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About this issue

Behavioral Health and Primary Care Coordination

This issue is focused on the coordination of behavioral health and primary care. Articles from experts in healthcare emphasize the need for integrated care to promote overall wellness and provide insights on funding, clinical, and structural models for coordination. Behavioral health and primary care providers share success stories (see pages 12–18) from coordinated care models that they have implemented. One clear theme emerges, as the National Council President and CEO Linda Rosenberg emphasizes in her editorial, “Just as screening and evaluation for behavioral health disorders is appropriate in primary care settings, screening and evaluation for general health problems should be available to individuals in behavioral health settings.”

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Each issue provides in-depth perspectives and tools on a key issue in behavioral health. We would love to hear from our readers about whether this newsletter is helpful to you and about themes you would like to see covered in future issues. Please email your feedback and suggestions to MeenaD@nccbh.org.

The Quiet Tragedy of Premature Death Among Mental Health Consumers

Ronald W. Manderscheid, PhD, Director, Mental Health and Substance Use Programs, Constella Group, LLC

Persons with serious mental illnesses die 25 years younger than the general population, based on reports for consumers served by state mental health agencies. Male consumers are likely to die at about 53 years and female consumers, at 59 years. The 25-year disparity is due to two factors, chronic physical disabilities (which account for 15-20 years of the difference) and mental disabilities such as suicide (which account for 5-10 years).

These troubling numbers were uncovered by Craig Colton and me and reported in *Preventing Chronic Disease* in April 2006.¹

The data used in the study that we reported on was submitted by public mental health agencies in eight states (Arizona, Missouri, Oklahoma, Rhode Island, Texas, Utah, Vermont, and Virginia) for 1997 through 2000. The data was

submitted during the 16-State Study on Mental Health Performance Measures, funded by the Substance Abuse and Mental Health State Administration’s Center for Mental Health Services in collaboration with the National Association of State Mental Health Program Directors.

Compared with findings from a much earlier related study,² mental health consumers’ disparity in length of life appears to be worse in 2006 than in 1986. The causes of premature death among persons with mental illnesses are equally disturbing. The chronic physical disabilities contributing to premature death result from the lifestyle problems of many Americans.

The disabilities are obesity, high blood pressure, diabetes, stroke, chronic heart disease, and heart attack. Collectively, these chronic health

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CMHC and CHC Collaborate to Expand Mental Health Services in Kansas

Lougene Marsh, Executive Director and Lanis Dieker, LCSW, Behavioral Health Consultant — Flint Hills Community Health Center, Emporia, Kansas

The Flint Hills Community Health Center (Lyon County Health Department) and Mental Health Center of East Central Kansas in Emporia, KS, have come together in an excellent example of collaboration between public health, mental health, and primary care providers. Such collaboration is essential in light of the fact that psychological distress, which most often contributes to or is the result of medical illness, can complicate medical treatment and increase medical costs. Psychosocial factors are related to poor general health status, functional disability, and long term health morbidity and mortality. Almost

70% of all health visits have a psychosocial basis. In turn, mental illnesses can have an impact on chronic conditions. Left untreated, these conditions may trigger unhealthy behaviors, diminished immune functioning, and poor prognosis outcomes for the patient.

FHCHC participates in the Health Disparities Collaborative for depression and successfully applied for a mental health expansion grant through the Bureau of Primary Health Care (Health Resources Service Administration). MHCECKS supported that grant application

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Who is Advocating for the Health Needs of Persons with Serious Mental Illness?

Linda Rosenberg, MSW, President and CEO, National Council for Community Behavioral Healthcare

In this issue, Ronald Manderscheid (see page 1) outlines the findings of a study, funded by the Center for Mental Health Services in collaboration with the National Association of State Mental Health Program Directors, that compared the mortality of consumers of public mental health services in eight states with the mortality of the states' general population. Using age-adjusted death rates, standardized mortality ratios, and years of potential life lost, the study found that individuals with serious mental illness die on average 25 years younger than the general population! Joseph Parks (see page 10), chair of the NASMHPD Medical Council, also discusses the implications of these findings in the context of an upcoming technical report.

These horrifying findings on premature death corroborate what we have been hearing anecdotally from those working directly with the vulnerable population with serious mental illness. The findings are a national call to action.

The eight-state study findings support the growing acknowledgement of the connection between general health and behavioral health (mental health and addictions treatment). Former Surgeon General Satcher, the President's New Freedom Commission on Mental Health, and the Institute of Medicine have addressed the importance of mental health and freedom from addiction disorders to overall health. And each has urged coordination and collaboration between behavioral health and primary care.

Most of the recent attention and activity on coordination of care has focused on primary care sites. Acknowledging that mental health is integral to overall health, the Health Resources Services Administration (HRSA) has underwritten many mental health expansion initiatives. As a result, the percentage of community health centers providing mental

health services has grown from 53.8% in 1999 to 72.2% in 2004, representing 139.8% growth in the number of persons served and 75.9% growth in mental health visits.

“Just as screening and evaluation for behavioral health disorders is appropriate in primary care settings, screening and evaluation for general health problems should be available to individuals in behavioral health settings.”

The general health of people with serious psychiatric illnesses and addiction disorders being served in public behavioral health systems has had far less attention, and no additional funding support. And the research tells the story: heartbreakingly high early mortality and medical co-morbidity rates, and healthcare that is often inadequate and poorly coordinated.

The National Council has long promoted referrals, collaborations, and contracting between behavioral healthcare and primary care. Information, materials, and manuals are available from the National Council (see Resources on page 24) and are used by states and provider organizations as they plan for and implement coordinated services. We have been less successful in encouraging a national dialogue about the supports needed to ensure that people with serious mental illness and addiction disorders are adequately screened and treated for physical illnesses.

Just as screening and evaluation for behavioral health disorders is appropriate in primary

care settings, screening and evaluation for general health problems should be available to individuals in behavioral health settings. The implementation of the Medicare Part D prescription benefit highlighted the role of mental health treatment agencies as the medical home for those with serious mental illness, and that home needs to be equipped to address the whole person (see page 3 for article on medical homes).

Who will champion the needs of those with serious mental illness who we now know are at risk of dying 25 years too soon? National Council member organizations are trying. In addition to leading the dialogue on coordination of care, the National Council has developed legislation that creates the capacity to begin to address the physical needs of persons with serious mental illness within behavioral health settings.

And we call upon the federal government, SAMHSA, and HRSA to set standards and ensure that funding is available so that every provider of public behavioral health services can assess the health status of all individuals receiving antipsychotic medications and has specific protocols in place for medically monitoring such individuals. An integral part of services is to assure that each person is connected to primary care, that there are specific mechanisms between the behavioral health and primary care providers for coordination of services, and that there is the option to bring primary care into behavioral health settings.

We have identified the problem and the solution is within our grasp. Transformation must include giving individuals with serious mental illnesses a chance for a full and long life.

The Four Quadrant Clinical Integration Model

National Council for Community Behavioral Healthcare

<p style="text-align: center;">Quadrant II — BH[®] PH[™]</p> <ul style="list-style-type: none"> • BH Case Manager with responsibility for coordination w/ PCP • PCP (with standard screening tools and BH practice guidelines) • Specialty BH • Residential BH • Crisis/ER • Behavioral health IP • Other community supports 	<p style="text-align: center;">Quadrant IV — BH[®] PH[™]</p> <ul style="list-style-type: none"> • PCP (with standard screening tools and BH practice guidelines) • BH Case Manager w/ responsibility for coordination with PCP and Disease Mgr • Care/Disease Manager • Specialty medical/surgical • Specialty BH • Residential BH • Crisis/ER • BH and medical/surgical IP • Other community supports
<p style="text-align: center;">Quadrant I — BH[®] PH[™]</p> <ul style="list-style-type: none"> • PCP (with standard screening tools and BH practice guidelines) • PCP-based BH* 	<p style="text-align: center;">Quadrant III — BH[®] PH[™]</p> <ul style="list-style-type: none"> • PCP (with standard screening tools and BH practice guidelines) • Care/Disease Manager • Specialty medical/surgical • PCP-based BH (or in specific specialties)* • ER • Medical/surgical IP • SNF/home based care • Other community supports
<p>BH: Behavioral health</p> <p>PH: Physical health</p> <p>PCP: Primary care physician</p> <p>SPMI: Severe and permanent mental illness</p> <p>IP:</p> <p>SNF:</p> <p>ER: Emergency room</p>	

Behavioral Health Risk/StatusHigh
Low

Low..... **Physical Health Risk/Status**High

➤ Plan for and deliver services based upon the needs of the individual, consumer choice and the specifics of the community and collaboration.

For a detailed discussion of the populations, services and financing related to the Four Quadrants, please refer to the National Council's Behavioral Health/Primary Care Integration Background Paper, available on www.nccbh.org (Quick Links/Primary Care Integration).

Medical Homes: An Opportunity to Promote Coordinated Care

Mohini Venkatesh, Policy Intern, National Council for Community Behavioral Healthcare

The concept of ‘medical homes’ evolved in an attempt to provide more effective and cost-sensitive care to children who have or are at increased of developing chronic physical and behavioral conditions.¹ Individuals are assigned to a medical home so that they have access to a regular, comprehensive, and continuous source of care.

There is growing support for medical homes from federal and state governments. A few states have implemented this concept for adults as well, and other states are soon to follow.² States such as West Virginia may be incorporating medical homes into their personal responsibility requirements as part of Medicaid reform under the Deficit

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To ensure the proper care of adults and children with severe mental illness, community mental health organizations must be clearly defined as their allowable medical homes.

”

Reduction Act. Therefore it is important that the model serve adults and children who have significant mental health needs. However, the National Council is concerned that the available guidance for the establishment of medical homes does not allow them to meet the needs of persons with severe mental illness.

Although the underlying definition of the target population for medical homes clearly includes children with serious mental health

needs, the planning and implementation of the model have focused on the pediatrician and not the mental health provider as the medical home or the “leader” of the medical home service delivery team. When the American Academy of Pediatrics developed the National Medical Home Mentorship Program in 2001, the first twelve state teams included six people each, including a family

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Financing to Support Coordination of Behavioral Health and Primary Care Services

Barbara J. Mauer, MSW, CMC, National Council Consultant and Managing Consultant, MCPH Healthcare Consulting

Integration of behavioral health and primary care has been described in many ways. There can be financial, structural, and/or clinical practice integration. Financial integration includes “carve-ins,” shared risk pools or other incentives. Structural integration includes services delivered under the umbrella of the same organization or behavioral health specialty services co-located with primary care services. Clinical integration — what is experienced by the consumer in relation to the providers — is the goal. However, this is difficult to achieve without financing mechanisms, structural relationships, and infrastructure that support the collaborative effort.

Evidence-Based Clinical Model

As clinical integration is the goal, a brief description of an evidence-based clinical model provides the context for a discussion of finances. In the largest treatment trial for late-life depression to date, IMPACT, a team of researchers led by Dr. Jürgen Unützer followed 1,801 depressed, older adults from 18 diverse primary care clinics across the United States

for two years. The key components of IMPACT include:

Collaborative care

- Patient, depression care manager (a nurse, social worker, or psychologist), and primary care physician develop a treatment plan.
- Depression care manager and primary care physician consult with a designated psychiatrist to modify treatment plans as needed.

Stepped care

- Measure depressive symptoms at the start of treatment and regularly thereafter.
- Adjust treatment according to an evidence-based algorithm. Aim for a 50% reduction in symptoms within 10-12 weeks. If there is no significant improvement, change the plan.

The IMPACT research sites represented a variety of insurance coverage and payment environments, ranging from integrated systems such as Kaiser or the Veterans Administration to safety net clinics. Sustainability of the IMPACT model has been a challenge to many settings outside of integrated care systems.

Financing Barriers: the Uninsured

A major question in providing integrated care is whether the consumer has insurance coverage (e.g., Medicare, Medicaid or commercial) or is indigent and/or uninsured. Community health centers have seen increasing numbers of uninsured in their service populations. Between 1999-2004, the percent of uninsured in CHCs grew three times as fast as the percent of uninsured nationally.

Unlike CHCs, community mental health centers have no national requirement to serve the uninsured population. CMHCs lack the equivalent of the Public Health Service 330 grant funding that CHCs receive to serve underserved populations and the special reimbursement relationship with Medicaid. A mandate to CMHCs to serve the uninsured and financing to support it has been a matter of state policy, with a great deal of variation among the states. Many states have shifted their mental health general fund financing to Medicaid match, leaving few to no funds for the indigent uninsured population, including individuals with serious mental illness. This policy environment has created a strain on the relationships between CHCs and CMHCs, at a time when collaboration is critical to provide integrated care to safety net populations.

Financing Barriers: Medicaid

The most complex situation vis-à-vis integration is that of the Medicaid system. For example, there has been considerable discussion about whether behavioral health should be “carved-in” or “carved-out” when states make purchasing decisions. Some “carve-out” models have been customized to support clinical integration efforts, while some “carve-in” models have had the effect of reducing overall levels of behavioral health spending and services, especially for the population with serious mental illness.



“Strategic partnerships between community mental health centers and community health centers are essential to overcome financial barriers and achieve clinical integration for positive outcomes.”

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Financing *Continued from page 4*

In October 2003, the Health Resources and Services Administration issued Program Information Notice (PIN) 2004-05 regarding Medicaid Reimbursement for Behavioral Health Services. The PIN requires Medicaid agencies to reimburse Federally Qualified Health Centers and Regional Health Centers for behavioral health services provided by a physician, physician assistant, nurse practitioner, clinical psychologist, or clinical social worker, whether or not those services are included in the state Medicaid plan. The PIN clarifies that “FQHC/RHC providers must be practicing within the scope of their practice under the state law.”

What might PIN 2004-05 mean for the Medicaid population? Categorically eligible Medicaid beneficiaries (e.g., TANF, aged/blind/disabled) may or may not be able to easily gain access to public mental health services, depending on definitions of target populations and medical necessity, which vary from state to state.

In states with public mental health systems that focus on populations with serious mental illness and serious emotional disturbance, PIN 2004-05 creates an opportunity for other Medicaid populations, with higher physical health and lower behavioral health risks, to obtain behavioral health services through a CHC. This is consistent with the HRSA initiative to reduce health disparities and create behavioral health capacity in CHCs. PIN 2004-05 helps to assure that safety net populations are served.

But what does PIN 2004-05 mean in terms of financing and the behavioral health services now provided to populations with serious mental illness? The answer varies from state to state because of differing Medicaid models. This variability requires every community partnership between a CHC and a CMHC to assess their specific financing and policy environment in order to identify a business model that will support integration activities. Such partnerships must develop policy direction that addresses the need for greater access to



behavioral health services for the Medicaid population, without disadvantaging any populations now served by the public mental health system.”

Learning from Pilot Sites

“Depression in Primary Care: Linking Clinical and System Strategies” is a Robert Wood Johnson Foundation national program to increase the effectiveness of depression treatment in primary care settings. The program charged its eight demonstration sites with addressing financial and structural issues as well as implementing clinical models. A special issue of Administration and Policy in Mental Health and Mental Health Services Research contains a series of resulting papers, some of which speak directly to the financial and policy barriers in the system.

The pilots reveal the commitment of sites around the country that continue to patch together funding because they believe in the integration approach. For example, in Washington State there is a partnership between the CMHC and the Federally Qualified Health Center, where the CMHC’s clinicians in the FQHC sites are financed by an annual golf tournament — hardly a sustainable model.

The IMPACT trials, Depression in Primary Care project, state Medicaid pilot sites, and an Aetna project all identify similar components for financing:

- Screening
- Care management
- Psychiatric consultation

These are close to the components identified in the report of the President's New Freedom

Commission on Mental Health, which emphasized that there must be a relationship between mental health and general health. However, these service components are currently missing from public and private sector billing codes and financing policy.

The challenge — for federal, state and private payors — will be to align financial/policy incentives to support clinical integration, which research demonstrates is effective in achieving positive outcomes.

➤ Go to www.nccbh.org (click on Primary Care Integration under Quick Links) for the National Council discussion paper by Barbara Mauer on the current status of financing and policy support for behavioral health and primary care integration. The paper further explores the financing barriers discussed above as well as Medicare and commercial insurance.

Barbara Mauer is a nationally known expert in behavioral health and primary care integration. She has more than 15 years of experience in this field and is a managing consultant for MCPP Healthcare Consulting in Seattle as well as a National Council senior consultant. She offers consulting services to public and private sector health and human service organizations on integration as well as strategic planning, quality improvement, and project management. Mauer has authored many papers and books on behavioral health and primary care integration.

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Lack of Coordinated Mental and Primary Healthcare Endangers Lives of Persons with Schizophrenia

Henry Nasrallah, MD, Professor of Psychiatry, Neurology, and Neuroscience, University of Cincinnati College of Medicine

Individuals with serious mental illnesses such as schizophrenia or bipolar disorder are burdened enough in their daily struggle to maintain their mental health. However, an even more serious challenge faces these individuals: the threat of higher morbidity and mortality due to medical illness. Extensive studies have shown that psychotic disorders and their pharmacotherapy are both associated with physical health problems, especially metabolic illness and cardiovascular disease. But perhaps the greatest jeopardy for persons with schizophrenia is how the current mental health system has failed to provide them with the most basic primary care assessments, monitoring, and treatment.

In a recent book¹ about medical illness and schizophrenia, a large body of evidence is presented to show that schizophrenia is linked to a high prevalence of several medical conditions. These conditions, especially

obesity and its cardiovascular consequences, lead to the well-

documented shortening of the average lifespan in persons with schizophrenia by about 20 years. Part of the problem is the high-risk lifestyle of persons with schizophrenia, which includes sedentary living, smoking, unhealthy dietary habits, and obesity, all of which contribute to diabetes, hypertension, and coronary artery disease.

Metabolic pathology, such as visceral adiposity and insulin resistance, appear to be present even at the onset of schizophrenia. With the advent of the atypical class of antipsychotics, the incidence and prevalence of serious metabolic disorders have increased significantly,² prompting the Food and Drug Administration to improve a class warning in the fall of 2003. The FDA class warning requires physicians to monitor the patients before and after the start of antipsychotic therapy, a procedure that was rarely being done at that time.³ A few months after the FDA warning was imposed, several medical organizations, led by the American Diabetes Association and the American Psychiatric Association, published a consensus statement based on an extensive literature review, pointing out that obesity, diabetes, and dyslipidemia appear to be associated with some atypicals but not others.⁴

The most recent and definitive evidence for metabolic complications of some atypical antipsychotic agents emerged from the landmark five-year CATIE (Clinical Antipsychotics Treatment Intervention Effectiveness) study sponsored by the National Institute of Mental Health.⁵ The CATIE study found that 42% of the subjects with schizophrenia who participated in the trial met criteria for the metabolic syndrome at the time of enrollment into the trial⁶ and had significantly higher risk for cardiovascular mortality.⁷

Even more worrisome are the findings in the CATIE study that the majority of the community-based schizophrenia subjects who already had metabolic diseases when enrolled into the study were not receiving the standard medical treatments for their conditions.⁸ For example, in the schizophrenia sample, only 55% of patients with diabetes were receiving a

Health Screening Emphasizes Need to Manage Overall Wellness

Evidence suggests that people with serious mental illnesses like schizophrenia and bipolar disorder may be at an increased risk for developing cardiovascular disease. However, many risk factors, including high cholesterol, obesity, insulin resistance and diabetes, often go undetected and unaddressed in the course of treating psychiatric symptoms.

In an effort to raise awareness and urge action around the importance of maintaining overall wellness in people living with these conditions, Pfizer initiated a health screening program that

is taking place at local mental health centers nationwide. This new program offers clinics a full day screening, involving a weigh-in,

blood test and blood pressure assessment, to identify metabolic disturbances that can lead to cardiovascular events.

*To date, results from these screenings echo baseline observations in the National Institute of Mental Health-sponsored CATIE study, where 44% of patients entered the study with metabolic abnormalities.¹ Many of the patients participating in the Pfizer screening program had metabolic risk factors. **80% of the patients were either overweight or obese. 33% had borderline high or high cholesterol and nearly 30% had high blood pressure.***

Findings from the Pfizer screening program reinforce the need for the mental health community to better manage overall wellness of patients. Some practical measures include routine metabolic screenings, encouraging healthy lifestyle choices, evaluating the impact treatment may have on metabolic parameters, and potentially adjusting dosage or medication to help reduce risks.

“Winning the battle against psychosis in a community mental health clinic will ring hollow when the war of life and death is lost.”

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Lack of Coordinated Care Endangers Lives

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hypoglycemic agent, only 38% of those with hypertension were receiving an antihypertensive medication, and only 11% of those with hyperlipidemia had received a cholesterol-lowering drug. These findings confirm that there is a serious disparity of healthcare for patients with chronic psychotic disorders and that the mental health system is not providing the most basic primary care treatments for citizens with disabling mental illness. Given that individuals with serious brain disorders tend to neglect their own health needs or do not know how to find a primary care physician on their own, it is appalling that they are also neglected by the system in charge of providing them with psychiatric health services.

It is becoming quite apparent that the lack of integration of mental healthcare and primary care for persons with severe and persistent mental illness represents a major hazard to their well-being. Winning the battle against psychosis in a community mental health clinic will ring hollow when the war of life and death is lost.

Experts agree that the lack of seamless and effective integration of psychiatric care and primary care represents a major risk for patients suffering from schizophrenia and related disorders. It is simply unacceptable to let disabled psychiatric patients at high risk for medical diseases be neglected, as demonstrated by the CATIE study. At a press conference during the American Psychiatric Association Annual Convention in Toronto, May 19-23, 2006, a panel of research psychiatrists and internists urged for more vigorous monitoring for metabolic complications in persons receiving atypical antipsychotics, and for an integrated system of care to address all the medical needs of the patients, psychiatric and nonpsychiatric. The Veterans Administration Healthcare System was lauded for its best practices in this area because every mentally ill patient in the VA system is assigned both a psychiatrist and a primary care provider, and annual physical exams and laboratory screening are mandatory.

In conclusion, there is now a clear call to remedy the untenable situation of inadequate medical care for vulnerable persons with mental illnesses who depend on the mental health system for their healthcare. Mental health administrators, medical directors, and practitioners should also implement the ADA/APA guidelines and use the CATIE findings as a roadmap to initially select the antipsychotic medication least likely to induce new or exacerbate pre-existing metabolic disorders in patients with schizophrenia and other psychotic disorders.⁹

Henry Nasrallah is an internationally recognized psychiatrist, educator and researcher. He is currently Professor of Psychiatry, Neurology, and Neuroscience at the University of Cincinnati College of Medicine. He has published more than 300 articles and 10 books and is editor-in-chief of Schizophrenia Research and The Journal of Psychotic Disorders. Dr. Nasrallah is board certified in both adult and geriatric psychiatry. He has been recognized with numerous teaching, research, and clinical awards including the 2005 Psychiatric Times Teacher of the Year Award.

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Managing Diabetes in Persons with Schizophrenia

By 2030, more than 30 million people in the United States are expected to have diabetes. Studies have suggested that patients treated with antipsychotic medications have a higher risk of diabetes than the general population.

In "Diabetes and Schizophrenia" a special section supported by Eli Lilly and Company in the April 2006 issue of Behavioral Healthcare, Leslie Citrome, MD, MPH, a professor of psychiatry at the New York University School of Medicine, examines various studies on schizophrenia and diabetes and points out the following:

- *Patients with schizophrenia often are disadvantaged economically, so they may not be able to afford healthier eating habits. They also may not have access to adequate primary care services.*

- *For a patient with both schizophrenia and diabetes, effective treatment of schizophrenia is a necessary prerequisite for the successful treatment of diabetes. A person with uncontrolled schizophrenia will be unable to follow a regimen to control diabetes.*
- *Patients treated with antipsychotics may have a greater risk of developing diabetes than patients who are not treated with antipsychotics.*
- *Patients with schizophrenia can be difficult to treat, and prescribers need access to all available options. If second generation antipsychotics are avoided because of their potential diabetes risk, and first-generation antipsychotics are preferred, this could result in poor adherence to the treatment medication.*

 **Download a PDF of Diabetes and Schizophrenia from www.nccbh.org (click on Primary Care Integration under Quick Links).**

Funding Models for Depression Care Management in Primary Care Settings

Harold Alan Pincus, MD, Director and Jeanie Knox Houtsinger, BA, Deputy Director — National Program Office, Depression in Primary Care

Optimal primary care for a variety of chronic illnesses, including major depression, has been demonstrated through the use of the chronic illness care model (CCM) developed by Wagner and colleagues.^{1,2,3,4} A key component of this model is care management, a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality and cost-effective outcomes.

funds three related grant components — incentives (demonstration projects), value research, and targeted leadership awards — to stimulate innovation in primary depression care. These components help to identify and implement economic and organizational strategies that, along with evidence-based clinical best practices, will sustain chronic illness care improvements in the primary care treatment of depression.¹² Several extant models for funding depression care management services have been piloted through the

to certain plan members with specified diseases, including depression. In these arrangements, care managers are typically located at the practice site(s) and may be employees of the practice, the health plan, or another entity (e.g., a community mental health organization or a disease management company). Such arrangements can include providing full or partial salary reimbursement to practice sites for depression care managers. Revenue for the care managers' services is generally based on historical estimates of both the service costs and the number of members served, and takes the form of monthly or yearly retrospective payments.

“Because care management services fall outside the conventional margins of the healthcare delivery system, third-party payers require cogent demonstrations of their value in order to justify subsidizing them.”

Several well-controlled studies have demonstrated the clinical efficacy and cost effectiveness of care management for behavioral disorders in general^{5,6} and for depression in primary care settings specifically.^{7,8,9,10,11} In these studies, care managers provided combinations of the following services

- Patient and family education about depression and its treatment
- Development of treatment and self-management plans
- Coordination of care with primary and behavioral health specialty providers
- Assessment and monitoring of patients' preferences, needs, barriers, and progress
- Encouragement of treatment adherence by patients and medication guideline compliance by physicians
- Brief, structured forms of psychotherapy
- Specialty referrals and hospitalizations as needed

A significant challenge to providing depression care management is finding sustainable funding mechanisms for these services. The Robert Wood Johnson Foundation's \$12 million national program, “Depression in Primary Care: Linking Clinical and Systems Strategies,”

program's demonstration projects and similar programs as described below.

1. Practice-Based Care Management on a Fee-for-Service Basis

In the fee-for-service model, care managers are employees of the primary care practice and located within its clinical site(s). Revenue flows from the insurer (e.g., a health plan or governmental payer) to the primary care practice upon the insurer's receipt of properly coded billing statements and in accordance with the payer's benefits structure and coverage policies. Few, if any, explicit care management billing codes are recognized by third-party payers, especially private insurers, thus making fee-for-service billing dependent on “medically necessary” services rendered “incident to” physicians' care. To be a viable source of funding, however, any fee-for-service care management billing from primary care would have to address current constraints on billing for patient telephone contacts and inability of the sites to bill for multiple primary care provider encounters in the same day.

2. Practice-Based Care Management under Contract to Health Plans

Health plans can contract with primary care practices to provide care management services

3. Global Capitation

Group model HMOs, which are generally fully capitated and have a relatively flexible capacity to allocate resources, can provide and fund care management services internally.

4. Flexible Infrastructure Support for Chronic Care Management

This funding model includes an allocation of money by health plans to practices designed to support specific quality improvement efforts, such as infrastructure developments (e.g., information system upgrades), provider training, or care manager salaries that will improve clinical outcomes and patient satisfaction. The additional money is available to a practice either to meet specific, predetermined expenses or, more flexibly, for purposes of its own choosing. In the latter case, practices may choose to reward physicians for meeting or exceeding pre-selected clinical performance expectations, reinvest the money to enhance quality infrastructure (e.g., support care managers), or do both.

5. Health Plan-Based Care Management

Managed care and/or managed behavioral healthcare organizations employ care managers in a variety of roles to perform multiple tasks, with a focus on utilization review and treatment planning with treating clinicians via telephone. These typical managed behavioral healthcare

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Funding Models

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care management services usually involve minimal or no contacts with patients or primary care providers. As health plan employees, care managers' salaries and expenses are typically absorbed in the administrative costs charged to the health plan's customers (i.e., purchasers). In some cases, health plan-based care management targets specific diseases (e.g., asthma, diabetes, depression) or populations (e.g., the frail elderly). Demand for enhanced, collaborative care by purchasers and consumers will be instrumental in managed behavioral healthcare organizations' commitment to invest in care management services to support primary care providers.

6. Third-Party Based Care Management under Contract to Health Plans

Health plans may subcontract with disease management organizations, managed behavioral healthcare organizations, and/or community mental health organizations to provide off-site care management services for specific patient populations (e.g., chronically ill elderly patients) and/or diagnostic classes (e.g., patients with depression). These arrangements are typically capitated wherein the subcontractor receives per patient per month revenue that is generally based on historical estimates of both the service costs and patients served. As with the other funding mechanisms, consumer expectations and purchaser demands will exert clinical and economic pressure on health plans to extend support to third parties to provide care management services.

7. Hybrid Models

Combinations of the funding mechanisms listed above results in various hybrid-funding models for care managers and their services. For example, community mental health center counselors can be placed in primary care practices and funded partly through fee-for-service billing and partly through health plan contracts.

Challenges and Opportunities

Because care management services fall outside the conventional margins of the healthcare delivery system and are delivered by

healthcare professionals whose training cuts across traditional boundaries, third-party payers require cogent demonstrations of their value in order to justify subsidizing them. However, a decade of well-controlled health services research demonstrating the benefits of depression care management (i.e. better integration of primary and behavioral healthcare for depressed patients, improved clinical outcomes) and the strong endorsement of major health policy institutions (such as the President's New Freedom Commission, the Institute of Medicine, and the Centers for Medicare and Medicaid Services) can drive ongoing efforts to find sustainable mechanisms for funding these services

Harold Pincus is Professor and Executive Vice Chairman of the Department of Psychiatry at the University of Pittsburgh School of Medicine. He directs the Robert Wood Johnson Foundation's national program on "Depression in Primary Care: Linking Clinical and Systems Strategies." Jeanie Knox Houtsinger brings more than 10 years of research management experience to this program. The "Depression in Primary Care" program is intended to increase the use of effective models for treating depression in primary care settings. Learn more at www.depressioninprimarycare.org.

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Perspectives on Premature Death Based on the Upcoming NASMHPD Technical Report

Barbara Mauer, MSW, CMC, National Council Consultant, interviews Joseph Parks, MD, Chair of the Medical Directors Council of the National Association of State Mental Health Program Directors, on the technical report — publishing in fall 2006 — on chronic disease and premature death in the population with serious mental illness.

Dr. Parks, why did the Medical Directors Council decide to focus a technical report on the issue of chronic disease and premature death in persons with serious mental illness?

In the last four years, several new state studies and one large multistate study have found that persons in the public mental health system die 25 years younger than the general population. This is absolutely shocking! The Medical Directors Council concluded that these findings represent a public health emergency that calls for immediate action. We wanted to alert other stakeholders and advocates and provide them with information to fight this epidemic of early death.

Has there been a change in what we know about premature deaths in the population with serious mental illness?

Yes, previous studies from one to two decades ago reported that the persons we serve die 10-15 years younger than the general population. The new studies have found that persons with serious mental illness die earlier of heart disease, hypertension, stroke, diabetes and other general medical conditions. In fact, many more persons with severe mental illness are dying of general medical conditions than are dying of suicide. If we want the people we serve to recover from their mental illnesses, we have to keep them alive and healthy.

Why are people with serious mental illness dying so much earlier than the general population?

The marked increase in early death is due to several factors. Our whole country is in the middle of an epidemic of obesity and decreased physical activity, which has led to a general increase in heart disease and other medical conditions. Persons with mental illness have always had greater difficulties in these areas and now their rates are increasing even faster those of the general population. Second, many of the newer psychiatric medications have metabolic side effects that lead to these conditions and we haven't made managing those risks the same kind of focus that we made tardive dyskinesia. Third, we have failed to adequately address addictive disorders, in particular smoking. Approximately 70% of the people we serve smoke and smoking increases the rates of all these medical conditions. These factors multiply one upon another.

What should National Council members, community-based mental health/behavioral health treatment organizations, be doing to improve the health status of the people they serve?

Like most public health crises, this one is being driven by many factors and addressing them will require multiple approaches. To be successful, we will have to change our

thinking and redirect our efforts in several broad areas. First, we need to focus on overall wellness as a central part of promoting recovery. Second, treatment plans must address how to achieve a healthy lifestyle. Third, we need to prioritize and emphasize adherence to general medical care and good preventive care as much as adherence to mental health treatments. The NASMHPD technical report will contain a wealth of background information and evidence-based practices that National Council members can draw from to develop their own action plans to keep the people they serve alive to enjoy their recovery.

Joseph Parks, along with Dale Svendsen, MD, led a workgroup convened by the Medical Directors Council of the National Association of State Mental Health Program Directors in Columbus, Ohio, in May 2006 to address the problem of premature death in persons with mental illnesses as revealed by multistate studies. The workgroup provided input for a technical report, which is intended to serve as the basis for developing a national strategy for the coordination of mental health and primary care. The report will be available in fall 2006 at www.nasmhpd.org/publications.cfm#meddirectors.

The Quiet Tragedy *Continued from page 1*

problems are known as the “metabolic syndrome.” However, unlike many other Americans, public mental health consumers are much less likely to receive care for these problems. As a result, they die prematurely.

Mental disabilities experienced by consumers can lead to suicide. Although effective treatments exist for many of these mental disabilities, the public mental health system has only recently begun to embrace the concept of recovery and its related notions of hope and independence.³ Frequently, persons with mental illnesses tell us that they have lost hope and don't envision for themselves a future in which they can live valued and productive lives in the community.

Addressing this silent tragedy must be a very high priority for the entire mental health field. Solutions are likely to be found through coordinating good care for chronic physical disabilities with good mental health care. The concept of recovery encompasses both types of care. It is the persons with mental illnesses that can and should provide leadership for such coordination. They have great insight about how current care systems can be improved. The “wellness model,”⁴ published more than 25 years ago, can also provide guidance in this work. The recent Institute of Medicine report on Improving the Quality of Healthcare for Mental and Substance Use Conditions⁵ is also a blueprint for coordinating mental health and primary care.

Treating Depression in the Primary Care Setting Proves Effective for Older Adults

Rita Haverkamp, MSN, RN, CNS, President-elect, California Chapter, American Psychiatric Nursing Association

The IMPACT treatment model is a stepped care program for the treatment of depression that utilizes a depression care manager who collaborates with the patient and the primary care physician and a psychiatrist as needed. Treatment includes depression education, Problem Solving Treatment, medication management, and behavioral activation. The patient is monitored closely using the PHQ-9 scale for depressive symptoms and the treatment plan is evaluated regularly to assure that new plans are developed as needed. A relapse prevention plan is developed when the patient is in remission to assure long term compliance.

I have been providing IMPACT depression care management to patients for the past seven years. I found this model to be very rewarding and effective as the research results verified and my personal experience confirmed. The results of the IMPACT clinical trials led by Dr. Jürgen Unützer showed that the IMPACT model of depression care more than doubles the effectiveness of depression treatment for older adults in primary care settings.

Older adult patients often express that it is easier to receive care from a person in the primary care office. They are less likely to go to a mental health clinic than younger adults and they express more concern about stigma. They often say they feel comfortable when the primary care physician says “Go see

Rita in my office.” As older adults are often treated for numerous other conditions they appreciate that their care is coordinated with their PCP. IMPACT results concluded that with the collaborative care model, more patients in the intervention group received depression care as compared to those in usual care.

The IMPACT model of depression care is similar to care management programs for other chronic conditions like diabetes. We have a flyer in the PCP exam room which allows patients to talk to their PCPs easily about depression and PCPs aren’t reluctant to open the conversation because they know the care manager is available to follow up with the patient.

Depressed patients have poor adherence to treatment and worse health outcomes than non-depressed patients when treated for other chronic medical disorders. My patients improve their adherence to medical regimes as I reinforce the plans. I use “Problem Solving Treatment” at times to help them plan for how to get exercise or stay on a diet. I can discuss other medical issues that affect depression with the PCP more easily since my office is in primary care. Patients experience less pain and improved functioning as a result of the treatment. I think the improved continuity of care for patients in this system helps them to achieve these results.

Having a systematic way to evaluate the effectiveness of treatment using the PHQ-9 helps the patient and care manager have a clear goal for improvement and to plan changes in care accordingly. Treating depression in the primary care setting can be described as taking the depression blood pressure — patients and PCPs understand the concept and the numbers. The Problem Solving Treatment model empowers patients and teaches them skills that help them with interpersonal and medical problems. Behavioral activation is an easily applied treatment that is helpful to all patients, even those who didn’t want therapy. I often found that patients who might have remained chronically depressed were more fully treated due to clear treatment goals and treatments that activate patients and increase their self efficacy.

As a mental health professional and cognitive/behavioral therapist, I have certainly found this model rewarding and effective.

Rita Haverkamp was awarded the Psychiatric Nurse of the Year Award for Expanded /Advanced Practice by the San Diego Psychiatric Nurses Society. She has 35 years experience as a psychiatric nurse. She is a psychosocial clinician in the Department of Primary Care at Kaiser Permanente of Southern California, La Mesa, CA. Haverkamp played a significant role in the IMPACT research trial and subsequent trained hundreds of clinicians in the IMPACT model, both within Kaiser and around the country.

Community mental health centers have been at the forefront of efforts to coordinate mental health and primary care for the past decade. Hence, any national strategy will need to reflect this excellent work. A major first step will be defining a very clear goal, with an iron commitment to achieve it. For me, this goal would be to reduce 10 years of the disparity within a 5-year period. Persons with mental illnesses should demand no less.

Ronald Manderscheid spent more than 30 years in government service and was branch chief of the Survey and Analysis Branch at SAMHSA’s Center for Mental Health Services. He received the National Council’s 2006 Award for Excellence in Public Service for his multifaceted efforts to support and encourage a comprehensive public health system that incorporates quality behavioral healthcare.

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Behavioral Health and Primary Care Coordination Roundup

Community-based behavioral health organizations and community health centers across the country as well as two state associations of behavioral health providers — in Massachusetts and North Carolina — have implemented several models of coordinating behavioral health and primary care. Here, they share their challenges, successes, experiences, and lessons learned.



Massachusetts State Association Initiative Helps to Overcome Financing and Administrative Barriers to Coordination of Care

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Massachusetts behavioral health providers have learned that clinical integration happens when behavioral health and primary care clinicians are empowered to work together, regardless of administrative, management, and financing barriers.

Unlike community health centers, community mental health and addiction treatment clinics do not have a federal mandate or resources to care for uninsured individuals. Massachusetts has never expanded public reimbursement for uncompensated care to include the provision of services in community behavioral health clinics. The state eliminated outpatient mental health resources for the uninsured when it

shifted the financing of these services to Medicaid in order to capture federal matching funds. State licensing and other regulations prevented community behavioral health clinics and CHCs from partnering to better coordinate patient care.

Despite losing millions of dollars providing free care, behavioral health clinics in Massachusetts had to turn away growing numbers of people who desperately needed their services but who lacked insurance. Those who were seen mostly showed signs of medical neglect. At the same time, CHCs were struggling to treat uninsured individuals with far more intensive mental health and addic-

tion treatment needs than the community had historically seen.

Behavioral health providers identified operational barriers to collaboration and began to develop proposals that would eliminate these barriers. Providers also adopted the Four Quadrant model because it best meets the healthcare needs of all people in settings most appropriate to their needs without mandating a one size fits all approach. Behavioral health providers, represented by the nonprofit association, The Mental Health and Substance Abuse Corporation of Massachusetts, then

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CMHC and CHC Collaborate

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and provides clinical supervision to FHCHC's behavioral health consultant. The consultant's services are directly integrated into FHCHC's primary care clinic and provide mental health services to FHCHC patients and consultation to its primary care providers. Patients seen by the behavioral health consultant receive short-term, solution-focused interventions. More complex patients and those not stabilized on psychotropic medications are referred to MHCECKS for specialty care.

For several years, FHCHC and MHCECKS have both been involved in a community coalition, Healthier Community Alliance, which includes a focus to increase awareness and understanding of depression and treatment options. From this work and the prior partnership, another collaboration emerged to apply for participation in the National Association of County and City Health Officials' demonstration site grant, "Increasing Collaboration between Mental Health, Public Health, and Primary Care." This grant, which was implemented between July 2005 and April 2006, provided an opportunity for FHCHC and MHCECKS to strengthen and expand their established relationship and to engage the existing coalition in crafting a strategic plan and goals.

The NACCHO grant allowed FHCHC and MHCECKS to strengthen both agencies and enable them to

- Develop and deliver strong health education messages
- Increase the understanding, perception, and receptivity to mental health services in the Hispanic community
- Increase motivation for racial and ethnic minorities to seek care

- Strengthen the ability of private sector providers to screen for mental health issues
- Respond with appropriate treatment interventions.

One of the significant accomplishments of the demonstration site project was increased collaboration and cooperation between public health, community mental health, private sector providers, and Hispanic community leaders. These relationships provide a foundation for future work to continue to address health disparities in the Hispanic community and to promote further integration of mental health services into the primary care setting.

To learn more, email lmarsh@flinthealth.org or lanisd@flinthealth.org.



Mass. State Association Initiative

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sought to collaborate with the state and our colleagues in the CHC community to improve behavioral health and primary care coordination.

The state adopted the idea and contributed administrative and support resources. The group decided on six demonstration projects in which community behavioral health clinics and community health centers partner. Common elements of the projects include colocation, enhanced referral processes, patient access to behavioral health services,

improved population identification for integrated services, shared patient information between sites, consultation between clinical staff, and cross-training between behavioral health and primary care staff.

The state health department must now waive regulatory requirements in order to allow CHC and community mental health center patients use the same waiting room, group treatment room, and conference room and for staff from both centers to share common space. One set of clinic licensing requirements has been amended to permit provider coocation and streamlined care plan review, and a second set with similar barriers is under review.

Trainings focused on increasing the ability of primary care clinicians to identify and treat mental health disorders are under way. The project is also pursuing a reimbursement model to pay for physician-to-psychiatrist consultation via telephone.

Initially, there was no funding for the demonstration projects, but our promising results led to the availability of public-private funding for the projects beginning in FY2007. We hope to continue to tackle the financing, regulatory, and information technology challenges that remain barriers to better care.

HES Persists in Coordination Efforts Despite Financing Challenges

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The long-term survival of innovative program models for behavioral health and primary care service integration clearly depends on effective financing strategies supported by policy reform at the state and national levels. One of the most effective models is that which provides primary care in the behavioral health settings. However this model, like other integration models, is fraught with financing challenges and frustrations and is need of reform.

Health and Education Services, Inc. — a mental health and substance abuse treatment provider organization in Beverly, MA — supported by its parent corporation, Northeast Health System, Inc., and the Blue Cross Blue Shield of Massachusetts Foundation, provides routine primary care to adults with serious mental illness in the behavioral health setting. Staffed by nurse practitioners, the program has been in operation for more than three years and is currently part of a controlled field study conducted by Boston University.

The good news is that preliminary results from the HES program show dramatic improvements in appropriate healthcare access for participating consumers. The bad news is that despite persistent and creative efforts on multiple fronts, the program has not even come close to supporting itself due to current available financing options. The dead ends relative to reimbursement are reflective of the problems described first in the Surgeon General's Report on Mental Health¹ then in the report by the President's New Freedom Commission on Mental Health² — fragmentation of services resulting in serious access barriers. Over the past 25 to 30 years, Massachusetts reimbursement structures, similar to other states, have evolved into impenetrable silos. Payment is awarded based on strict population criteria, procedure codes, prior authorization, telephonic review, or any combination of the above.

Attempting to work within the current system to obtain reimbursement for services provided through this model, HES approached the

state's Department of Mental Health, suggesting a capitated model. This seemed to make the most sense since our service utilization reflected the 80:20 rule; about 20% of our consumers were using 80% of the most expensive services, including emergency department visits and inpatient stays. Given the current structure, the department was unable to meet the request, but instead offered HES a contract to provide integrated services to currently institutionalized adults with mental illness and co-morbid medical conditions in a community residential setting. This supported department deinstitutionalization goals, but fell short in terms of this program's need.

HES approached the state behavioral health managed care organization for Medicaid, again suggesting a capitated model of reimbursement. We were assured unequivocally that the program's integrated services were entirely reimbursable through Medicaid, using primary care procedure codes. Although technically true, we found that this solution not viable due a range of problems. For clean reimbursement, the ducks must be perfectly aligned: the right consumer, the right health benefit coverage, the right provider credentials, the right procedure codes, and the right date of service.

In the school of integrated care, the learning curve is steep. It is next to impossible to recruit nurse practitioners with experience in adult primary care and an interest, ideally a solid comfort level, with the range of mental illnesses and addiction disorders. And finding this type of practitioner with Spanish language skills has been impossible to date. Hoping to mold and train, we have resorted to hiring recent graduates. In these cases, the credentialing process geared toward successful billing takes about three months, during which time there is no reimbursement.

It has been difficult to adjust to the world of primary care procedure codes. We painfully learned not to include the behavioral health

diagnoses on the bill, as the reimbursement defaulted to the lower rates associated with behavioral health diagnostic categories. Longer appointment times are required to elicit adequate histories. Patients often do not keep appointments and outreach is necessary. Travel and home visits frequently are needed to engage the patient or to establish a health status that will allow visits to the office. Interface with existing primary care providers and other healthcare team members is key. Much of the above is not reimbursable under current codes.

Perhaps most frustrating of all has been the fact that in order to demonstrate efficacy and define the model as evidence-based, the program must engage in controlled research, using study and control or usual treatment groups of patients. This necessary approach seriously hampers enrollment in the program, essentially cutting potential reimbursements in half. This then limits the funds coming in to support the nurse practitioner salaries and supervising physician fees, which are the primary expenses associated with the model.

However, there does appear to be a light at the end of the tunnel. The six-site Massachusetts demonstration pilot yielded financial support for each integration program site. We recently presented the integrated model of care for adults with serious mental illness at the International Sociological Association conference in Durban, South Africa. It was exhilarating to learn that globally, academicians and human services providers are concerning themselves with issues of access to care and reimbursement structures to ultimately reduce the burden of disease and disability.

We hope the Massachusetts healthcare reform initiatives currently underway will serve to break down the silos of service delivery and encourage integration and coordination at the provider level, thereby making appropriate care accessible to consumers, especially for those who need it the most.

Cherokee's Coordinated Services Provide a Hybrid Community Safety Net

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The 2005 National Comorbidity Survey Replication of the prevalence and severity of mental health disorders revealed that the median delay from onset of a mental disorder to first treatment contact is nearly a decade.¹ The study also indicated that the likely point of access for mental health services is primary care settings rather than specialty mental health settings.² Incorporating behavioral health expertise into primary care is essential in order to speed initial treatment contact and to reduce the burdens and hazards of untreated mental disorders.

Integration of services blends the talents of behavioral health and primary care providers in a manner most convenient to those who access care. Integration removes barriers to care and has demonstrated clinical efficacy. Further, integrated care offers improved patient and provider satisfaction and delivers medical cost savings.³ Integrated care has evolved into a core theme of organizational mission at Cherokee Health Systems. Cherokee began as a small community mental health center that embraced the healthcare movement as a way to help meet the needs of patients. Today, Cherokee has 14 primary care sites with co-located integrated behavioral services in 11 counties in East Tennessee. In our clinical model, psychologists are key members of a multidisciplinary primary care team and provide assessment, consultation, and intervention to primary care patients and providers. Primary care patients are routinely screened for mental disorders. Behaviorists are integrated into primary care protocols for chronic disease management and wellness programs. Psychologists, clinical social workers, case managers, and psychiatrists are on site to provide more intensive specialty behavioral services as necessary. Our path to integration has led us to become a hybrid safety net for the community.

Integrated care involves a seamless coordination of structural, clinical, and operational systems that is geared toward population based man-

agement of healthcare. Successful integration of behavioral services into primary care requires radical changes in system design as well as training of healthcare providers. The entire organization — including front desk staff, nurses, providers, and upper level administration — needs to be committed to an integrated delivery system. Building the right workforce requires the right type of training. Behaviorists must be embedded in the primary care area, even though this consumes valuable medical space. And finding the right behaviorist, well matched to the primary care team, is especially critical to making integrated care work.

Financing integrated care has posed its own challenges for Cherokee. As is often the case, clinical innovation far outpaces financial restructuring. However, the new health and behavior CPT codes (96150-96155), which reflect primary behavioral care services, are gaining recognition and reimbursement, reflecting a move in the positive direction.

Effective integration of behavioral health and primary care demands revised clinical skills, new service delivery models and possibly, organizational restructuring. But the benefits far outweigh the effort required. Patients prefer, and thrive, in integrated health care models. If we want to optimize our ability to provide quality care to an underserved population, integration is a clinical imperative.

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The Providence Center Partners With the Local CHC for Effective Coordinated Patient Care

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Integrating behavioral and primary care is a priority on many health agendas these days. Most agree that providing today's patients with care that coordinates both their behavioral and physical wellness is optimal. However, few have solutions to the practical snafus that can impede even the most well-intentioned integration efforts.

Historically, primary care physicians and mental health specialists have practiced separately, as if there were no proven mind-body connection. For patients of The Providence Community Health Centers, this essential link to integrated care is a reality on account of the partnership with The Providence Center.

The Providence Center provides community-based treatment and supportive services to adults and children affected by psychiatric illnesses, emotional problems, and addictions. The Providence Community Health Centers provides medical care to low-income and medically underserved adults and children. In 2002, these two entities teamed up to implement a grant that funded Providence Center services at one of the health center's locations. Each week psychiatrists and social workers from The

Providence Center visited the health center to see patients — regardless of their insurance status — and to consult with physicians.

"Research shows that people most often seek care for mental health problems, such as depression and anxiety, from their primary care doctors," says Dale Klatzker, president and CEO of The Providence Center. "Therefore, it makes all the sense in the world for primary and mental healthcare providers to co-locate and coordinate patient care."

Initially, the project was funded by a grant from the Substance Abuse and Mental Health Administration. Funding became a dilemma when the grant ran out at the end of 2003.

Neighborhood Health Plan of Rhode Island, which provides managed care services to Rhode Islanders covered by the state's Rite Care health plan, stepped in early in 2004 to continue funding The Providence Center's care of NHPRI members onsite at the health center. While The Providence Center must serve uninsured patients at its own location, a significant number of Rite Care members still can access mental healthcare in the familiar surroundings of their health center.

"We've learned a lot by working with the Providence Community Health Centers and NHPRI," says Klatzker. "The arrangement has not been without the inevitable administrative mishaps that occur when organizations begin a new partnership, but there has been a remarkable effort and commitment among us to make the project work so patients can conveniently access good, coordinated care."

The effectiveness of integration is most evident in patient care. Today, at the Providence Community Health Center site, health center physicians can be seen conferring with Providence Center psychiatrists on the proper dosing of psychotropic medications, and patients can receive guidance and support for their mental health conditions from specialized mental health professionals.

This exercise in integration was a profound learning experience. Characterized by a cooperative spirit and moments of frustration in the face of swelling demand and inadequate funding, this project demonstrates that this manner of collaboration can be successful for providers and patients.

CPCS to Colocate With Local FQHC to Enable Convenient Access to Care

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Integration of behavioral and primary health care is becoming an exciting reality in Alaska's central Kenai Peninsula. In November 2007, Central Peninsula Counseling Services, a 30-year old community mental health agency and Central Peninsula Health Centers, a 5-year old Federally Qualified Health Center, will colocate in a new 30,000 square foot building currently under construction.

CPHC, the project developer approached CPCS in 2004 with the proposal to colocate. The CPCS board of directors embraced the concept as it offered obvious benefits for consumers, providers, and the community. While CPCS and CPHC will each retain their independent, non-profit corporate identities, a condominium approach to ownership of the new facility is being employed, assuring that each organization has a voice in decision making.

The new facility will offer comprehensive services "under one roof" with a primary care clinic on the first floor and behavioral health services on the second floor. This will prove very convenient for those seeking care. The colocation represents movement towards an integrated culture that supports both physical and mental health. In addition, the arrangement will provide economies of scale and operating efficiencies for both organizations through shared maintenance, phone systems, information technology, and meeting room space.

With the constriction of traditional behavioral health revenue streams, the opportunity to collaborate with CPHC has become an integral component of CPCS' strategic business plan. CPHC has access to behavioral health funding streams unavailable to CPCS, and it is clear that a partnering effort will serve the local

community far better than establishing a competitive environment.

In 2004, CPHC secured a grant to provide behavioral health screening and brief intervention counseling services to its medical patients and then subcontracted with CPCS to provide these services in the primary care setting. This initial experiment in partnering proved effective, and served as an impetus for the colocation project.

Bringing together two organizational cultures is not an easy task. Increasing the comfort levels of boards of directors and employees, understanding and adapting to new office locations, and conducting a community capital campaign are just a few of the many challenges that we face. Nevertheless, we anticipate that the benefits of co-locating will justify the considerable investment made by both organizations.

Washtenaw Realizes Return on Investment in Care Coordination

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The Washtenaw Community Health Organization is an administrative service organization that administers mental health, substance abuse and developmental disability services in southeastern Michigan. WCHO developed a collaborative partnership with the University of Michigan Department of Psychiatry to create innovative best practices in the delivery of integrated health care to Medicaid and indigent patients. WCHO began planning its integrated initiatives in 1998 and launched its first integrated clinic in 2003.

The goals for WCHO’s integrated clinics include

- Creating medical homes for consumers where they can receive their mental health, substance abuse, and primary care at one site
- Reducing stigma by treating consumers in primary care settings

- Improving physical and mental health outcomes
- Creating cost savings for the medical and mental health systems

The structural and clinical models used in the clinics are similar and are adapted to the culture of the primary care setting. The ultimate goal is one location, one team, one record, and one plan of care. The model includes co-locating clinicians working for the local community mental health system at the primary care site. The clinicians are dually trained in mental health and addictions treatment and see anyone referred by the primary care practitioner for case management and/or brief solution focused therapy. A consulting psychiatrist is available to evaluate complex issues and to assist the primary care physician in choosing an education regime for consumers with less com-

plex mental health concerns. Joint team meetings, an integrated and web-based electronic medical record, and a commitment to shared health outcomes are key components of the integrated system.

Nearly all costs of placing existing community mental health staff in primary care settings in Michigan are reimbursable with existing healthcare funding. To achieve sustainability, a mix of cost off-sets are necessary including Medicaid reimbursement, capitated health plan allocations, third party billable services, and the cost reduction for a consumer to be treated in primary care verses community mental health. The following chart provides an overview of the clinics, the mental health and primary care staffing ratios, and costs of the mental health services.

PRIMARY CARE CLINICS <i>All are not-for-profit clinics that serve safety net patients</i>	RETURN ON INVESTMENT (Financial Costs)				
CLINIC TYPE Primary Care Staff	Mental Health Staff	FY07 Costs for Mental Health Staff	FY07 Budgeted Cost Off-sets*	Variance	FY07 Projected Savings for Community Mental Health**
Clinic #1: Serves all ages, 3rd year of operation. <i>4 MDs; 2 nurse practitioners; 1 physician assistant; 1 nutritionist</i>	1 FTE MSW; .10 FTE Psychiatrist; .10 FTE Admin	\$97,040	\$98,967	\$1,927	\$98,967
Clinic #2: Homeless health clinic for adults, 2nd year of operation. <i>2 half time nurse practitioners; volunteer MDs and health providers</i>	.30 FTE Psychiatrist; .10 FTE Admin	\$78,608	\$52,576	(\$26,032)	\$52,576
Clinic #3: University-based, training site, serves all ages, 1st year of operation. <i>6 family MDs; 1 nurse practitioner; 4 pediatric MDs</i>	.10 FTE Psychiatrist; .10 FTE Admin (FTE MSW planned in 2007)	\$35,459	\$25,770	(\$9,689)	\$25,770
Clinic #4: Serves ages 12-20 and their children, 7 months of operation. <i>2.5 MDs; 1 nurse practitioner; 2 nutritionists</i>	1.0 FTE MSW; .10 FTE University Psychiatrist;*** .10 FTE Admin	\$71,516	\$24,806	(\$46,710)	\$24,806
Clinic #5: Safety net clinic, arm of local private hospital, 5 months of operation. <i>2 MDs</i>	1.0 FTE MSW; .10 FTE Psychiatrist; .10 FTE Admin	\$88,218	\$44,627	(\$43,591)	\$44,627

* Budgeted cost offsets derive from capitated Washtenaw Health plan enrollees and Medicaid allocations in WCHO setting, but potentially fee-for service billing in other settings.

** Projected savings are calculated by taking average cost per case for treatment in the separate CMH system and multiplying by the number of consumers expected to be transferred to the clinic in 2006-2007. Figures are not included in 06-07 cost off sets except for Clinic #1 where some transfers have already occurred. Comparable data on cost for care in Clinics is being determined and not factored in at this time.

*** University covers psychiatrist preceptor costs under medical education allocation.



North Carolina Improves Health Through a Coordinated Approach to Behavioral and Medical Care

Jean Overstreet, Director of Marketing and Communications, and Carol Duncan Clayton, former Executive Director — North Carolina Council of Community Programs jean@nc-council.org

The North Carolina Council of Community Programs is the nonprofit association representing public mental health, developmental disabilities, and substance abuse services in the state. The NC Council, through new ways of communication and collaboration with physical health providers, is strengthening the whole person approach for those with mental illness and positively impacting the overall health status of North Carolina residents.

About three years ago, the NC Council began to collaborate with the Community Care of NC, the North Carolina Department of Health and Human Services funded program that organizes medical case management services for Medicaid enrollees.

Under CCNC, North Carolina began to build a robust system of physical health networks to achieve long-term quality, cost, access, and utilization objectives. At the same time, North Carolina was transforming its public mental health, developmental disabilities, and substance abuse system in similar ways — building a robust system of private and nonprofit providers in order to achieve higher quality and greater access to services with a focus on consumer directed supports and services. These two parallel efforts seemed ripe for collaboration.

CCNC and the NC Council initiated four pilot sites to develop a model for integrated care that would be sustainable and replicable across the entire state. The model was to focus on

- Integrating the identification and care of depression in the primary care physician's office.
- The Four Quadrant Model as the basis for screening, identification, and triage of patients with complex needs (combined

medical and behavioral concerns.

- Demonstrating effectiveness in communication and consultation between primary care physicians and psychiatrists.

CCNC funded the pilots for two years, beginning July 2005. The pilots have several standard components. They must

- Focus on adult and pediatric populations.
- Have strong collaboration between the CCNC network and the Local Management Entity, the local public authority for mental health, developmental disabilities, and substance abuse.
- Use the Four Quadrant Model as a foundation for screening, identification, and triage of patients.
- Use common forms and tools for screening and communication developed and endorsed by the pilots.
- Use the CCNC medical case management system to document and share information.
- Track common outcomes identified by the pilots.

Outcome Measures

The common outcome measures for the pilots included trends in pharmacy, trends in outpatient medical and behavioral units, emergency room visits, hospitalizations over a two-year period, overall medical costs per patient, overall screening rates, ADHD follow-up two times a year, and administering the PHQ9 for depression at least three times a year.

Functional assessments (missed school/work days, appointment adherence, medication adherence) as well as consultations between physicians and psychiatrists (type, time, cost, person centered planning, satisfaction) were

also tracked. One of the primary goals of the pilots was to determine if paying the primary care physician for psychiatric consultation time resulted in better outcomes for the patient and increased the primary care physician's knowledge and comfort with care for low-need behavioral health patients. Policy changes related to payment for psychiatric consultation will be recommended if this model should prove to be of value to patients and physicians.

Spotlight on the Buncombe County Pilot

Buncombe County in North Carolina is one year into their CCNC pilot demonstration. However, Buncombe County Health Center in Asheville, NC, has, since 2000, operated an innovative program to integrate behavioral health into its primary care clinic, which serves uninsured and Medicaid populations. Initially supported through grant funding, the integrated health services are now sustained through billing and contributions from stakeholders who benefit from the program. The clinic used office redesign techniques to incorporate universal screening for depression and other behavioral health problems and provides enhanced mental health and primary care through a team of primary care physicians and therapists who have access to a psychiatrist. When patient needs fall outside the realm of primary care, the team works to link the patient with the specialty mental health system. The program conducted a rigorous evaluation, which demonstrated a cost-offset: patients who received integrated care had decreased healthcare costs, more than enough to pay for the program. Patients receiving integrated services showed decreased depression scores, improved functioning, and fewer missed work/school days.

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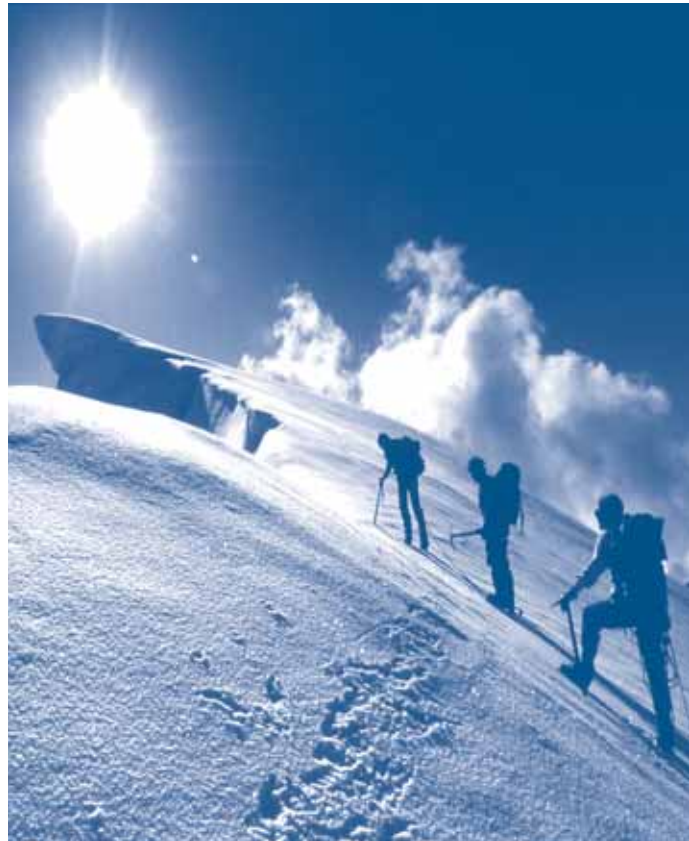
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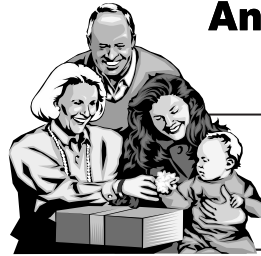
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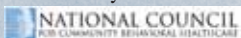
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Medical Homes

Continued from page 3

physician and a family representative, but did not explicitly include a mental health provider, nor was one suggested as “integral to the implementation of a statewide strategic plan.”³

To ensure the proper care of adults and children with severe mental illness, community mental health organizations must be clearly defined as their allowable medical homes. In addition, states should include community mental health organizations in the planning and development of medical homes.

Community mental health providers should work to create and sustain partnerships with community health centers with the goal of providing well-integrated care that meets the diverse needs of people with mental illness. With this as a goal, there is great opportunity to lay the groundwork for the improvement of care.

There are several benefits to making the community mental health organization the medical home for persons with mental illnesses. First, this will help to prioritize the continuity of care because it will allow such persons to continue to seek care from providers they know and trust. Individuals who did not have a regular source of care in the past are also likely to receive comprehensive care that best serves their needs at a community mental health organization.

Second, persons with mental illness need providers who are knowledgeable about their behavioral, medical, and social needs. Often, the medical and social needs are directly related to symptoms of the mental illness and are specific to the individual. Community mental health providers are best suited to understand and meet the spectrum of needs. Sending a person with a well-established relationship with a community mental health organization to a primary care physician they do not know or trust can have serious consequences in states like West Virginia that

require Medicaid beneficiaries to agree that they will use their medical homes or face enrollment in a benefit package that excludes mental health services.

Third, establishing community mental health organizations as medical homes can also minimize the increase in administrative costs because these organizations already maintain detailed client records and would just have to expand their documentation process. Many community mental health providers already have established referral relationships with primary care providers and can therefore easily provide integrated care.

Given concerns about rising healthcare costs and the effects of psychiatric patients seeking care in hospital Emergency Departments,⁴ states must find ways to make the mental health system more efficient. States have an excellent opportunity to lay the foundation for integrated care. By acknowledging community mental health organizations as medical

homes and encouraging them to create and sustain relationships with primary care and other specialty providers, the healthcare system will be able to better serve persons with mental illness.

Mohini Venkatesh is a Master of Public Health student at the Yale School of Epidemiology and Public Health, with a concentration in Health Policy. She was a public policy intern at the National Council for Community Behavioral Healthcare in summer 2006. During her internship, Venkatesh researched and wrote several issue briefs, discussion papers, and fact sheets on key mental health policy issues.

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4. Institute of Medicine Report, “Hospital-based Emergency Care: At the Breaking Point”, pg. 48



➤ Go to www.nccbh.org (Click on Policy) for an Issue Brief that further discusses the concept of community mental health organizations as medical homes.



The National Council for Community Behavioral Healthcare is pleased to announce the launch of a nationwide primary care-mental health collaborative care project, with funding from AstraZeneca Pharmaceuticals. The goals of the project are to increase primary care clinics' ability to screen for bipolar disorder and suicidal risk as part of depression screening and to support a stepped care model through increased training and backup from community mental health organizations to primary care clinics. Primary care and specialty mental health teams from three pilot sites will convene for an initial learning session to be followed by a 6-month implementation period. The teams will then reconvene in a Learning Congress to share accomplishments, data, learning, and tools. The Learning Congress will form the basis for project expansion to additional sites and the preparation of a toolkit for wide dissemination. The National Council will soon provide a detailed project description and application form to member organizations.

Book Review

Raising the Bar: Moving toward the Integration of Healthcare

Kristin Battista-Frazeo MSW, Education Services Manager, National Council for Community Behavioral Healthcare

Many providers are striving to provide an integrated array of behavioral health and primary care services to combat the grim mortality rates and to lower the prevalence of chronic illnesses like diabetes and heart disease. The National Council publication, *Raising the Bar: Moving Toward the Integration of Healthcare* by Virginia Koster LMSW, ACSW and Kathy Reynolds LMSW, ACSW, is an insightful, practical reference for providers who wish to embark on the integration journey.

The book provides an inside look at Washtenaw Community Health Organization's successful efforts to integrate behavioral health and primary care services in Washtenaw County, Michigan. This collaborative effort harnessed support from multiple

stakeholders to provide better care and services for those in the community.

Raising the Bar provides step-by-step guidance to providers in crafting their own integration initiatives. While the book focuses on the local issues and policies that shaped Washtenaw County's program, it provides insights replicable nationwide for providers wishing to integrate services. Readers should pay special attention to the reported data outcomes that show the successes of the Washtenaw County project. The book emphasizes the well-recognized National Council Four Quadrant Clinical Integration Model, which frames the continuum of care that can be offered in a partnership between behavioral health and primary care settings.

The authors discuss the difficulties in integrating two different work cultures and give a realistic perspective about what to expect when dealing with this issue. They include helpful tips for handling the barriers to integration. Additional appendix documents, a sample affiliation agreement, and assessment tools, are a big value added.

The National Council recommends *Raising the Bar: Moving Toward the Integration of Healthcare* as a must-have reference for any provider organization considering an integration initiative. To order, call **301.984.6200** or go to **www.nccbh.org** (Click on Services/Publications).

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Resources for Behavioral Health and Primary Care Coordination

Since 2002, the National Council for Community Behavioral Healthcare has been at the forefront of the national discussion on the coordination of behavioral health and primary care services and has developed a rich array of products and services to help providers improve service delivery.

Planned offerings at the **37th Annual National Council Conference, March 26-28, 2007 in Las Vegas, NV**, include an all day Preconference Institute (on Sunday, March 25) on clinical operations in integrated care; workshops on business models, financing, and the Four Quadrant model; and 1.5 day special workshop on IMPACT depression treatment. Details at www.nccbh.org/vegas. The **National Council's Primary Care Integration Resource Center** at www.nccbh.org (Quick Links/Primary Care Integration) contains an array of National Council papers, tools, and conference such as

- *Behavioral Health and Primary Care Integration Background Paper*, featuring the Four Quadrant Model.
- *Behavioral Health and Primary Care Integration: Finance, Policy and Integration of Services*, a discussion paper that looks at the current status of financing and policy support for integration.
- *State Level Policy and Financing Environmental Assessment Tool*, a review of state level policy and financing environments that helps examine

the extent to which these environments support integration.

- *Crosswalk of Evidence Based Practices to the Four Quadrant Model*, a paper that demonstrates how EBP projects being sponsored by foundations, SAMHSA, and HRSA come together conceptually.
- *The Organizational Readiness Assessment Tool*, one for behavioral health providers and another for community health centers, is organized around the Care Model, the foundation of the IHI/HRSA Health Disparities Collaboratives.
- *CHC Development Overview*, a paper for behavioral health providers, summarizes the process and requirements for application to HRSA to become a federally qualified health center with 330 grant funding.

Behavioral Health/Primary Care Integration Listserve. Listserve is a rich forum for learning and support and is used daily by community providers, researchers, and others working on integration around the country. Access and sign

up at www.nccbh.org (Quick Links/Primary Care Integration).

Consulting and Technical Assistance. Barbara Mauer, MCPP Consulting and National Council Senior Consultant, has written many of the National Council's papers on primary care and has consulted with several states and providers on coordinating behavioral health and primary care. Kathy Reynolds, CEO of Washtenaw County Health Organization, Michigan and National Council Consultant, is a sought-after expert on operationalizing integration and coordination of services. To learn how you can access consultants' services, email KristinBF@nccbh.org.

Recording and Handouts from the National Council Meet Me Call "How to Integrate Primary and Mental Health Care: Review of the Washtenaw Model," presented by National Council consultants, Barbara Mauer and Kathy Reynolds. Available at www.nccbh.org (Services/Meet Me Calls).