Bringing Together Physical and Behavioral Health Care: An Exploration of Current Practice and Future Directions in Pennsylvania

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Message from the Funders

The Pennsylvania Health Funders Collaborative is committed to the health and wellness of the citizens of the Commonwealth of Pennsylvania. The integration of behavioral health into primary care represents one component of creating healthier communities. This integration can increase access to services for all people, but perhaps most critically for those living at or near the poverty level. Much attention has been given to the significant health needs of those living with serious mental illness. The goal of this report, however, is to focus on advancing the integration of behavioral health care and primary care for the general population.

The Pennsylvania Health Funders Collaborative commissioned a report by RAND in 2009 that provided a high-level assessment of the state of integrated care in Pennsylvania. The project described in this report was initiated to build on what was identified by RAND, to identify specific innovations in Pennsylvania, to explore the lessons learned from these innovations, and to learn about developing trends from those actively involved in these innovations. The four goals of this report are:

- Identify the barriers to advancing integrated care for the economically challenged in the state;
- Identify major policy considerations that the Pennsylvania Health Funders Collaborative might address;
- Identify potential philanthropic funding strategies to advance further innovations in models of collaborative care and community health and wellness; and
- Create a snapshot of the range of models and environments in which integrated care has been advanced across the Commonwealth.

In addition there are several secondary, supportive goals:

- Identify successful models and the factors that contribute to their readiness and success;
- Identify local experts willing to mentor others and share advice with others developing their programs; and
- Encourage the development of statewide or regional learning communities to advance the knowledge of people across the state.

This report has been written at a time of tumultuous change. At the federal, state, and local levels budgets are strained beyond the breaking point. At the same time there is the opportunity to build on the momentum of health care reform to transform our system of care into one more responsive to the needs of all its citizens. Our hope and belief is that this report will contribute to and expand the conversation here in Pennsylvania.

Executive Summary

This monograph explores the benefits of integrating behavioral health care and primary health care, as well as the barriers, models, pathways, and opportunities for philanthropy to advance community health and wellness via integrated care.

The Need. The following facts help clarify the need for integrated health care:

- Three out of ten people (29%) with a medical disorder also had a mental health condition.
- Seven out of ten people (68%) with a mental health condition also had a medical condition.
- Major depression is a risk factor for developing medical conditions characterized by pain and inflammation (including cardio vascular disease).
- The risk of self-reported depression among people reporting diabetes was two times the risk for individuals without diabetes.
- Eight out of ten (79%) disabled and six of ten (56%) nondisabled adult Medicaid enrollees nationwide had one or more chronic conditions.
- People with a diagnosis of asthma were 2.3 times more likely to screen positive for depression.

The Environment. The current health care environment is in flux, and includes the following characteristics:

- We are moving from an acute care system to a chronic care system. This system needs to support the long-term management of many chronic conditions.
- Health care reform embraces the patient-centered medical home, which at many levels of accreditation (for example, the National Council on Quality Assurance) must include behavioral health care.
- Potential changes in funding mechanisms will further strengthen the delivery of enhanced primary care and increase the need and financial capacity for integrated behavioral health care.

The Models. This report covers four models of providing mental and physical health care. These models may be thought of as moving from "playing alongside" one another to becoming fully integrated, as follows:

- **Colocated:** In this model, primary care and behavioral health services are delivered in the same location. Collaboration or integration will only be developed with intentional planning and effort.
- **Coordinated care.** In this model, care is coordinated between two or more behavioral health and physical health providers.
- **Collaborative care.** In this model, behavioral health works with primary care.
- **Integrated care.** In this model, behavioral health consultation services work within and as part of primary care.

The Challenges. To deliver the integrated care that will best serve people, the system needs to overcome the following challenges:

- Shifting from a model that focuses on acute care to a chronic care model that focuses on the needs of all people served in a care setting.
- Lack of communication between managed care organizations and lack of communication of care data from managed care organizations to providers.
- Developing sustainable financing models for integrated care.
- Navigating confidentiality regulations.
- Working with the constraints of different benefit packages and payment structures across insurance plans.
- Increasing the ease of collaboration with specialty behavioral health via, for example, the creation of preferred referral status, granting open access, and resolving issues that prevent communication between the specialty provider and the primary care (referring) provider.
- Procuring reimbursement for psychiatric consultation.
- Dealing with workforce issues:
    - Need an expanded acceptable provider panel.
    - Access to training in working in primary care settings.

The Opportunities. The following actions can help transform our system of care:

- Advocating for models of integrated care, including changes in payment mechanism.
- Requiring all insurance plans in the state (and future health exchanges) to recognize models of integrated care as unique instead of attempting to fund them as extensions of traditional outpatient care models.
- Enacting state-level policies that require communication between managed care organizations and with providers in order to integrate critical care information.
- Implementing regulatory changes to support integration, including:
    - Standard coding for behavioral health consultation services in primary care.
    - Managed care organization payment for integrated services in Federally Qualified Health Centers (FQHCs), FQHC lookalikes, and primary care settings.
    - Expanded workforce.
    - Reimbursement for psychiatric consultation to primary care providers, including pediatricians.
    - Waive copayment for behavioral health consultation services in primary care.

- Changing the delivery of specialty behavioral health services, including:
    - Open access.
    - Communication with primary care.
    - Preferred referral status for people already screened in primary care.

Author's Preface

Over the past nine months, interviews and follow-up conversations have taken place with many stakeholders from across the Commonwealth. (For a full listing of the people who were interviewed, please see appendix A.) Pennsylvania is fortunate to have people willing to take risks to develop or adopt innovative models of care in spite of barriers, in order to advance the wellness of individuals and communities. The contributors to this report have been generous with their time and honest with their sharing; without them this report would not have been possible. Without a doubt there are key thinkers and planners involved in these issues who were not consulted. I apologize in advance for this omission.

In addition to local stakeholders, this report is informed by conversations with people from other states. This report attempts to capture the voices and the consensus that emerged as I listened across these past nine months.

The extensive literature available is not formally reviewed in this report but provided background. The case for integrated care is made across reports from the National Council for Behavioral Healthcare Organizations, the Milbank Report, the Agency for Healthcare Research and Quality and Robert Wood Johnson Reports. Providers across the state echo these common themes:

- People seek care first from their primary care providers.
- Primary care providers often feel unequipped to meet the needs of their patients with chronic illnesses who also live with subclinical or clinical levels of anxiety and depression that interfere with their ability to self-manage.
- The transfer of people into specialty behavioral health services is limited by issues of access and of stigma.
- For both mental health and substance use disorder, early intervention is critical to long-term outcomes.

In addition to these general conclusions, a few compelling findings call for a different system of care that focuses on the whole person:

- 45% (125 million) of Americans have one or more chronic health conditions at a cost of 75% of direct medical care in the US (Mauer, 2010).
- 29% of people with a medical disorder had a comorbid mental health condition (Druss and Walker, 2011).
- 68% of people with a mental health condition had a comorbid medical condition (Druss and Walker, 2011).
- Major depression is a risk factor for developing medical conditions characterized by pain and inflammation (including cardio vascular disease) (Druss and Walker, 2011).
- The risk of self-reported depression among people reporting diabetes was two times the risk for individuals without diabetes (Druss and Walker, 2011).
- 79% of disabled and 56% of nondisabled adult Medicaid enrollees nationwide had

one or more chronic conditions (Druss and Walker, 2011).

- People with a diagnosis of asthma were 2.3 times more likely to screen positive for depression (Druss and Walker, 2011).

This is a sample of the data suggesting the need for collaborative care models that take into account the intricate connection between mind and body—between physical health and mental well-being. The data indicate that systems must change to address these holistic needs. This report will address the current national and state situation, current models of integrated care, barriers to advancing them, and recommendations for policy and funding changes.

Bringing Together Physical and Behavioral Health Care:

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The National and State Context

At the National Council of Behavioral Healthcare Organizations meeting in May 2011 (San Diego, CA), Don Berwick, the director of the Center for Medicare and Medicaid Services, said, "We don't have a health care system, we have a sick care system; changing that is at the heart of Health Care Reform."

Our current health care system is built on episodic, acute care needs. For the most part, it fails to meet the needs of people with chronic physical or behavioral health challenges. The fact that the two challenges often occur together while the health care system addresses them separately heightens the need for a better system. The reality is that we need to transform the health care delivery system. Modest changes will not succeed.

A transformation of this magnitude involves many financial and political interests. This is not change from a known old condition to a known new state. It is change guided by a vision of a health care system that truly focuses on increasing the wellness of the entire population and on improving the ability of individuals to manage their chronic illnesses over a lifetime. It is informed by the growing body of research into what helps promote wellness and manage disease. The vision of health care reform coupled with the federal commitment to developing prevention-prepared communities creates an opportunity for a major step forward in the way health care is both conceptualized *and* delivered. This transformation will emerge differently in each local context because of individual community factors. Different models will be developed to best meet the needs of specialized populations.

The implementation of all the provisions of the Affordable Care Act is in question. However, change at the delivery level is already underway. Many of the Act's provisions will have a tremendous impact on the financing of publicly funded health care. The development of Accountable Care Organizations (ACOs), the impact of recently passed parity legislation, the implementation of Health Care Exchanges at the state level, and the expansion of Medicaid eligibility will drive this transformation but are beyond the scope of this report.

The ongoing debate about the role of Medicare and Medicaid and the outcome of that debate will influence how the health care system is transformed. On the one hand, debate could paralyze efforts to influence policy, causing some to take a "wait and see attitude." On the other hand, debate could be an opportunity to advocate a major improvement in the way health care is delivered.

The Pennsylvania Health Funders Collaborative and the people who contributed to this report recognize the need for change and are exploring models of improving care to people. Pennsylvania is a laboratory for exploring these models because of the state's variety of geography, population densities, and cultures. This diversity presents challenges. What works in the metropolitan areas of Philadelphia and Pittsburgh will not work in the center of the state due to the vast distances between people and providers. The unique challenges of each setting require creative and potentially different approaches to care delivery. Some of the innovative programs that currently exist or are being developed are used as examples in this report or are described in Appendix A.

Changing Concepts, Practices, and Context

The traditional health care system focuses on episodes of illness. The transformation to one that focuses on wellness over a lifetime will impact every aspect of care, including financing, the way that providers interact with people and the way members of the health care system interact. Efforts to advance a transformation of this magnitude require a framework for change. A useful framework for exploring this transformation is the notion of alignment of concepts, practices, and context. *Concepts* refers to the core values and principles that direct health care practices. *Practices* refers to the ways in which care is delivered. *Context* refers to the regulatory, funding, relationships and community factors that either support or interfere with the change at hand. (Achara, Evans, and King in Kelly, White, 2011)

In the nearly three years since the RAND report (May 2009) was published the national direction on health care reform has only strengthened the movement toward transformation of the system. The *chronic care model* is critical to this reform movement. "The Chronic Care Model (CCM) identifies the essential elements of a health care system that encourage high-quality chronic disease care. These elements are the community, the health system, self-management support, delivery system design, decision support, and clinical information systems. Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise." (Robert Wood Johnson web page, "The Chronic Care Model"[1])

While this model is concerned about the health of individuals, it focuses on structuring the overall health delivery system to support care for all. The focus of care is on the interaction between informed, activated patients and the team of health care professionals that support them. According to the model, the system will deliver "healthier patients, more satisfied providers, and cost savings."

This is a major conceptual shift from an expert-driven model where the patient is "acted upon" or treated by providers and the health care system. Instead, the patient in this

[1] http://www.improvingchroniccare.org/index.php?p=Model_Elements&s=18

model is a partner in their own care and the goal of the system is to activate the person's ability to manage their own health and wellness. This is a shift from an individual practitioner-based model to a team-based model based on the concept that care is best provided by a health care team in which members collaboratively perform their given unique functions. The chronic care model also recognizes the critical role the community plays in overall health and wellness.

The embodiment of the chronic care model is the *person-centered medical home*.[2] The patient at a person-centered medical home encounters a team of providers whose shared goal is to support the health and wellness of the individual. This home becomes the "base" of care. Patients may leave for specialty care but always with the knowledge that they will return "home." Care is coordinated and managed from the person-centered medical home.

The person-centered medical home goes beyond the earlier gatekeeping functions of primary care providers in the 1990's era of managed care. As standards develop for health care homes, issues of access, quality, and outcomes all dictate that this model is not business as usual. The Joint Commission Standards, built on the Agency for Healthcare Research and Quality definition include: patient-centered care, comprehensive care (including physical and mental health care needs, prevention, wellness, and acute and chronic care), coordinated care (particularly in times of transition), access to care, and a systems-based approach to quality and safety.

These standards are one expression of the recognition that primary care is the place that most people go first when facing either physical or mental health challenges. In a traditional approach to care, primary care providers may not be equipped or have the resources to meet behavioral health challenges. The person-centered medical home potentially provides resources for intervention that is evidence-based, reaches a larger percentage of the population, and improves health outcomes.

These developing models of care use another key concept, that of *stepped care*, in developing their practice patterns. "This concept holds that, except for acutely ill patients, health care providers should offer care that:

- "Causes the least disruption in the person's life;
- "Is the least extensive needed for positive results;
- "Is the least intensive needed for positive results;
- "Is the least expensive needed for positive results; and

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[2] This is also referred to as the *person-centered healthcare home* in some publications (National Council, 2009 and 2010) because this more expansive term recognizes "that behavioral health is a central part of health care and that health care includes a focus on supporting a person's capacity to set goals for improved self-management" (National Council, 2009). While this language debate continues, both the National Council on Quality Assurance (NCQA) and the Joint Commission on Accreditation (JCAHO) use the language of the medical home in their standards, and so it will be used in this document.

- "Is the least expensive in terms of staff training required to provide effective service." (Milbank, 2010)

The implementation of these concepts at the practice level has taken many forms. The language to describe these forms is inconsistent across the field. The two most common terms to describe the interface between primary care and behavioral health are *collaborative care* and *integrated care*. The Milbank report (2010) highlighted the basic definition used by Strosahl (1998): "Collaborative care involves behavioral health working *with* primary care; integrated care involves behavioral health working *within* and as a part of primary care." These definitions will be used in the duration of the report when describing the programs in Pennsylvania.

Two other terms of note that add to the confusion are *coordinated care* and *colocated*. *Coordinated care* refers to care that is coordinated between behavioral health and physical health or between different physical health providers, but is provided in different settings. This coordination facilitates the exchange of information while care continues to be provided in its traditional setting and usually in traditional ways.

While focused on the population of people with serious mental illness and co-occurring physical health challenges, the HealthChoices HealthConnections project in Montgomery County is one example of the critical role coordination of services, in this case through the use of health care navigators, can play in improving outcomes. In a recent analysis of data looking back at the six months before enrollment in the program and six months after enrollment there was an 11% decrease in use of Emergency Room visits, a 56% decrease in medical hospital admissions, and a 43% decrease in psychiatric hospitalizations.

Another example is the program the Community Services Group has in development, which will use a mobile team of trained navigators. These "navigators" will provide direct service in terms of education in chronic illness management but will also support participants in "navigating" the complex health care system of primary care, especially behavioral health care. Like the HealthChoices HealthConnections project, this project is also starting out with a focus on the population of people with serious mental illness (SMI). However, it is expected to expand into the general Medicaid population. This model has promise as a way of delivering population based care to people in scattered rural areas.

Colocated refers to having behavioral health and physical health services in the same geographic location or building. Referrals are made between the two and the possibility for increased communication, collaboration, and coordination of care exists. Pennsylvania examples of this model exist on both the public and private side. Creative Health Services in Pottstown, and the Federally Qualified Health Center (FQHC) located in the same building, is one example. Family Services of Western Pennsylvania has a colocated model that is moving toward integration. Abbottsford Health Center in Philadelphia started with a colocated model and now is fully integrated with a colocated mental health clinic on site. These are all publicly funded providers. On the private side, Delaware County Professional Services has developed a co-location model that provides ser-

vices to people with a variety of insurance plans. The movement from co-location to collaboration and finally to integration requires intentional effort, development of clear communication strategies and committed leadership.

Integrated care means that the behavioral health provider works as part of the team with the primary care provider. The behavioral health care is delivered by a behavioral health consultant who works at a pace similar to that of the primary care provider (seeing patients for approximately 15 minutes) and is perceived by the patient as part of the primary care team. (See Appendix C for a full description.) Behavioral health consultation uses a stepped care approach, starting with the problem identified by the primary care provider or patient and generating immediate interventions and strategies. Usually behavioral health consultation services are delivered in the exam room. Charting is done in a unified record. In well-functioning integrated care practices, there are warm handoffs[3] and multiple informal communications during the day among the health care team members. Follow-up, if needed, may be done by the behavioral health consultant or by the primary care provider with recommendations from the behavioral health consultant.

The fully integrated models in Pennsylvania that were identified in this study exist in Federally Qualified Health Centers and FQHC lookalike settings. Family Services of Western Pennsylvania, the FQHC staffed by Community Services Group in Lycoming and multiple FQHC sites in Philadelphia, are just a few examples of practice locations where integrated care is being practiced. (See Appendix B.)

There are multiple challenges to implementing integrated care, but the sparse population of the rural environment presents unique challenges. In this environment there are often small, solo practices without enough volume to support a full time behavioral health consultant. As an example, in the Lancaster County area that the Lancaster Osteopathic Health Foundation covers, there are 75 small primary care offices that provide services to Medicaid recipients. The principles of integrated care will need adaptation and innovation to fit the rural setting.

While outside the scope of this report, it is worth noting an additional category of model, the *reverse co-location model*. This model places primary care providers in large behavioral health care organizations. This approach also requires intentional, directed strategies to move from co-location to full integration. Horizon House in Philadelphia is one example of a reverse co-location practice. In this case Delaware Valley Community Health, with a long history of providing integrated care in their FQHC sites, has placed a satellite clinic at Horizon House to serve Horizon House participants and staff.

Each of these three approaches—collaborative, colocated, and integrated—present contextual challenges. Regulations, funding requirements, diagnostic and coding restrictions, and workforce issues have a direct impact on the initiation and sustainability

[3] A "warm handoff" refers to the direct transfer and introduction of the patient from primary care provider to behavioral health consultant, as opposed to a referral.

of these and other innovative approaches. Geography, leadership, and community culture are additional variables that impact the possibility of advancing practice change. The geographic environment affects both the models that can be tried and the impact of these contextual barriers on service delivery. Four case examples are provided below as illustrations of creative approaches to addressing some of these contextual barriers.

Overcoming Geography as a Barrier to Integration

Community Services Group

Description of Approach

Community Services Group (CSG) is a large behavioral health organization serving people in 19 counties in the center of Pennsylvania. The counties it covers include semi-urban, suburban, and rural areas. It recognizes that the rural counties provide a particular challenge to developing models of collaborative or integrated care. The primary care provided in these areas tends to be solo practice sites in which patient volume does not justify a behavioral health consultant.

CSG is exploring the development of a "mobile health home" for Huntingdon, Mifflin and Juniata counties. This exploration started as an educational program for people with serious mental illness and diabetes using an evidence-based practice that supported self-management and coordination of care.

As the project continued it became apparent that people with other chronic illnesses could benefit from this approach and that people benefitted from services that could be delivered in their home or community settings. Through a partnership with the Behavioral Health Managed Care Organization, CSG is now developing a mobile team with a nurse care manager, certified peer specialist, psychiatric rehabilitation staff, and case manager. CSG believes this model can become a mobile health home that provides collaborative care to support disease self-management.

Factors for Success

1. Established partnership relationship with Behavioral Health Managed Care Organization, which recognizes that alternative models can meet the challenges of rural environments.
2. Strong organizational leadership with awareness of approaches in other parts of the country that might be imported.

Overcoming Financing Barriers through an Entrepreneurial Approach to Co-location with High Collaboration

Delaware County Professional Services Group
Greater Philadelphia Area

Description of Approach

Initially Delaware County Professional Services (DCPS) was approached by Dr. Alan Crimm, a primary care provider. In his work with the Chronic Care Initiative in Penn-

sylvania, he became aware of the behavioral health needs of his patients and the impact those needs were having on their ability to self-manage and recover. He approached DCPS about the possibility of working with him. He had three requirements for the behavioral health provider who would colocate in his office:

1. All patients would be seen regardless of ability to pay.
2. The behavioral health provider had to be willing to reach out to patients to schedule appointments.
3. The behavioral health provider had to be willing to be open in their communication back to the primary care provider.

Dr. Crimm's requirements are highlighted here because they represent typical expectations primary care providers have of behavioral health providers.

In the model developed by DCPS, the first few behavioral health appointments are offered in the doctor's office. When a patient needs continued care, subsequent visits take place in DCPS's private practice offices. Because the relationship is well established at that point, moving to a different location has rarely been a barrier to care. The carefully-timed transfer of visits from the doctor's office to the behavioral care provider's office is critical. Some behavioral health care patients are unwilling to move into specialty care settings because of stigma, burden, or inconvenience. In this case the existing relationship between the person and the therapist provides a natural bridge.

As DCPS expanded beyond Dr. Crimm's practice into medical clinics in two large teaching hospitals, it encountered challenges with Medicaid reimbursement. To date, it has not been able to become a credentialed provider through the behavioral health managed care organization. In spite of this it continues provide care to this population. As DCPS attempts to refer people to existing public behavioral organizations, it encounters many barriers. These barriers include long wait times, challenges with responsiveness from community providers, and the lack of psychiatric care in community-based facilities.

Factors for Success

1. Entrepreneurial approach to new business development: there was no clear guarantee that the co-location approach would work, but DCPS was willing to take the risk because it "seemed like the right thing to do." The combination of service to physician and to patients has made the model successful.
2. Developing multiple ways of billing: sliding scale for people without coverage, accepting multiple private insurances, and using interns to increase access for Medicaid recipients all have contributed to the financial success of this model.
3. Developing a "preferred referral source" relationship with a local community mental health center has helped surmount barriers in the public behavioral health system.
4. Training all staff, including interns, in primary care behavioral health integration has increased the practitioners' skill in this model (http://umassmed.edu/FMCH/PCBH/welcome.asp).

5. Developing and nurturing the relationship with the primary care provider ("being the pearl in the oyster shell, not the grain of sand") was critical to the success of this co-location model.

Development across the Continuum(Integrated and Colocated)

Abbottsford Falls Health Center
Philadelphia

Description of Approach

Abbottsford Falls Health Center, a nurse-managed FQHC located in the East Falls section of Philadelphia is one of several FQHCs in Philadelphia using an integrated model. It is presented here as a case example because of the way the history of its development impacts its current care model.

In recognition of the many behavioral health needs of people who were coming for primary care, a licensed outpatient clinic was colocated at the clinic site. The same access problems that plague the rest of the public behavioral health system quickly developed: long waiting times and high no-show rates. The co-location had improved collaboration but had not solved these problems

Through the work of the Health Federation, the clinic director, Donna Torrisi, became aware of the work of Dr. Neftali Serrano, an expert in developing behavioral health consultation services, and determined to change their model to an integrated approach. She says, "If I had it to do all over again, I would have started with integration." She also credits the ability to financially maintain the behavioral health consultation services to the willingness of Community Behavioral Health (the local BHMCO) to develop strategies to reimburse those services. The center recently received a grant to develop peer-specialist services and another to develop behavioral health consultation services for patients with substance use disorders.

Factors for Success

1. The strong partnership between the Health Federation, Abbottsford, and Community Behavioral Health has allowed for the development of sustainable integrated behavioral health services. Community Behavioral Health has provided reimbursement for behavioral health consultation services and has waived the traditional outpatient documentation requirements to allow for problem-oriented, brief documentation.
2. While the presence of colocated specialty services is not necessary for an integrated care model, co-location does provide easy access when specialty behavioral health services are needed.

Colocated to Integrated

Family Services of Western Pennsylvania
Greater Pittsburgh

Description of Approach

Family Services has an eight-year relationship with a University of Pittsburgh Medical Center clinic. Eight years ago Family Services began providing behavioral health services at the Pittsburgh Medical Center clinic in a colocated model. Two years ago it moved to a model of providing integrated behavioral health consultation services.

Family Services has been part of the Integrating Treatment in Primary Care Project, a project funded by three foundations (Fine, Staunton Farm, and Jewish Healthcare Foundation) and overseen by the Pittsburgh Regional Healthcare Initiative. The project focused on identifying and addressing depression and unhealthy substance use as part of routine primary care through a combination of two evidence-based, integrated, team-driven models: Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) and Screening, Brief Intervention and Referral to Treatment (SBIRT). This approach has had positive outcomes and has led to comprehensive screening for depression and substance use disorders. The SBIRT has been found to be most effective when administered by physicians.

Particular challenges facing Family Services and others using this model include:

- The existence of multiple payers at each of site, which requires establishing payment mechanisms for behavioral health consultation services with each payer.
- Unbillable services. Half of the activity consistent with the Wagner Chronic Care Model is not billable as a behavioral health service, including consultation with nurses, primary care provider, and psychiatrist; outreach; phone reminders; and tracking outcomes.
- Finding and supporting qualified staff. There are several interrelated issues here. First, a shortage of Licensed Mental Health professionals in rural Western Pennsylvania makes hiring such staff difficult. Second, if the practice is smaller, supporting the salary of a high-level professional presents challenges. (See Appendix C.) This has led to some consideration of using bachelor's level staff for initial engagement, assessment, and simple interventions as a recruitment strategy and cost-savings measure.

Factors for Success

1. As with the other three examples presented in this section, the critical role of leadership is evident in this organization. There is an unwavering commitment to identify and overcome challenges.
2. Different size practices require different financing models. (For a full treatment of this issue, see Appendix D.)
3. A potential solution to workforce and financial issues is the proposed use of bachelor's level staff to provide some parts of integrated care. This is being explored in the Integrating Treatment in Primary Care model. It has met with some initial positive outcomes and bears further consideration. Expert clinical supervi-

sion by an LCSW, psychologist, or other mental health professional may make this approach successful. However, bachelor's level staff members lack clinical expertise, which may present challenges in a fully integrated approach rather than a disease specific approach.

These organizations have each developed individualized approaches, based on practices that meet the unique needs of their particular community of patients, providers, and payers. (Other models are presented in Appendix A.)

Despite nuances in approach, there are wide areas of consensus around key issues and barriers. We will explore those next.

Key Consensus Points from Statewide Conversations

- There is clear consensus that developing models of integrated care:
    - Have the potential to improve health outcomes for chronic illnesses when the behavioral health consultant is used to increase motivation, increase positive health behaviors, and help develop coping strategies for psychosocial stressors;
    - Expand population-based care;
    - Create a natural context in which universal screening could improve early detection and intervention in both physical and behavioral health issues; and
    - Have the potential to increase capacity in the specialty behavioral health care system by more appropriately locating routine care in primary care.
- The person-centered medical home is a sensible approach to supporting wellness, not just treating illness. Having a "home" base where the health care team is committed to the overall health of individuals and families—where not just medical care, but health care, is coordinated—has the potential to radically transform our "sick care" system into a true health care system. Primary care providers and behavioral health consultation staff who practice in integrated settings report that such integration is a key to increasing self-management and patient activation (the patient's level of skill, knowledge, and confidence in self-management).
- Innovative models of care, whether coordinated, colocated, or integrated, present financial challenges. Frequently the description of how the funding works was "on a wing and a prayer." There are significant barriers (addressed below) to financial sustainability. The system needs attention to this issue through the development of models and through expert consultation.
- The importance of tracking clear outcomes to demonstrate positive health outcomes and cost effectiveness cannot be overstated. Everyone knows this "makes sense." There are some national outcome studies that demonstrate some outcome improvements when care is coordinated, but there is no clear agreement on definition of terms (see AHRQ Publication No. 09-E003). The terms coordinated, collaborative, colocated, and integrated are sometimes used interchangeably. Cri-

teria such as those identified in the Milbank Report (2010n) and reported earlier in this section need to be applied by funders when developing requests for proposals and funding new programs.

- There is tremendous expertise already present in the state, but often the people who hold the expertise don't recognize it. Conversations among behavioral health and physical health providers across the state at the provider and policy levels must be encouraged. Where the expertise is shared, it is often within the confines of specific professional trade groups. The "integration" of this conversation across interest groups, including the people on the ground providing the services, is a logical next step.

These general observations are discussed in more detail in the sections to follow. We turn now to considering specific barriers to the ongoing development of models of integrated care.

Barriers to Improving the Integration of Care

System Level Barriers

1. **Focus on Acute Care Model vs. Population-Based, Chronic Care Model**. The current regulations governing patient care were built around an episodic model of care, not a population-based model that addresses chronic illness management as well as psychosocial stressors. Most physical and behavioral health providers are reimbursed in a fee-for-service model when they see patients rather than for the effectiveness of their services. The delivery of care is dictated by diagnosis and billing/procedure codes. These codes don't consistently allow for critical integrated and collaborative care services such as health education, health behavior change activities, and care management. While these services are covered under the health and behavior codes when linked to the primary physical illness for Medicare and some private insurance plans, they are not covered by most Medicaid/HealthChoices managed care organizations.

2. **Lack of Plan to Plan Communication among Managed Care Organizations.** The regulations governing information sharing among health plans and between health plans and providers are confusing and are interpreted differently by different managed care organizations. This regulatory confusion creates barriers to the integration of care at the plan level and at the provider level. Access to all health care information (hospitalizations, specialist visits, and pharmacy data) is critical for the coordination of care and for its effective and efficient delivery. (For example, consider the complex issues for a person using three specialists and two pharmacies.) Without a clear state mandate requiring this communication (without requiring patient consent every 6-12 months), there is little to no incentive for managed care organizations to change. Giving primary care providers access to this information is a critical policy issue.

3. **Financing for Integrated Care.** Some models require additional staff and therefore, finances. For example, the Health Federation of Philadelphia's model (described in Appendix C) requires a behavioral health consultant. This model requires funding to support the functions of the behavioral health consultant. At present the behavioral consultation is provided three ways.

    a. *Directly hired by the primary care setting as staff*. The Health Federation of Philadelphia is an example of a best-case scenario: its managed care organization allows billing of behavioral consultation as unique services, not as traditional outpatient services. This distinction is critical because it frees the behavioral health consultant from the documentation and other requirements governing outpatient services. The financing remains a challenge even in this best-case scenario due to uninsured patients and plans that do not cover behavioral health consultation. A universal approach is that once a behavioral health consultant is introduced into a setting, all patients seen in the setting must have access to this service.

    b. *Subcontracted from a specialty behavioral health provider* designating the primary care setting as an outpatient satellite.

    c. *The behavioral health consultant remains on staff at the specialty behavioral health setting* but has their own provider (or Promise) number and the primary care setting does the billing. This specific situation requires that the provider be a qualified mental health professional as per the Office of Mental Health and Substance Abuse Services (OMHSAS) regulations, a licensed clinical social worker, or PhD psychologist. (See Workforce Issues.)

    Both b) and c) above present reimbursement challenges. Both require the provider to meet time-consuming outpatient clinic standards for documentation. In addition this may prevent documentation in the patient's electronic medical record, which presents a barrier to coordination. Under outpatient regulations, care is delivered when connected to a mental health diagnosis code. This presents a billing and treatment challenge for patients who do not meet the criteria for a diagnosis but still need behavioral health support. Finally, the issues related to insurance company coverages persist in both b) and c).

    There are several advantages to using staff from behavioral health organizations. First, these staff can provide a bridge to the specialty provider when needed. They can make a direct connection inside the organization and may be able to negotiate a "preferred referral" status, expediting appointments since the patient has been prescreened. Second, the behavioral staff members have experience in and knowledge of the broader community and its resources. Finally, behavioral staff members have expertise in long-term chronic disease management. This is because the skills needed to manage substance use disorders and serious mental illnesses can be translated to other chronic illnesses. Behavior change strategies, self-management, shared decision making, stages of change knowledge, and mo-

tivational enhancement skills are all required for behavioral health professionals working in primary care settings.

Of note here is a study by Roger Kathol et al. (2010) that looked at eleven nationally established models of primary care with behavioral health integration. Ten of the eleven, with the Veteran's Administration being the exception, identified financial challenges as the biggest barrier to successful and sustainable integration. This was true whether behavioral health was carved in or out.

4. **Confidentiality Regulations.** A variety of regulations safeguarding patient confidentiality have been developed over time. The interpretation of the varying regulations is inconsistent. Still, there is a shared belief that the confidentiality regulations related to substance use disorders (as well as in other health challenges) are seen as a major impediment to coordination of care.

    - Primary care providers are particularly frustrated with their attempts to communicate with specialty behavioral health providers. As one physician put it, "Any other colleague I refer a patient to sends me a consultation note with the outcome of the visit. When I refer to behavioral health providers—if I can get them on the phone—I can't even find out if the person went for their appointment. I have to wait to hear a report back from the patient themselves and trust I am getting accurate information."

5. **Different Requirements and Payment in Different Insurance Plans.** Whether the site is an FQHC or a traditional primary care practice, for co-location or integration of services to be successful the primary care provider must be able to refer without regard for insurance. Figuring out whether the person has coverage adds a burden and an obstacle that primary care providers do not want to deal with.

    The Kathol (2010) study also identified this as an issue in maintaining clinician motivation. "Clinicians in integrated care clinical settings were also less willing to participate when only a portion of their patients could receive integrated support, e.g., only patients covered by selected health plans or patients with one mental condition, i.e. depression."

Specific reimbursement challenges include:

a. *Multiple plans covering patients in the same site with differing coverage for behavioral health consultation services or colocated outpatient services*. In many cases behavioral health consultation services are not covered but colocated services are covered.

b. *Particular challenges related to patients who are dual-eligible Medicare/Medicaid*. In Medicare there is no provision for integrated care, but the health behavior codes are billable if provided by an approved provider. The definitions of "approved providers" in Medicare differ from those in Medicaid. These variations in coverage and in interpretation of coverage

create obstacles to moving forward with integrated and collaborative care models that can focus on all patients seen in a primary care practice.

c. *Constrained CPT codes*. Health promotion, health education, and health behavior activation are not covered as services by all plans. (http://flash1r.apa.org/apapractice/hbcodes/player.html)

d. *Co-payments for services vary*. Co-payments vary from plan to plan and behavioral health care co-payments often differ from those for physical health services.

e. *Lack of coverage*. There are a high number of uninsured people, especially in Federally Qualified Health Centers.

6. **Current Structure of Behavioral Health Service Delivery System.** One of the many incentives for moving to an enhanced primary care model with behavioral health consultation on site is to be able to deliver services that support behavioral health and wellness in an effective and efficient way. Both primary care providers and behavioral health consultants working in these settings recognize the need for specialty behavioral health services. While recognizing that need, there is nearly universal frustration with the following:

    a. *Access*. People routinely have to wait a week or more for a first appointment and then may have to wait again to see a psychiatrist before services can begin.

    b. *Engagement*. Both primary care and behavioral consultation providers report that when they do convince people to go for services, often the settings in which care is delivered are not welcoming and patients are reluctant to return. Of particular concern is the practice of having the initial interview done by a person who will not be seeing the patient again. The movement from provider to provider is often seen by the client as disruptive to care.

    c. *Disconnect between mental health and substance use disorders treatment*. Because of the bifurcation of these two systems, the burden of patient care coordination falls on the primary care provider or the behavioral health consultant.

    d. *Pattern of specialty behavioral health service delivery*. The specialty mental health system has been geared toward the needs of those with serious mental illness. When people have needs beyond those of the behavioral health consultant but do not have serious mental illness, it is difficult to find appropriate treatment and use the same model that is used when people are referred out to other specialists. In those cases, they leave the primary care venue, receive specialty treatment, and return. This approach to care is foreign to most specialty providers, who are accustomed to working only with clients who usually receive longer-term care—typically, clients with serious mental illness.

    The challenges above (labeled *access*, *engagement*, *disconnect*, and *pattern*) result in several outcomes:

- Primary care providers without behavioral health consultants on staff are reluctant to conduct even routine screening for alcohol and other drugs or mental health disorders, even though these have a profound impact on physical health. As multiple providers told me, "If I don't have a place to send people if I find a problem, I am not going to look for a problem."
- Behavioral health consultants find themselves dealing with complexity that they know would be better dealt with in the specialty system. Patients who should be referred to a specialty system but are not require more visits. This reduces the time the behavioral consultant has for the clinic population as a whole.

7. **Reimbursement for Psychiatric Consultation.** In an integrated system, primary care providers may be called on to prescribe medications for behavioral health challenges that are beyond their training or comfort level. Therefore, access to psychiatric consultation can support integrated care when the primary care provider is unsure of diagnosis, has tried medications without success, or lacks appropriate expertise to combine medications. In these cases, the psychiatrist is not assuming prescribing responsibility and often may not even see the patient. He or she is consulting with the health care team, but there is no reimbursement structure for this role. Given the system-wide issues with psychiatric access, creating a means to support this consultation role would improve the system of care. Such support could reduce unnecessary referrals to specialty care, thereby allowing more efficient use of psychiatrist's time. This is critical given the shortages of community psychiatrists across the Commonwealth.

Workforce Issues

There are multiple considerations that drive the integrated care workforce issues identified by the informants to this report. To understand these issues, it is necessary to look at the characteristics of the dominant primary care culture. The focus in this culture is on efficient patient care that meets the person's immediate concerns within the constraints of the primary care provider's productivity expectations. The unit of service is the patient visit, not the 15-minute unit of case management or the 50-minute psychotherapy hour.

There is a need for "personal transformation" for both the primary care provider (Mauer, 2010) and for the behavioral health provider working in these environments. One physician described it this way: "I always knew there were issues my patients were struggling with, but I didn't want to get into it because I didn't know where to go once I opened this up. Even with a behavioral health consultant on site it is still hard sometimes to open up Pandora's box, but I have changed myself and understand that these issues have as much impact as the physical ones I was trained to deal with."

This personal transformation for the behavioral health provider requires giving up the 50-minute hour and being willing to try a different approach. It requires leaving behind the quiet of the private practice office and entering the noisy and brightly lit environment of primary care. Treasured beliefs and "specialty" knowledge are sometimes called

into question. As one person working in this environment described it, "I had to rethink my whole mental mindset. I started trying different things out, not really believing they would work and then discovered that to my surprise people were responding. People who never would have gone for specialty behavioral health care started getting better, and when I did really need someone to a specialty care provider they were more comfortable going, because they knew they could come back to us."

The practice-based changes in these models include changing documentation and communication to be brief, problem-oriented, and solution-focused. The primary care provider is the clear leader of the team. As one behavioral health consultant put it, "One of the biggest challenges for me was learning to work with what the physician identifies as the problem, which is not always what the patient identifies as the problem. I have had to learn to do both at the same time—it is a difficult balancing act."

The behavioral health consultant working in this environment has to learn the primary care provider's more abbreviated style of communication. Several informants described this as "learning to speak the language of primary care."

The work also demands a full tool box of skills, because in any given day the behavioral health consultant may be faced with a person struggling with depression, anxiety, or substance use; dealing with an abusive relationship; struggling to manage a medical condition; unsuccessfully striving to lose weight; or learning to manage stress to help reduce their blood pressure. Given this variety, behavioral health consultants need to have superb engagement skills and to be flexible and nimble as they relate to patients. They must quickly assess the patient and then engage him or her in problem solving and planning. Because of the high prevalence of alcohol and other drug issues, the behavioral health consultant needs knowledge and background in the current research on addiction treatment, including screening, early intervention, and harm reduction strategies.

There are a number of important personal qualities required of behavioral health consultants. These include the courage to ask the hard questions, work in an uncertain environment, and face the complex challenges people present. An outgoing personality and willingness to actively engage both patients and other members of the health care team helps to facilitate the delivery of integrated care. Finally, a sense of humor was also frequently identified as important.

The required skills, abilities, qualities, and openness to transformation limit the potential pool of workers. For those who are interested in and temperamentally suited to this work, training is a major issue. While the number is increasing, there are few graduate programs that provide even basic coursework on the integration of physical and behavioral health. (For example, Dr. Alexander Blount at the University of Massachusetts offers an online certificate program in Primary Care Behavioral Health Integration.)

Dr. Neftali Serrano provides consultation, training, and coaching to health care providers interested in developing integrated care programs. He has been key to the development of integrated care models in Philadelphia, Carlisle, and other places in Pennsylvania. Residency programs for physicians are beginning to provide some training and ex-

perience in this area, but many clinicians physical and behavioral health clinicians learn on the job.

The current insurance requirements to provide behavioral health consultation services are another barrier to gathering a sufficient workforce. Medicaid in Pennsylvania requires an LCSW or PhD in psychology to bill for these services when provided in primary care sites. This eliminates whole disciplines in the workforce which, in many cases, would be ideally suited for this environment. Many of these professions are eligible for third-party reimbursement through other insurance plans. The professions excluded from Medicaid include licensed professional counselors (LPC), licensed marriage and family therapists (LMFT), and clinical nurse specialists (CNS). The exclusion of these disciplines further shrinks the pool of potential staff.

There are workforce challenges for both urban and rural providers. Rural providers find themselves without educationally prepared people in their communities. Urban providers find themselves with people who are prepared but not interested in or willing to work in these settings.

Policy and Advocacy Implications for the Pennsylvania Health Funders Collaborative: Improving the Integration of Care

While there are policy implications that cut across evolving models, it seems that in order to advance a robust advocacy agenda some thought might be given to what members of the Pennsylvania Health Funders Collaborative ultimately want to advance. There are three models of approaching a system transformation of this magnitude: *additive*, *selective,* and *transformative*, defined below. (Achara-Abrahams et al. in Kelly and White, 2010) Each of these models brings benefit and in some sense they all fall on a developmental continuum with additive at one end and transformative at the other. Services will continue to progress across the continuum however only if there is a clear vision of the need for transformation.

> **The additive model** is one in which services are added without changing the actual practice of existing services. This model is represented in services that are colocated but not integrated—that is, they share real estate but the connection ends there. They share space but lack clear assertive policies toward sharing information and regular, formalized patterns of coordination. This has advantages for the people served in that there is a familiar location in a non-stigmatized environment. It is a first step toward better care. For programs using this model, Pennsylvania Health Funders Collaborative might suggest the programs move beyond co-location, to intentionally collaborate with an eventual goal of integration. Several providers in this survey referred to co-location, or an additive model, as “dating,” not really being married. They viewed it as a necessary step (in many cases) or as a way to get a foot in the door, but not the final destination.

The selective model could be used to describe the introduction of one or more evidence-based practices or treatments for specific diagnoses. For example, the provider might provide an integrated approach for depression, but not for other behavioral issues. There are documented positive outcomes for each of these interventions, and a change with the approach a provider uses for one diagnosis (such as depression) often influences its approach with other diagnoses (for example, the eating disorders). However, without deliberate work toward integration, the entire service delivery will not change. While supporting the value of the selective approaches (in that it at least offers integrated care for some disorders), the overall policy and advocacy agenda for Pennsylvania Health Funders Collaborative might be to focus on the most comprehensive changes possible in current care delivery systems.

The transformative model is one in which a primary care practice completely incorporates behavioral health consulting services and is integrated at every level. Such practices move from seeing themselves as just a primary care practice to seeing themselves as enhanced primary care working to develop integrated approaches to all patients in the practice. All people seen in the practice have access to the same level of care; the movement between physical and behavioral health services is seamless. When behavioral or physical health clinicians in these practices speak about their work they say they can't imagine working without the services the other discipline offers. In the most advanced models the practice patterns are changed, and the staff shares space, patients, and expertise.

Each of these models adds value to the system, but may not always be possible. As previously discussed, in rural areas truly integrated models may not be feasible. In those cases, the principles of integrated care will need to be adapted; the continuum of models from additive to transformative may be a useful way to conceive of how to adapt to the constraints of the rural environment. For those locales where a transformative model is possible, Pennsylvania Health Funders Collaborative might advocate strongly and regularly for fully integrated care, as it will truly improve the health of communities.

In light of that here are specific policy considerations and advocacy issues:

1. **Advocate for models of integrated care, moving toward the person-centered health care home (with connected changes in payment mechanisms and other regulatory changes) wherever possible.** In rural areas, advocate for the development of innovative pilots for collaborative care, including the use of technology-based interventions (for example, providing not just psychiatry but behavioral health consultation via Skype or other telemedicine technology).
2. **Require all insurance plans (and in the future, health exchanges) functioning in the state to recognize models of integrated care delivery and fund them accordingly, instead of looking at them as extensions of traditional outpatient treatment.** The Health Federation of Philadelphia's success with developing integrated care in the FQHCs in Philadelphia could serve as a model for the state. With health care reform and the develop-

ment of health insurance exchanges and accountable care organizations on the horizon, now is the time to push these conversations.

3. **Support state level policies and regulations that *require* communication between physical and behavioral health managed care organizations.** These regulations and policies are needed whether or not the carve-in is maintained, because even in carved-in systems there is usually an internal carve-out within the managed care organization that may inhibit communication. Thus, communication policies must require the establishment of easy provider access to patient profiles that identify levels of care, care gaps, and pharmacy utilization to support planning of care across physical and behavioral health. (There is precedent for this in the HealthChoices HealthConnections project in southeastern Pennsylvania, which used a comprehensive patient profile to guide the care given by the health system navigators.)
4. **Streamline confidentiality requirements to increase communication that improves care coordination, particularly as it relates to substance use disorders.** Put ownership of confidentiality back in the hands of the person receiving services, not in the hands of the provider.
5. **Promote regulation changes to support integration of physical and behavioral health, including:**
    a. Establish standard reimbursable procedure codes for behavioral health consultation services; if codes already exist, clarify the acceptable procedure codes with written policy.
    b. Require all managed care organizations to financially support the provision of behavioral health consultation services in FQHCs, FQHC look-alikes, and primary care settings.
    c. Expand the definition of qualified workforce beyond psychologists and licensed clinical social workers to include Licensed Professional Counselors (LPCs), Licensed Marriage and Family Therapists (LMFT), and Clinical Nurse Specialists (CNS).
    d. Establish billing codes and rates for reimbursement for psychiatric consultation.
    e. Waive the co-payment requirement for behavioral health consultation services in primary care practices.
6. **Support improvements in the access and responsiveness of specialty behavioral health services.** Access and responsiveness are critical concerns of both physical and behavioral health providers. Moving to open or same-day access for people who have already been evaluated in integrated care settings would help support better care and would allow the behavioral health consultants working in primary care settings to provide an appropriate level of care. In addition, the ability for the specialty system to provide short-term interventions for people without serious mental illness but with significant, immediate behavioral health challenges will be necessary to support integrated settings. Examples include people with significant trauma issues; people in early substance

abuse progression who need harm reduction interventions; and people who need other early intervention approaches on a more frequent basis than the behavioral health consultation can provide. This issue will become more pressing with Medicaid expansion.

The addition of consultation and collaboration codes for sharing of information would also ease this burden on providers.

7. **Develop and implement Mental Health First Aid Training.** While this falls outside the development of integrated and collaborative models of care, it goes to the issue of addressing stigma and community wellness. Mental Health First Aid Training is a model developed by the National Council of Behavioral Health Care Organizations, which describes it as follows: "Mental Health First Aid is a public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders. Mental Health First Aid USA is managed, operated, and disseminated by three national authorities—the National Council for Community Behavioral Healthcare, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health." (http://www.mentalhealthfirstaid.org/cs/.) Supporting the delivery of this training and developing local trainers will contribute to the broader community understanding of mental health challenges.

Potential Funding Opportunities for Improving the Integration of Care

1. **Start-up funding.** Provide funding to establish integrated services (using the Health Federation of Philadelphia standards as a best practice model) and to move colocated services to full integration as follows:
    a. Provide funding for 12-36 months to support new sites moving directly to integration. This funding would support the hiring of behavioral health consultants; give staff time to build relationships internally and in the community; and facilitate the development of an integrated practice. "Even in the NDP (National Demonstration Project on Practice Transformation to a Patient Centered Medical Home) with highly motivated and capable practices, full transformation to a [patient-centered medical home] was not achieved within the two years of the project because of the multiple challenges of personal transformation, developing teams, recreating job descriptions and work flow, implementing multiple technologies, building adaptive reserve, accommodating change fatigue, adjusting for problems, learning along the way, and maintaining financial integrity. For most practices this transformation is likely to require an ongoing process." (Nutting et al. 2009)
    b. Provide funding for 12-24 months to support movement from co-location to true integration.

2. **Workforce development.** Training is required to develop a variety of skills among the current and potential staff of integrated care providers. Support must go beyond initial training and include ongoing consultation and support for the first several years of practice. Training should introduce concepts and language, coaching, and changes in consulting practice. This could be accomplished through regional training centers and could include both behavioral health consultants and primary care providers. These regional learning centers could also provide training and support for financial model development and could be linked with other training centers nationally. Training should help clinicians on both sides understand how to use the data that is already available to them to influence care. This training could be provided in a train-the-trainer approach. (Trainings to consider include the University of Massachusetts online program in integrating physical and behavioral health care; management of co-occurring disorders; and motivational interviewing and stages of change.)
3. **Outcomes monitoring.** Fund the development of plans to collect practice-based outcomes to demonstrate the effectiveness of the delivery model from the perspective of access, clinical services, and cost. This could involve partnerships with local universities with expertise in research.
4. **Community coalition building.** Provide 12-18 months of funding for development of connections with and among local community resources that can support the wellness of patients and clients. Community health impacts individual health. Funding would allow for staff time to develop these coalitions and support the nominal costs of local meetings (food, space, and so forth).
5. **Development of electronic medical records systems.** Provide funding to develop electronic medical records systems that support integrated care and to convert existing systems to mobile capacity (via iPads, tablets, or other mobile technology).
6. **Use of peer staff.** Certified peer specialists are people who have personal experience with serious mental illness and have received specialized training to provide peer support to others. For example, peer specialists may share their recovery journey with a person currently undergoing treatment. Peer specialists have firsthand knowledge and skill in accessing community resources such as finances, housing, and community-based support groups, and in negotiating treatment decisions, navigating the health care system, and managing one or more chronic illnesses.

   There are several training programs in illness management that are being used with peer specialists. For example, Magellan Behavioral Health Company has a program called Peer Whole Health, and Michigan has trained over 150 peer specialists using the Stanford Chronic Disease Management program (http.//patienteducation.stanford.edu/programs/cdsmp.html). These and other available programs could be used to support skill development in a peer workforce to support integrated care. Philanthropic support would facilitate hiring certified peer specialists and additional training and support for the first 12-24 months until financial sustainability can be achieved. Possible roles for peers:

a. Conducting on-site screening activities in clinic settings to support early identification and intervention.

b. Supporting people during the transition to specialty behavioral health care, staying engaged and connected during periods of waiting, and possibly attending first appointments in a navigation role.

c. Working with the primary care team to provide additional support and education for patients who are struggling with change strategies for targeted health behaviors.

d. Conducting peer support groups in clinics.

e. Supporting patients in developing wellness-sustaining connections in the community: volunteer opportunities, mutual self-help groups, housing, benefits, etc.

7. **Screening.** Fund start-up development of comprehensive screening procedure for mental health and substance use disorders building on the Integrating Partners in Care (IPIC) experience with Screening, Brief Intervention, and Referral for Treatment (SBIRT) and Improving Mood Promoting Access to Collaborative Treatment (IMPACT). Funding should include:

    a. The establishment of evidence-based screening practices.

    b. Training staff in follow-up strategies.

    c. Integration of screening tools with electronic medical records.

8. **Pilot projects.** Around the state there are a variety of initiatives based in FQHCs or FQHC lookalikes. For areas without these resources, pilot projects are needed that use innovative approaches to move integrated care forward in an enhanced primary care model. Possible pilots:

    a. Mobile teams that build off chronic disease management pilots currently being tested around the state.

    b. Use of technology to provide long-distance telepsychiatry, teletherapy, or behavioral health consultation at remote primary care sites.

9. **Ongoing support to establish an integrated care learning community.** In early July a first telephone meeting of a potential learning community was conducted. Approximately ten providers were present. Attendees and additional potential members agreed on the value of effort learning community focused on integrated care. They noted, though, the difficulty of transportation, time away from the office, and other logistical issues. The Pennsylvania Health Funders Collaborative could lead the establishment of monthly phone-in learning community meetings. The membership of this learning community should initially be drawn from those people directly involved in service provision, who could establish what expertise exists in this group. A second phase would be the inclusion of policymakers to inform the discussion.

Some of the potential areas of learning for this community could be:

a. The development of technical assistance capacity from within the group to craft workable financial methods to support the continued development of integrated care models.
b. Success strategies for workforce development.
c. Informing the Pennsylvania Health Funders Collaborative policy and advocacy agenda.

10. **Convening community conversations on developing integrated care programs.** As neutral parties concerned with community wellness, foundations can play a critical role in convening all partners in a particular community to explore the development of integrated care models and practices. Because there are financial and turf issues at play in any change in health care delivery, foundations' capacity to build consensus around common goals places them in a unique position to start these critical conversations.

Additional Considerations for Making Smart Funding Decisions

1. **Strength of core structure.** An organization's core structure includes its "capabilities to manage basic finances and clinical and practice operations during times of stability and modest change." (Nutting et al. 2009) Practices moving from traditional care to the person-centered medical home face multiple challenges, including that of maintaining day-to-day operations while in the process of transformation. If the practices are not strong organizations with committed senior leadership and board, they will not be able to accomplish the change. Key questions:
    a. What is the "change history" of this organization? Has it been flexible with other changes in the past? How has it adopted other new practices?
    b. What is the board support for transformational practice change? Are board members willing to ride out the rough first months and years until the new norm is established?
    c. How much change has the organization undergone in the last three to five years? Is there additional capacity for change?
    d. Is sufficient financial and human resource capital available?
2. **Adaptive reserve.** The adaptive reserve of an organization "includes such capabilities as a strong relationship system within the practice, shared leadership, protected group reflection time, and attention to the local environment." (Nutting et al.2009) Adaptive reserve may not exist at the beginning of the transformation. When considering the likelihood of success of the project, explore the organization's openness to employing a change management strategy, attention to the overall process, recognition of the need for transformation (not just incremental change), and attention to ongoing relationship development among team members. These are critical components of success. Key questions:
    a. Is there a "change leader" within the organization who understands bottom-up and top-down change?

b. Is there a movement toward a partnership-based approach or an openness to it? Do the organization's leaders form collegial relationships and are they open to the contributions of many?

c. What is their language and understanding around the need for a functional team?

d. Is the leadership open to taking personal and professional risks? Do leaders have the courage to embark on unfamiliar paths?

e. Is there a history or readiness to use data to inform decisions and improve outcomes?

3. **Support for personal transformation.** To function in the person-centered medical home, both primary care and behavioral health providers must change their professional identities and the ways they were socialized to provide care. This moves beyond a change in reimbursement structures and practice patterns. Developing a clear conceptual model for what the change is and why the change is important will guide the effort forward. Training, ongoing coaching, case consultation, and mentoring will advance these transformations. Key questions:

    a. Do key leaders understand the need for substantial reorientation in the way they think about and conduct their practice? Are they at least open to this possibility?

    b. Have leaders considered the need for outside coaching, mentoring, and consultation?

    c. Have leaders visited, researched or been informed by other organizations and providers who have gone through this change process?

Conclusion

It is clear that people with clinical and subclinical anxiety, depression, and substance use disorders most often seek help first from their primary care provider. There is a growing body of evidence that integrating behavioral health services into primary care improves access and provides an opportunity for early intervention.

Many questions about integrated health care remain, as explored in this report. The outcome studies on clinical and cost outcomes are mixed. There are many barriers to moving these models forward. The significant challenges to overcome include workforce training and acceptance; regulatory barriers from a system that was developed based on an acute care model and that impede the flow of important clinical information; and financing models that are predicated on the number of visits as opposed to the care delivered and outcomes achieved.

There are also major open questions regarding the full implementation of the Patient Protection and Affordable Care Act. As currently projected, there will be a major expansion of the number of people receiving Medicaid funding; how will this impact the development and financing of these collaborative models? Accountable Care Organizations

were beyond the scope of this project, but will be a key factor in influencing local models of care. Will behavioral health providers and experts be partners in the development of such organizations and will the critical nature of managing co-occurring behavioral health challenges be recognized as these organizations plan for health care delivery? At the state level, how will the parity provisions be addressed in the development of standards in state health exchanges? What regulatory requirements will be developed regarding the coordination of care, sharing of information, and benefit packages? These questions and others will have a major impact on the future of the health care delivery system.

In spite of this uncertainty, providers across the state are finding ways to confront challenges and build practice models that meet the complex needs of patients who face physical and behavioral health challenges alongside the challenges of poverty. This population particularly needs a "home" where health care is both delivered and coordinated, and where the needs and wellness of the whole person are addressed.

The members of the Pennsylvania Health Funders Collaborative are in a unique position to advance integrated care. They are members of communities across the state and so have access to what is actually happening on the ground. As a group, they can pool their knowledge and their ability to influence regulatory, clinical, and financial policy to support the good work providers have already taken on. In addition, through their connections with foundations in other states, members of the Pennsylvania Health Funders Collaborative can encourage action based on local, state, and national successes. The movement toward integrated care requires direct funding as well as policy advocacy. The Pennsylvania Health Funders Collaborative is uniquely situated to provide both.

Budget dynamics on Capitol Hill remain complex and the future is uncertain. Serious cuts in Medicaid are being debated. It is a strange time to be thinking about the transformation of our health care delivery system, and yet Pennsylvania Health Funders Collaborative and providers across the state dare to think that even in the midst of chaos, new life and new ways of supporting people can and will emerge. May this report advance the conversation, learning, and growth.

"In times of change learners inherit the earth;
while the learned find themselves beautifully equipped to deal with a world that no longer exists."

~Eric Hoffer

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Appendix B: Program Descriptions

Delaware Valley Community Health
Philadelphia and Montgomery County, PA
Federally Qualified Health Center (FQHC) with integrated care and reverse co-location

- Delaware Valley Community Health, Inc. (DVCH) currently operates six Federally Qualified Health Centers in Southeastern Pennsylvania: Fairmount Primary Care Center (and its three satellite centers); Maria de los Santos Health Center, Norristown Regional Health Center; and St. Joseph's hospital. Fairmount Primary Care Center and Maria de Los Santos Health Center operate with fully integrated model with behavioral health consultants as part of the primary care team. One of the three satellites is at Horizon House and is the first reverse co-location project in Philadelphia. At Horizon House, a large behavioral health provider, the satellite health provider (Fairmount Center at Horizon House) provides primary care to members of the Horizon House Community.

Public Health Management Corporation (PHMC)
Philadelphia, PA
FQHC with integration at some sites and co-location at others

- PHMC's Federally Qualified Health Center, Healthcare for the Homeless, has four sites: Mary Howard, Rising Sun, HealthConnections, and the Care Clinic. PHMC provides services at shelters and low-demand sites throughout the Philadelphia region. The Primary Care Behavioral Health (PCBH) model, a fully integrated approach to providing behavioral health services with primary care, is used at Mary Howard and the Care Clinic where a behavioral health consultant is a fulltime member of each primary care team. Mary Howard also has two psychiatric certified registered nurse practitioners on staff. The Health Connection and Rising Sun intend to implement the PCBH model as soon as their impending relocations allow sufficient space to do so.

Esperanza Health Center
Philadelphia, PA
FQHC integrated

- Esperanza Health Center is located in Philadelphia, PA and is an FQHC with fully integrated services. Esperanza Health Center has its own staff behavioral health consultants on site, working as part of the primary care team. Many of the people who come for care at Esperanza are Latino. A large number of the patients seen at Esperanza have outside psychiatric services so there is no psychiatric consultation on site.

  Like many FQHCs using an integrated model, Esperanza faces challenges with funding, finding licensed staff to provide the service, and coordinating with community-based providers.

Family Practice and Health Center
Philadelphia, PA
Integrated

- In addition to the Abbottsford Falls Center, the Family Practice and Counseling Center has two additional FQHCs in Philadelphia. The Health Annex provides integrated physical and behavioral health services through staff behavioral health consultation services. In addition to the standard FQHC services, the Health Annex has a men's family planning grant, a peer support model that utilizes a person with lived experience with mental health challenges as a support to others with mental and physical health issues, a health program for students at the local Bartram High School, and an HIV practice on site.

- The 11th Street Center is a partnership with Drexel University. In addition to physical and fully integrated behavioral health services the 11th Street Center has a family nurse partnership on site and also has a Healthy Living Center that includes cooking classes, physical therapy, yoga, reiki, and other alternative health practices. All the centers have dental practices and an outpatient mental health service.

Creative Health in Pottstown
Pottstown, PA
Colocated

- Creative Health Services in Pottstown has colocated their specialty behavioral health services with a federally qualified health center in Pottstown, PA. People who receive services can be cross-referred and coordination of care is facilitated by the co-location of services in the same building. The long-term hope is to provide fully integrated services and this practice change is in discussion. Sparked by this co-location and commitment to developing collaborative models of care, Creative Health also collaborated with county, state, and other providers on the development of the SMI integration project for persons with serious mental illness. (See description of HealthChoices HealthConnections Montgomery County project, below.)

Lehigh Valley Health Network Department of Psychiatry
Allentown, PA
Multiple models: colocated, collaborative, and integrated

- Lehigh Valley Health Network Department of Psychiatry coordinates the placement of psychiatrists and behavioral health specialists to a variety of physician practices and health centers connected to Lehigh Valley Health Network. The model used varies from practice to practice. In some practices the behavioral health staff works in an integrated fashion in exam rooms, seeing people along with (or during the same visit as) the physician. In other practices, the behavioral health staff works on a referral basis in a more colocated model. Most practices are more likely a blend of a number of models. All staff is provided with group and individual supervision by the department of psychiatry, even though they are hired by the practices. This supervision is seen as a critical component of continuous improvement of practice.

Behavioral health staff is currently working in primary care, adolescent medicine, neurology, weight management, burn, cardiology, and women's health and oncology practices. The process of behavioral health integration has been occurring for over ten years with continuous efforts to improve the initiation and support for all providers and practices.

Milestones Center and Squirrel Hill Health Center (FQHC)
Pittsburgh, PA
Colocated and collaborative services

- Milestones Center in Western Pennsylvania, in partnership with Squirrel Hill Health Center (FQHC) in Pittsburgh, has received a SAMHSA integration grant to provide mobile medical services at several of their behavioral health locations. Squirrel Hill Health Center provides weekly primary care doctor visits using their mobile medical unit. This reverse co-location project is staffed by a nurse who makes the connections between physical and behavioral health providers, a care navigator who focuses on community connections, and a peer specialist who provides support and the wisdom of lived experience in navigating the health care system. Because of the SAMHSA funding they are able to offer a strong wellness component focusing on diet, exercise, and smoking cessation.

- In addition, Milestones is providing psychiatric time to Squirrel Hill. The psychiatrist remains on the staff of Milestones and is paid by them but provides services at the FQHC. At this point the psychiatric time is being funded through a separate grant that Squirrel Hill Health Center has through a local foundation. They are also investigating the use of a psychiatric nurse practitioner.

Adams Hanover Counseling Services Integrated Health Services (AHCS)
Hanover, PA
Colocated and collaborative

- Adams Hanover Counseling Services Integrated Health Services has developed three components to provide collaborative care for people and improve health outcomes. AHCS stations therapists at the regional FQHC, Family First, to provide behavioral health interventions using the SBIRT model with a "warm handoff" from the primary care provider. Other components of collaborative care are cognitive behavioral therapy for weight loss, smoking cessation, stress management, and a ten-week structured curriculum called the I CAN CHALLENGE for individuals with diabetes or heart disease. The Robert Wood Johnson Foundation funds the I CAN CHALLENGE curriculum.

Sadler Health Center
Carlisle, PA
Colocated with eventual move to integrated care

- Sadler Health Center is an FQHC look-alike in the Carlisle area. The area covered is a mix of urban, suburban, and rural. Sadler Health Center is a full-scale medical home with a dentist, nurse/family practitioner, and pharmacy. Over the

past year it has begun the process of introducing behavioral health care using behavioral health consultation with a long-term goal of developing integrated care. The county MHMR has been supportive and working in active partnership with them as has the managed care company (CBHMP) to support the introduction of this service.

Catholic Charities
Lancaster, PA
Developing colocated, integrated services, or both

- Catholic Charities is in the early stages of a partnership with South East Lancaster Health Services to embed behavioral health consultation services in a new site on Arch Street in Lancaster. It is the intention of this project to fully integrate services using behavioral health consultation staff from Catholic Charities located at the FQHC site. Anticipated start date is late 2011 or early spring 2012. The behavioral health consultants will be trained by Dr. Neftali Serrano if the funding can be obtained to support the training.

Community Services Group
Lancaster, PA and 19 counties
Coordinated model, colocated model, and integrated model

- Community Services Group (CSG) is involved in the development of a physical and behavioral health self-management program. It will provide collaborative care via both mobile and site-based delivery to a primarily rural area. Its eventual goal is to become a health home for Huntingdon, Mifflin, and Juniata counties. The focus of the project is to improve outcomes for people with serious mental illness and diabetes. CSG has used an evidence-based intervention in existing psychosocial rehabilitation programs. Through this experience it became apparent that there were other chronic illnesses that could benefit from this approach. It also became clear that some people would need to be seen in their home, in their community or in their primary care provider's office, and that CSG needed to be mobile in order to better meet the needs of their participants and to better coordinate care.

  The next step in developing this model is to develop a mobile capacity with a team comprised of a nurse care manager, certified peer specialist, psychiatric rehabilitation staff, and case manager. The team will be trained as health care navigators, meaning given skills in navigating the health care system, overcoming barriers, and bringing all parties together for the good of the patient. Payment for this team, with the exception of the nurse, has been negotiated with the local Behavioral Health Managed Care Organization, Community Care Behavioral Health.

  While the focus is on the serious mental illness population at this time, the development of a navigation model that builds on health education, motivational enhancement strategies and strong care coordination skills has the potential to become one model of providing coordinated and collaborative care in the rural areas of the state where there are no FQHCs or large physician practices that can

support a behavioral health consultant. If funding can be developed, the long-term plan is to extend these services beyond the population with serious mental illness to patients who are struggling with multiple chronic illnesses. The transfer of the skills of behavioral health providers in recovery and rehabilitation is a critical issue in moving integrated care forward. This project has the potential to inform practice changes in other areas of the state.

Lancaster Federally Qualified Health Center
Co-location with a goal of integration

- Community Services Group has longstanding relationship with the FQHC in Lancaster. They have placed a psychiatric nurse practitioner on site at the FQHC. CSG will begin supplementing that position with an outpatient therapist operating as an employee of CSG who will provide outpatient therapy on site. Initially this will be a colocated model. Appointments will be scheduled and the service delivered will be outpatient therapy services, but both the FQHC and CSG hope that over time strategies to move to full integration will be developed.

Lycoming County FQHC
Integrated care

- The Lycoming County Coalition was responsible for birthing this partnership between an FQHC and Community Services Group. The partnership provides a good example of the power of community coalitions comprised of multiple stakeholders to change their local community. In this case CSG has been involved in these conversations from the beginning and has kept the voice of behavioral health care at the table. This project is highlighted here due to several factors:
    - There was a strong hospital system in the community and their role in the FQHC was unclear. While at this time the regulations for Accountable Care Organizations prohibit participation by FQHCs, the presence of ACOs will have an impact on care delivery in a given community. Navigating this relationship, whatever form it takes, will be a critical issue, particularly in smaller and mid-sized communities.

    - There was extensive discussion about whether the FQHC would hire its own behavioral health staff or partner with CSG. CSG was able to make the case that their expertise in the provision of behavioral health services provides strength to the FQHC. The issues of needing to have two medical records (because of using external behavioral health staff) and of payment for uninsured people remain and will provide challenges in the implementation process. Both sides are committed to moving to a fully integrated model.

Delaware County Professional Services
Greater Philadelphia Area
Colocated services in private physician offices

- Delaware County Professional Services is highlighted in the body of this report as an example of a private practice model currently providing collaborative ser-

vices in three physician practices in the greater Philadelphia area. These practices are colocated but have a high and increasing degree of collaboration with the primary care providers.

Pittsburgh Regional Health Initiative
Pittsburgh, PA
Integrating treatment in primary care

- In 2009, the Pittsburgh Regional Health Initiative (PRHI) launched a demonstration project in southwestern Pennsylvania called Integrating Treatment in Primary Care (ITPC), in a rural FQHC, an FQHC lookalike, and a residency family health center. ITPC combines Screening, Brief Intervention, and Referral to Treatment (SBIRT) and Improving Mood-Promoting Access to Collaborative Treatment (IMPACT), along with Wagner's Chronic Care Model. PRHI provided training and coaching to the sites, and funding was provided by the Jewish Healthcare Foundation, the Staunton Farm Foundation, and the Fine Foundation.

- The University of Pittsburgh's Evaluation Institute independently evaluated the demonstration, and at the end of ITPC, an implementation toolkit with tools and billing strategies was produced to facilitate dissemination. The demonstration resulted in a three-year dissemination grant from the Agency for Healthcare Research and Quality, called Partners in Integrated Care (PIC). The grant forms a partnership between PRHI and three organizations in Minnesota and Wisconsin that have implemented IMPACT in 86 medical groups and SBIRT in 31 clinical sites. Together, the PIC partners are developing marketing, training, implementation, and measurement toolkits for implementation in Pennsylvania, Minnesota, and Wisconsin and for dissemination through the Network for Regional Healthcare Improvement.

HealthChoices HealthConnections
Montgomery County, PA
Collaborative care, building a virtual health home

- The HealthChoices HealthConnections project in Montgomery County is part of a larger project to integrate care for people with serious mental illness and co-occurring chronic physical conditions. The model developed in Montgomery County uses a team approach with a behavioral health clinician paired with a nurse to provide community-based services to people with co-occurring behavioral and physical health challenges. The teams are trained as health care navigators and work with the person receiving services to develop an integrated care plan with wellness goals. The teams provide direct services to people, review the provider profiles generated by the managed care companies (behavioral and physical health managed care organizations), and coordinate all aspects of the person's care (primary care, specialists, and other behavioral health providers) as needed until the person is able to achieve independence with their own care management.

Western PA SMI Integration Project
Allegheny County, PA
Collaborative and colocated care

- The SMI integration project for Southwestern Pennsylvania, Connected Care, used a population-based approach to meet the needs of people with serious mental illness and co-occurring medical disorders living in Allegheny County. Consent was obtained from participants that allowed information sharing by all providers (managed care organizations, physical health providers, and behavioral health providers). This comprehensive information allowed for the development of an integrated plan and weekly care conferences based on this plan. Staff encouraged members to sign a consent form so that information could be shared with the providers that were designated on the form. There was an integrated care plan that was based on information that that the managed care company had for that member. The integrated care plan and care conferences could be done for any identified member. The higher-level care coordination occurred with their physical health and behavioral health providers when the member gave consent.

  Training on chronic disease definitions and management was provided to physical and behavioral health providers. This provided the primary care staff and staff of the managed care company with training on the types of services both organizations offered and with training on the new program. Meetings were held with the key behavioral health provider groups and primary care provider groups to review the program so that they understood how the project could help. The provider meetings were done with representatives from the managed care provider. Coordination with existing intensive case management services was essential and interventions were developed that capitalized on this existing relationship.

  In addition, nurses were used both in physicians' offices and to provide direct intervention in the community. In the physician's office, nurses were able to intervene directly with the patient as needed but also had access to practice data. This enabled the nurses to identify the chronic care issues confronting the practice and to provide education and intervention as helpful for the practice. This was part of the patient-centered medical home program. The nurses in the practice had access to the health plan data, integrated care plan, and the primary care provider's medical records. They used all of that data to help inform the provider of what was going on with the member. They also used this to help them with member and caregiver education and care coordination.

  When comparing the baseline data to the first year results for Medicaid members, there were decreases in behavioral health admissions per 1,000 members; decreases in physical health and behavioral health readmissions per 1,000 members; decreases in the percent of unique members who had a behavioral health and physical health admission; improvements (increases) in the length of time between admissions; and improvements (increases) in the percent of members on atypical antipsychotics who were tested for the development of diabetes,

a major side effect of these medications.

Family Services of Western Pennsylvania
Greater Pittsburgh Area, PA
Colocated to integrated

- Family Services has an eight-year relationship with a University of Pittsburgh Medical Center Clinic. In 2003, Family Services began providing behavioral health services at the clinic in a colocated model. Six years after the project began, Family Services and University of Pittsburgh Medical Center Clinic moved to a model of providing integrated behavioral health consultation services. Family Services has initiated a second site at an FQHC, New Kensington Health Center, where in the next few months a behavioral health therapist will begin working.

- Family Services has been part of the Integrating Treatment in Primary Care Project, a project funded by three foundations (Fine, Staunton Farm, and Jewish Healthcare Foundation) and overseen by the Pittsburgh Regional Healthcare Initiative. The project focused on identifying and addressing depression and unhealthy substance as part of routine primary care through a combination of two evidence-based, integrated, team-driven models: Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) and Screening, Brief Intervention and Referral to Treatment (SBIRT).

Helen L. Coons, Ph.D.
Private practice approach to co-location moving toward integration

- Dr. Helen L. Coons is a clinical health psychologist who has developed a colocated practice with several women's health offices in Philadelphia and its suburban counties. For the past decade, she has rotated to women's multi-specialty; obstetrics and gynecology; reproductively endocrinology; and surgical and medical oncology practices run by academic hospitals or private physician groups. Her practice, which includes additional psychologists who also rotate to medical offices each week, is included here because it provides another example of the possibilities for developing population-based approaches for Medicaid recipients and others.

  Dr. Coons has faced many successes and challenges in colocating care in these varied practices, where a broad range of insurances are accepted including Medicaid. Medicaid presents a particular problem because of the limited panel and lack of recognition of mental health and health psychology services. An additional barrier to care is that private insurance companies in Pennsylvania do not accept the health and behavior codes that allow for the provision of behavioral health services to those who have sub-clinical issues. Many women seeking care for common health problems (e.g., diabetes, obesity, stress-related physical symptoms) or who are facing major medical challenges (e.g., cancer, heart disease, disabilities) have difficulty with issues (e.g., weight, sleep, treatment adherence, etc.,) that respond well to evidenced-based health behavior interventions but do not meet diagnostic criteria for depression or other mental health

diagnoses.

Dr. Coons rotates to different medical practices each week where she accepts warm handoffs and does consults with physicians, nurse practitioners, and nutritionists. In addition, she provides education to the physicians and other health care providers in the practice about health, mental health, psychosocial and health behavior issues, and treatment options.

Appendix C: Federation Approach to Integrated Care

Philadelphia Integrated Care Network: Health Federation of Philadelphia
The Health Federation of Philadelphia, in collaboration with several community health centers, has developed a model of *enhanced primary care* by fully integrating primary care/behavioral health and incorporating the following core components. The model is based on principles of behavioral health consultation integrated in primary care and on best practices that have been emerging in the field of psychology for nearly two decades. Philadelphia Integrated Care Network (PICN) has embraced these best practices to create a uniquely adapted model at the system level. The intention of putting forth these core elements is to define a minimum standard for replication of the PICN model. The fully integrated care includes the following core components:

- Applies principles of population-based care using a generalist model of practice.
- Provides a primary level of behavioral health intervention that mirrors primary care practice.
- A behavioral health consultant (BHC) is embedded within the primary care practice and is available for on-demand consultations.
- BHC completes, on average, 8 to 12 consultations per day, ranging from 15 to 30 minutes each, as part of a program commitment to providing ready, efficient access to the population*
- BHC is primarily responsible for assisting the primary care provider (PCP) and their patient panel and does not develop an independent therapy caseload.
- Behavioral health intervention is based on functional assessment and focuses on improving the patient's quality of life and problem solving skills.
- Treatment plan reflects behavioral goals targeted at patient's readiness to change and a well-planned visit strategy based on the step-wise and episodic care models familiar to primary care.
- BHC uses outcomes (standardized measures) to assess progress
- Behavioral health visit documentation is integrated in the medical record and uses SOAP note charting (charting that covers four components—*subjective, objective, assessment,* and *plan*).
- BHC and PCP regularly communicate to discuss patient treatment plans and make collaborative decisions regarding patient care management.
- BHC appropriately triages to mental health, substance abuse and other community services (but does not directly provide social case management)
- BHC demonstrates adequate knowledge of psychotropic medications and their indications
- PCP makes "warm handoffs" to BHC and incorporates behavioral health consultation into the treatment plan.
- PCP has (or develops) competence in managing a range of psychotropic medications.

- The program maintains commitments to ongoing supervision that includes opportunities for reflection, direct observation (shadowing), case review, ongoing training, professional development and quality improvement.

The Health Federation (HFP), as the central organizing entity, has developed a training and technical assistance approach to assist providers and organizations to implement the model. HFP has also learned valuable lessons regarding the developmental trajectory, the selection and engagement of providers, the training needs, the quality improvement protocols, and the advocacy strategies necessary to create this practice change at a system level. Local program development began with one pilot site and has expanded to nine sites with two others soon to follow. Several health centers are now also serving as training sites for graduate social work and psychology students. HFP and network members are regularly invited to speak at regional and national conferences, to participate as key informants on related task forces, and to provide informal technical assistance to those interested in replication of the model.

One of the most important lessons learned is the critical role of ongoing professional development and advocacy. The Health Federation has developed a training program to support ongoing skills development, program technical assistance, peer support, opportunities for leadership and collective advocacy. These have been instrumental in building champions and a learning community, mobilizing change in local payment policies and promoting spread and replication of the care model. The current training program provides a strong foundation for an expanded training institute to serve the needs of providers and funders within the region.

Training Institute

In addition to the experience described above, the Health Federation also serves as the Local Performance Site of the Pennsylvania/Mid-Atlantic AIDS Education and Training Center (ETC) as well as home to several other significant training and capacity building initiatives (see www.healthfederation.org for more information).Therefore, the vision for the Primary Care/Behavioral Health Integrated Care Training Institute is modeled on success, experience and core best practices in the field of professional development.

The training philosophy is grounded in the participatory principles of adult learning. In the behavioral health integration initiative, we clearly demonstrated that practice change is best accomplished when providers can adopt a new skill or practice, experience the process, and reflect on that experience before moving to the next stage of development.

Likewise, the developmental trajectory and program design are, in turn, informed by the field experience of practitioners. We are also very well aware that new professionals or professionals who are learning to practice in a new way need opportunities to build clinical skills, observe and learn from peers, identify with a professional group, display leadership and receive positive support for their efforts.

In 2006, we had kick-off training for all participating clinical staff with Dr. Kirk Strosahl, the leading developer of the behavioral health consultation model. As we pro-

gressed, we demonstrated a commitment to ongoing professional development and continuous improvement. Currently, HFP convenes the network of behavioral health providers on a monthly basis. Through this development of champions and skilled professionals, we have been able to establish and spread the successful integrated practice model. We have been supported in our work by a training consultant, himself a dedicated practitioner and behavioral health consultant leader and teacher, Neftali Serrano, PsyD, who is based in Madison, Wisconsin. During monthly clinical team meetings, ongoing professional development, group problem solving, content training and peer mentoring is facilitated by the Health Federation. A local and distance learning strategy has been implemented to offer supplemental support to behavioral health providers new to the network and integrated care. On a quarterly basis, behavioral health directors meet for ongoing program development, quality improvement, and advocacy planning.

HFP maintains a lending library of reference materials (books, journals) and serves as a hub for organizing and disseminating information. We have been able to invest in leaders and in our internal capacity by sponsoring attendance at relevant conferences or trainings. Behavioral health practitioners rely on HFP and each other when they have a question, a difficult case, wish to share a new resource or otherwise seek and offer support to benefit the entire network. This ongoing "home" for behavioral health consultants adds to their sense of professional identity, reduces burnout, and maintains their role as agents of change.

Modeled on the work already established within the Integrated Care Network and the modalities of technical assistance and capacity building typically associated with the national AIDS ETC program, HFP is poised to expand as a regional primary care and behavioral health care Integrated Care Training Institute. Given the rising interest in integrated care models, health funders and providers across the region (and, to some extent, nationally) have been seeking technical assistance from the Health Federation.

Advocacy
The Health Federation has developed a strong working relationship with the Department of Behavioral Health and Community Behavioral Health. An important component of the model has been the arrangement of payment and credentialing policies that are consistent with and supportive of the integrated care model. This has been accomplished through consistent communications and an iterative process to establish a partnership.

Appendix D: Model for Integrated Care Early Identification of Behavioral Health Disorders with Specific Attention to Financing a New Model

Concept paper by Stephen Christian-Michaels

There have been many different models of integrated physical and behavioral care proposed but no guidelines for how they can be effectively reimbursed. Physical health providers note that their practice efficiency and service quality is enhanced by the presence of on-site mental health services. Behavioral health and medical providers have collaborated and offered these services in both funded and unfunded projects.

Ongoing barriers include:

- Two very different payment systems.
- Consults not a billable service.
- Coordination of care not billable.
- Phone follow-up and outcomes tracking not billable.
- Case management not billable.

Offering and thus funding efficient integrated health care systems will afford patients the highest quality of care by assisting care providers in treating "early stage" illnesses which will lead to:

- Improved behavioral health and physical health outcomes for patients.
- Reduced overall behavioral health costs that result from later stage identification of mental illness or addiction.
- Reduced long-term physical health costs resulting from a reduction in lab work and specialty care in attempts to address physical symptoms related to behavioral health conditions.

This concept paper will present a model of integrated care that utilizes a team of behavioral health staff located in a primary care setting, based on the IMPACT model developed at the University of Washington. The IMPACT Model utilizes 100% screening for depression and unhealthy substance use (alcohol or drugs). We will expand on the model with staffing recommendation and will propose methods of financing this model.

Many of the current models of integrated care depend on financing systems based on a fee for service for credentialed staff only. This model may work in high volume settings, particularly in urban settings. For suburban and rural medical practices or small medical offices with less than 5,000 patients, it is difficult to obtain the volume of services that would allow the practice or partnered behavioral health agency to support a licensed clinical social worker or licensed psychologist.

The National Council's Four Quadrant Model of Integrated Care outlines the types of patient need below (Mauer, 2009).

Table 1.
Four Quadrants of Integrated Care – Breakdown of Patient Populations

Types of Patient Populations	Low Physical Health Needs	High Physical Health Needs
High Behavioral Health Needs	II Screening tools Physical health nurse outstationed at community mental health center Behavioral health service coordinator links to primary care provider	IV Screening tools Physical health nurse part of community mental health center staff Behavioral health service coordinator External care manager
Low Behavioral Health Needs	I Screening tools Behavioral health clinician at primary care provider – Early identification Psychiatric consultation	III Screening tools Behavioral health clinician at primary care provider Focus on improving chronic care condition – adherence Psychiatric consultation Access to other consults

As primary care is not equipped, nor was it designed, to assist individuals in managing the needs of those with high behavioral health needs, the focus in this concept paper will be Quadrants I and III, individuals with low behavioral health needs.

Colocated Model

Many integrated care primary care/behavioral health arrangements start by providing a co-located staffing model. This model seeks to serve Quadrant I individuals in the medical setting while referring those with high behavioral health needs (Quadrant II) to traditional community behavioral health clinics. The predominant financing system for behavioral health services is "fee-for-service" while in the medical clinic it is capitation and fee-for-service, with ability to code for a higher level of care provided for people with complex disorders. In order to cover the costs of the behavioral health staff, usually a master's level staff or psychiatrist, licensed behavioral health provider, or psychologist, the staff need to be reimbursed for 75% of their available time, leaving the remainder of the time for documentation, follow-up phone calls, training, and supervision. Effective integrated care requires consultation between the medical and behavioral health disciplines; however, this is a challenge in a predominately fee-for-service financed system. Therefore in colocated models, the amount of time spent in consultation is very limited unless the medical practice or a third party pays for the consultation. Characteristics of

the colocated model are that it tends to serve a moderately high-risk population with a medium to high motivation for engagement in behavioral health treatment. Therefore, it tends to provide less early identification or preventive behavioral health intervention and more traditional crisis-oriented care.

Early Identification of Behavioral Health Disorders and Improving Chronic Medical Conditions

The University of Washington developed the Impact Model which uses consultation, cross discipline training, warm-handoffs, and screening of all patients. The goal is always to have a behavioral health staff, whether the master's level or bachelor's level staff, available for the primary care physician (PCP) to be able to provide a warm handoff of the patient. The warm handoff can best be described as a personal introduction and recommendation/referral for a behavioral health service. Warm handoffs can greatly influence the patient's decision to engage with behavioral health staff, reducing numerous well-documented barriers to behavioral health treatment, including: stigma, ambivalence to change, lack of convenience, lack of trust, and misperception of need. Particularly for the suburban and rural settings, where licensed behavioral health staff is a fixed and limited resource, the use of a bachelor's level behavioral health specialist extends the reach of the licensed behavioral health services.

Motivation for treatment, behavioral health complexity, and acuity can be initially assessed by a specialty trained bachelor's level clinician present in the primary care site. A stepped approach, utilizing higher level clinicians for addressing higher acuity/complex patient needs, can be used to cover the spectrum of moderate to high behavioral health need. An assessment of the patient's motivation for treatment takes into the account the patient's choice in engaging in appropriate treatment. The most complicated and high risk patients can be evaluated by a psychiatrist, or the patient can be immediately referred to the behavioral health center in an expedited manner. Patients with relatively high risk behavior health risks can be directed to the licensed clinical social worker or psychologist while the patients with mild to moderate risk/acuity can be treated by the bachelor's level staff with supervision and consultation.

The integrated care strategies include: early identification, improving adherence in chronic care conditions, and health promotion.

Early Identification

In the integrated care model, while the goal is to engage patients in the primary care setting, some high risk/acuity patients can be motivated to engage in a referral to a behavioral health clinic for access to more comprehensive services. For patients with moderate level disorders (risk or acuity) where the motivation for change may be limited, there is a need to educate the patient to the dangers of not treating the issue and the continuance of the current coping strategies (e.g., isolation, alcohol consumption, lack of physical exercise, poor nutrition). In this model, the goal is to engage patients in health modifying behaviors (harm reduction through decrease or elimination of drug and alcohol use, medical treatment adherence, diet, and exercise) and early intervention for emerging behavioral health disorders. The bachelor's level behavioral health specialist and the licensed behavioral health staff will employ different kinds of motivational interventions to engage patients in making very specific and limited changes to their life. Consultation

between bachelor's and master's level behavioral health clinicians and the primary care physician will enable the physician to support health modifying behaviors in a team approach.

Chronic Health Conditions—Non-Adherence
In the model, patients with chronic health conditions who have difficulty following through on the recommended changes to their lifestyle, medication, or follow-through with specialists can also be referred. Motivational interviewing and behavioral activation techniques can be used to increase adherence to medical recommendations. Patients who make frequent visits to the medical clinic but tend not to follow through on recommendations can be referred to either behavioral health specialists, reducing the reliance on the primary care physician. This can free up access to the physician for other patients, reducing clinic appointment wait time.

Health Promotion Services
The bachelor's level staff can also provide weight reduction groups, smoking cessation class, exercise groups, and consultation around pediatric milestones and other parental concerns (parenting, attention problems, healthy eating, and school refusal) that often present in primary care setting.

Different Staffing Based on Setting

This model suggests a variable array of behavioral health providers, depending on the type of medical clinic. In a large urban setting, where there may be easier access to psychiatrists and licensed behavioral health staff, the volume of patients can afford a rich staff pattern: five hours of a psychiatrist per week, a licensed behavioral health level staff, and a bachelor's level behavioral health provider. In the suburban setting, a psychiatrist would be utilized at two hours per week, along with a half-time licensed clinical social worker or psychologist and a half-time bachelor's level behavioral health provider. In the rural settings where recruitment and retention of licensed behavioral health providers can be very challenging, the psychiatrist will be two hours per week, often via video conference (telepsychiatry). There may be no licensed behavioral health provider and most of the behavioral health service could be provided by a bachelor's level social worker with extensive training in motivational interviewing, problem-solving therapy, and easy access to a licensed clinical social worker or psychologist, perhaps in a nearby behavioral health clinic.

Table 2.
Recommended Staff Patterns by Type of Practice

Type of Community	Size of Practice/#Patients	Psychiatrist	Licensed Psych. or Social Worker	BA BH Specialist
Urban	Over 7,500	0.125 FTE	1.0 FTE	1.0 FTE
Suburban	4,000 -7,500	0.050 FTE	0.5 FTE	0.5 FTE
Rural	Under 4,000	0.050 FTE	0.25 or None	1.0 FTE

Table 3.
Duties of Staff

Discipline	Duties
Primary Care Physician (PCP)	Leads patient care team Identification of patients with behavioral health concerns Communication with behavioral health staff for ongoing care
Psychiatrist	Diagnostic Evaluation of behaviorally complex patient Medication/Treatment recommendations to primary care physician Consultation with behavioral health staff and primary care physician
Licensed Social Worker/Psychologist	Therapy (can bill most payers including Medicare) Motivational Interviewing Problem-solving behavioral health interventions Psychoeducation groups
Bachelor's Mental Health Specialist	Receives most warm handoffs from primary care physicians Motivational Interviewing Problem-solving behavioral health interventions Tracks progress and provides phone reminder about follow-up visits Assists with the screening process

The challenge with this model is to change financing patterns to pay for behavioral health services provided by all members of the team, including the bachelor's level behavioral health provider.

Financing

The challenge in an integrated care model is the financing. Most behavioral health insurance providers do not cover having behavioral health staff available for warm handoffs, consultation without the patient present, consultation with "frequent visitors to primary care" and health promotion services..

Many primary care offices are applying for National Committee for Quality Assurance (NCQA) Medical Home status. Such designation would qualify for increased reimbursement for clinical services provided at those health centers. On-site, integrated behavioral and physical health care would be a cornerstone of achieving Medical Home status, and the improved reimbursement, including reimbursement for care coordination activities, would go a long way toward making the integrated program sustainable. Challenges toward financially supporting the behavioral medicine staff and other ancillary support staff (e.g. case managers, social workers) are significant, yet worth overcoming in terms of gains in patient satisfaction and medical outcomes and staff satisfaction.

It is critical that the medical clinic and the partner behavioral health agency work to develop a braided funding strategy that allows both entities to operate without losing money. These braided financing strategies are outlined in Table 4, below.

Table 4.
Financing Strategies

Financing Strategy	Medical Clinic	Behavioral Health Agency	Pros	Cons
Fee-for-Service (FFS)	Contracts with the regional Health Plans Bill for health promotion classes Pays mental health clinic for services provided	License medical clinic as a satellite Include clinic in Managed Care Organization contracts Negotiate rates to cover non-billable work including consults without patient present, tracking, prompts	Payment tied to service delivery Grow services with demand	More is not better quality Rates often don't cover costs Can only bill for hard-to-recruit licensed staff Can't bill for many services
Capitated Contracts	Contracts with the regional health plans Renegotiate contracts to include health promotion, behavioral health, screening, motivational interviewing	Health promotion from health benefit Early identification from health benefit Screen of all patients from health benefit	Revenue is predictable Rules can be rewritten Pay tied to quality	Fewer services More possible profit Must have good data
Purchase of Service	Purchase psychiatric consultation; licensed staff consultation; behavioral health promotion service using resources from capitation or from the improved efficiency	Purchase primary care physician for mental health clinic	Payment is predictable Behavioral health services can meet medical clinic needs	Difficult to increase services given cost Hard to demonstrate efficiency

The financing strategies can be applied to the different services provided as suggested in Table 5, below.

Table 5.
Applications of Financing Strategies

Discipline	Duties	Financing Strategy
Primary Care Physician	Identification of patient with behavioral health concerns Communication with behavioral health staff for ongoing care	Fee-for-service and health plan capitation, Health Resources and Services Administration (HRSA) FQHC-residual cost wrap payment
Psychiatrist	Diagnostic evaluation of complex patients Medication/treatment recommendations to primary care provider Consultation with behavioral staff and primary care provider	Fee-for-service – Behavioral health managed care organization, HRSA Medical clinic – consult fee, HRSA FQHC- Residual Cost wrap payment
Licensed Social Worker or Psychologist	Therapy (can bill most payers including Medicare) Motivational interviewing Problem solving behavioral health interventions Psychoeducation classes	Fee-for-service – Behavioral health managed care organization, HRSA FQHC-Residual Cost wrap payment
Bachelors MH Specialist	Receives most warm hand offs from physicians Motivational Interviewing Problem-solving behavioral health interventions Tracks progress and provides phone reminder about follow-up visits Assists with the screening process Health promotion classes	Health plan Capitation/medical clinic fee FQHC-Residual Cost wrap payment
Primary Care Office Staff	Screening of all new and returning patients	Paid by medical clinic FQHC-Residual Cost wrap payment

For Federally Qualified Health Center (FQHC) if there is an increased diversity of services beyond the current scope of the FQHC, this reduces the wrap payments which put the FQHC at increased financial risk.

Duplicate Co-Pays

An additional barrier to integrated services is the problem of the duplicate co-payment. For example, the patient seeing their primary care physician receives a warm handoff to a behavioral health professional to assess an identified depressive symptom. When the behavioral health provider provides a preliminary assessment, the patient is typically charged a second co-payment for the behavioral health service. Most patients are very reluctant to receive a second service involving a second co-pay for something that, up until the motivational interview, they did not think was a problem.

To solve this problem, agencies have written off the patient's co-pay so as not to interfere with the impact of the warm handoff. These write-offs contribute to financial loss to the behavioral health agency. A preferred strategy would be for the behavioral health agency to be able to bill the behavioral health managed care organization the full fee, which would include the patient's co-pay.

Conclusion

An integrated staffing model of coordinated behavioral health treatment in the primary care setting can be effectively implemented for early identification of behavioral health disorders. There are several logistical variables (staff level of expertise, time allocation) that must be matched to the clinic demographic in order to ensure feasibility. A braided financing strategy is key to maintaining a financially sustainability partnership.