abuse. One provider said, “We have no way to assess or stratify risk of suicidality.” A few also mentioned individuals with few social supports and the elderly were particularly at risk. Finally, several providers mentioned that “patients just don’t have one thing, they have HIV, diabetes,” so there was concern about how to manage medical chronic conditions along with depression.

Care Management. Providers were asked how they would use a care management system and additional personnel to provide follow-up calls and visits with patients if it was available. Most providers liked the idea of a care manager, someone who can assist them to provide ancillary services and supports for patients with depression. One provider noted, “We don’t know the resources, links are hard to make.” They also felt that the person should be on-site to be maximally effective: “They have to have a face, know someone will call if they miss their appointment. That gives motivation to comply.” One provider pointed out that all his commercial patients were receiving care management from a central health plan location via phone calls and letters, and felt a similar effort should be offered to Medicaid patients. Providers were unaware that patients could receive case management from the Medicaid-managed behavioral health care carve-out, and were unaware that they could refer patients for such care if the patient had a mental health diagnosis. On the other hand, some providers were skeptical, and preferred to keep patient management in their own hands: “I like to do my own thinking and don’t believe in delegating. . . care management is yours to keep.”

Most of the patients who completed the follow-up assessment for other psychiatric symptoms self-reported having been previously treated for depression.

Requested Decision Support Resources. When asked what type of information and tools providers might find helpful in managing their patients with depression, there was general agreement that information about antidepressant medications, dosing, and side effects would be useful, as well as appropriate patient education literature and videos. One provider acknowledged that determining if a patient was “getting better,” and

when to try other medications or other approaches did require a more rigorous evaluation and assessment. Several also requested ways to provide groups and alternative medicine activities (e.g., massage, yoga) to assist patients to self-manage their symptoms.

The Depression in Primary Care Intervention

Through the use of Robert Wood Johnson Foundation funding, the UMMS/DFM developed a comprehensive intervention using the six elements of the chronic care model: leadership, decision support, delivery system design, clinical information systems, patient self-management, and community resources. Leadership was provided by MassHealth staff, and staff of the managed care plans and the Massachusetts Behavioral Health Partnership, the behavioral health carve-out for the MassHealth program. Decision support included primary care training materials on a screening instrument (the PHQ-9; Kroenke, Spitzer, & Williams, 2001), antidepressant medication, assessment for suicide risk, assessment for comorbid psychiatric and substance abuse issues, and guidelines for when to access specialty mental health care. Delivery system design involved working with various types of medical practices serving MassHealth patients (e.g., community health centers, residency practices, outpatient departments, and small-group practices) to establish screening, treatment, and follow-up procedures, including the use of a project-funded care manager. The care manager in one large community health center was a bilingual R.N. The other care manager who served six sites, including four group practices, a residency practice and an outpatient practice, was a clinical social worker. A clinical registry was designed and used by the care managers to record characteristics of patients screened and treated for depression, and to record care management contact, patient compliance with medication, self-management activities, and outcomes. Care managers provided regularly-scheduled telephone or occasional in-person support sessions to patients diagnosed with depression. They also facilitated referrals by PCPs for psychiatry consultation or accessing psychotherapy, sought other social services for patients, and actively engaged patients in self-management plans and skills. Finally, appropriate community resources were identified to assist patients to improve functioning, symptoms, and social and instrumental support. These latter two roles were common to many managed behavioral health case manager protocols.

Preliminary findings from this intervention show that in the first seven months of the project, 559 MassHealth adults were screened for depression at clinical sites. Most high-volume sites targeted patients who were suspected of depression or who had other chronic conditions (e.g., dia-

betes, asthma) in order to reach the most acute and high-risk patients first. Patients who scored 15 or above on the PHQ-9 were asked if a care manager could call and assist them with managing their depression. Upon acceptance by the patient, the care manager initiated contact.

Note that scores on the PHQ-9 ranged from 0 to 27. A score of 15 or over indicated probable moderate to major depression, and required further assessment and treatment. Scores of 10–15 also indicated possible clinical levels of depression, and warranted further assessment and recommended treatment. The MCDPC used a cutoff of patients scoring 15 and above for care management services because trial data indicated 20–50% of the MassHealth population would score 15 or above.

A total of 169 patients (30.2%) from the 559 screened scored in the clinical range, suggesting moderate to major depression (see Table 1 for demographic and descriptive characteristics). Interestingly, consistent with the literature on rates of depression among patients with chronic illness (Eaton, 2002; Frasure-Smith, Lesperance, & Talajic, 1993; Kroenke et al., 1997), 64.4% of patients scoring 15 or over had at least one comorbid medical condition (47.7% for those scoring 10–14, and 31.9% for those scoring under 10). Those indicating major depression were also assessed for other psychiatric diagnoses (PCPs and patients completed this assessment for 77% of patients scoring in the major depression range) and we

TABLE 1
Characteristics of MassHealth Patients Screened for Depression (N = 559)

<i>Characteristic</i>	<i>Frequency</i>
Mean age	41.1 years
Gender	72.6% female
Ethnicity	White 45.1%
	Latino 42.0%
	Black 8.2%
	Asian 0.7%
Screening score 15+ (major depression)	32.2%
Screening score 10–14 (moderate depression)	15.4%
Screening score <10 (likely not depressed)	51.5%
<i>Comorbid medical conditions</i>	
Hypertension	16.8%
Asthma	11.3%
Diabetes	9.8%
Chronic pain	5.6%
COPD	2.1%
Other	17.2%

TABLE 2
Comorbid Psychiatric Conditions and Prior Depression Treatment
(N = 113 of n = 149 accepting care management)

<i>Condition</i>	<i>Characteristic</i>
Treated previously for depression (<i>n</i> = 78)	69.0%
Prior treatment helpful (of <i>n</i> = 78)	39.7%
Recent death of family member	32.7%
Ever told you were bipolar	12.4%
Experienced manic episodes	9.7%
Panic more than half the days in last 4 weeks	60.2%
Panic prior	91.2%
Anxiety more than half the days in last 4 weeks	46.0%
Experience of childhood physical or sexual abuse	48.7%
Experience of abuse as an adult	53.1%
PTSD symptoms/nightmares	26.6%
Any item on the CAGE (alcohol or drug abuse)	13.3%

have found very high rates of comorbid anxiety, panic, and histories of childhood and adult abuse (see Table 2). About 14% of patients (*n* = 169) who initially screened at scores of 15 or above were referred directly to behavioral health because of suspected bipolar or psychotic symptoms. Of those patients who screened for depression and accepted care management (*n* = 149) and had a full assessment and treatment plan (*n* = 113), 55% also asked for therapy services (see Table 3).

Patients with chronic mental illness often suffer from inadequate primary medical care.

There were three steps in the screening and referral process: PHQ-9 scores, preliminary assessment for bipolar and psychosis, and full assessment by the PCP or CM for those accepting care management. Many patients were assessed and continued on prior treatment plans without a full assessment, despite this being a recommended step in the process. More complete data were available for those patients where a full assessment was completed that included a specific treatment plan (*n* = 113 of *n* = 149 accepting).

Most of the patients who completed the follow-up assessment for other psychiatric symptoms (*n* = 113) self-reported having been previously treated for depression (*n* = 78 or 69%), while only 39.7% of this group reported prior treatment was helpful. The average initial PHQ-9 score for those scoring above 14 points, indicating major depression, was 18.33. Treatment implemented included medication, therapy, and care

TABLE 3
**Overall Referral to Care Management and Behavioral Health Treatment
 Provided, and Outcome for Care Managed Patients**

<i>Variable</i>	<i>Frequency or Mean (n)</i>
Percent referred to care management (<i>N</i> = 559)	30.2% (169)
Percent referred, but refusing care management (<i>n</i> = 169)	11.8% (20)
Percent referred behavioral health at screening stage (<i>N</i> = 559)	14.3% (80)
Percent referred to behavioral health after follow up assessment (<i>N</i> = 113)	29.2% (33)
Percent accepting antidepressant medication who had a recorded treatment plan (<i>n</i> = 78)	88.5% (69)
Percent accepting psychotherapy who had a recorded treatment plan (<i>n</i> = 78)	55.1% (43)
Percent with both medication and therapy who had a recorded treatment plan (<i>n</i> = 78)	46.2% (36)
Percent actively engaging in care management who accepted initially (<i>n</i> = 149)	65.1% (97)
Mean total # telephone contacts with care manager for those who had any telephone contact (<i>n</i> = 124)	3.18
Mean total number of in person contacts with care manager of those that had any in person contact (<i>n</i> = 91)	1.33
Mean total # collateral contacts on behalf of patient to PCP, behavioral health or social services by care manager (<i>n</i> = 149)	7.7
% care managed patients having recommended mini- mum of 3 contacts in 3 months-care manager con- tacts only (PCP contacts not recorded)	68.0%
% care managed patients having recommended mini- mum of 6 CM contacts in 6 months	54.8%
Average decrease in PHQ-9 scores (<i>n</i> = 108 patients with initial and follow up scores)	-6.4 points
Percent with improved scores at 1-3 months post diagnosis who have been enrolled in CM for at least 3 months (<i>n</i> = 65)	92.3% (61)
Percent with improved scores at 3-6 months post diagnosis who have been enrolled at more than 3 months (<i>n</i> = 43)	79.1% (34)

management (see Table 3). The majority accepted medication, while almost half accepted both medication and therapy. While initially about 12% of patients offered care management for depression refused care management, about one-third who accepted care management either did not respond to contacts by the care manager, actively engage, or were dropped from primary care management when they were sufficiently linked to specialty behavioral health care. For those that did have contact with the care manager, the average number of telephone calls and in-person contacts with the care managers was modest (three phone contacts and one in-person contact), with about half of the patients continuing to receive regular contact six months after initial enrollment. Despite modest levels of contact for most patients, however, the mean percent of patients who show some improvement in symptoms was 92% at three months, and 79% at six months after initial assessment (see Table 3).

DISCUSSION

The preliminary findings from the RWFJ depression in primary care intervention show that depression is highly prevalent among the MassHealth population, particularly those with other chronic conditions, and is accompanied by additional substantial comorbid psychiatric symptoms, such as panic, anxiety, and PTSD. The rates of depression and other psychiatric symptoms are well beyond the rates found in prior studies with disadvantaged populations (Olfson et al., 2000). A majority of patients with depression also had one or more serious chronic health conditions such as hypertension, asthma, or diabetes. The perceptions of primary care physicians revealed in the pre-intervention focus groups that patients who are complex and cannot be treated for depression alone were borne out in analyzing the characteristics of MassHealth patients in the primary care intervention sites. Further, while many patients reported prior treatment for depression, effectiveness of that treatment seems to be low. This points to a disconnect between appropriate and effective behavioral health care for patients who need it, reinforced by the experiences of primary care physicians that they have extremely limited access to such care for their patients.

The rates of illness detected in this primary care population point to the absolute necessity of primary care expertise in treating mental health issues. At the same time, the use of a depression care manager linked directly to the primary care site to provide the comprehensive support and linkages to necessary behavioral health care seems to be effective. In contrast, plan-based care management based on utilization review to iden-

tify high-cost patients and work with them directly to manage utilization rarely has involved the primary care physician. Up until the RWJF pilot intervention, none of the 40+ physicians at our pilot sites reported being aware of, or being contacted by, a case manager from the managed behavioral health carve-out, or from one of the MassHealth managed care plans, either for psychiatric or chronic illness issues. As feared by critics of carve-out managed behavioral health care, these data illustrate that behavioral health and primary care are two separate spheres with little communication and overlap. While this may not be entirely attributable to managed behavioral health carve-out arrangements, it does seem that creating separate administrative and financial arrangements for behavioral health care and medical care can exacerbate already difficult connections between the two sectors. As the Massachusetts Commissioner of Mental Health has suggested, patients with chronic mental illness often suffer from inadequate primary medical care, while patients in the primary care system suffer from inadequate behavioral health care (Childs, 2004).

Most providers liked the idea of a care manager, someone who could assist them to provide ancillary services and supports for patients with depression.

The use of a care manager located at primary care sites seems to have the potential to bridge the divide between primary care and behavioral health to the benefit of both patients and providers. One of the major functions of the care manager has been to develop and nurture relationships with behavioral health providers, make sure patients find their way to appropriate behavioral health providers, and encourage and facilitate communication between behavioral health and primary care providers. The project has also pilot-tested a psychiatric consultation process whereby psychiatrists are paid a small monthly retainer to accept urgent, brief consultation calls from PCPs. Ongoing data collection for the RWJF project will examine overall health care utilization, including medical, pharmacy, and behavioral health costs. While managed behavioral health care has demonstrated that case management can divert patients from more expensive and intensive behavioral health services (Lane, 2004), the challenge is to link medical and mental health management so that both systems are used appropriately and the patient receives optimal care. As learned in our focus groups, primary care physicians spend a lot of time trying to treat mental health issues in the guise of somatic complaints, with ineffective results. Costs accrue to the medical care system and then when a patient is in crisis, they may end up in costly and intensive behavioral health care. Anecdotally, our primary care-based care managers have been able to divert a number of patients from emergency room use and avert suicide attempts by linking quickly to

prearranged connections to behavioral health providers. These connections were developed to provide the systems integration not previously established between primary care and managed behavioral health care.

Despite the patient management strategies instituted by managed behavioral health care carve-outs, our experience with the PCC plan carve-out has shown that there remains both inadequate access to behavioral health care and inadequate mechanisms to connect behavioral health and primary care. This project illustrates an initiative co-sponsored by the Massachusetts behavioral health program designed to overcome barriers found in many states: to strengthen links between behavioral health and primary care and increase rates of treatment of depression. The bridge can be built if there is a function within primary care, where most of the patient population seeks care, to link appropriate patients to behavioral health after basic level screening, assessment, and intervention has been undertaken. Efforts on the part of managed behavioral health care alone to increase quality, access, and to reduce reliance on more intensive and expensive interventions will likely not succeed unless the continuum of care starts earlier, when patients seek care in primary medical care settings. This is due to both patient hesitancy to seek out behavioral health care, and the difficulties of navigating the behavioral health referral system without support, despite administrative rules that allow direct access. Our RWJF demonstration project chose to fund and locate the care management function at the primary care sites instead of the health plan administrative level. We believe that primary care site-based care management for mental health issues will be more successful, especially with the diverse and harder-to-engage Medicaid population. However, this function could equally well be funded and managed by behavioral health carve-out organizations, or behavioral health provider groups. The advantage of managed behavioral health care linking more directly with primary care sites would be a more population-based approach to addressing mental health needs, and the potential to leverage the already active involvement of primary care physicians in “treating the whole person.”

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