Integration of Primary Care and Behavioral Health

RAND Report to the Pennsylvania Health Funders' Collaborative

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INTRODUCTION

The Pennsylvania Health Funders' Collaborative seeks to support the development of best practice models for improving population health through the integration of primary care and behavioral health in a coordinated, high-impact way across the Commonwealth. The Collaborative has identified the population of interest as adults with a chronic physical health condition that is managed by their primary care physician (e.g., diabetes, asthma) but who also have behavioral health issues that commonly present in primary care settings (e.g., depression, anxiety, alcoholism). Primary care is understood to include family medicine and general internal medicine across all settings, including federally qualified health centers (FQHCs), nurse managed health centers, private practices, and others, but not including pediatrics or OB/GYN.

To assist with this effort, the Collaborative contracted with the RAND Corporation to develop a road map for refining the initiative's scope in such a way that the work to be conducted has a high likelihood of achieving the Collaborative's desired goals, is practical to implement, and will involve the active participation and support of a wide range of state and community partners. To this end, the RAND project team has undertaken the following tasks: (1) synthesized the results of literature reviews and related studies/programs to identify and describe existing models of integrated care and their key components; (2) identified key stakeholders in the Commonwealth to be interviewed and/or surveyed with regard to the desired scope of the initiative; (3) designed a protocol for the key stakeholder interviews and surveys; (4) sent email surveys to primary care and behavioral health providers across the Commonwealth and conducted telephone interviews with representatives of other key stakeholder groups; (5) analyzed and synthesized the results of the primary data collection; (6) based on the above information, developed a menu of options for the Collaborative to consider regarding how best to move forward with the proposed initiative.

In this report, we provide a summary of our findings organized into three parts: (1) developing a roadmap for integrating primary care and behavioral health; (2) adapting the roadmap to Pennsylvania; and (3) next steps for implementing the roadmap.

PART 1: DEVELOPING A ROADMAP FOR INTEGRATING PRIMARY CARE AND BEHAVIORAL HEALTH

Delineation of Terms

To date, a wide variety of models, clinical trials/studies, and initiatives/programs have been proposed, implemented, and/or evaluated for integrating behavioral health services in primary care settings. In this context, the term "integrated care" typically refers to on-site teamwork between primary care and behavioral health providers with a unified patient care plan, and often connotes close organizational integration, perhaps involving social and other services (Blount, 2003; Blount, et al., 2007). We note, however, that the term "integrated care" has many meanings, and is often used by different people to mean different things. We note further that integrated care is not a dichotomous variable, simply

present or absent; rather, it can be present to varying degrees and along a continuum that combines both intensity of care and specialization of services.

As explained by the Institute of Medicine, integration of care can be of three types: *(*1) clinical integration is the extent to which patient care services are coordinated across people, functions, activities, and sites over time so as to maximize the value of services delivered to patients; (2) physician (or clinician) integration is the extent to which clinicians are economically linked to an organized delivery system, use its facilities and services, and actively participate in its planning, management, and governance; and (3) functional integration is the extent to which key support functions and activities (such as financial management, strategic planning, human resources management, and information management) are coordinated across operating units so as to add the greatest overall value to the system (IOM, 2006).

In this report, we use the term "integration of primary care and behavioral health" to refer more generally to issues related to optimizing the working relationship between primary care and behavioral health care.

A wide range of other terms are also commonly referred to in the context of integrated care. To help clarify this sometimes conflicting terminology and to more clearly present the overall findings, we adopt the standardized nomenclature presented in Table 1.

Table 1. Operational Definitions of Terms	
Care management	Specific type of service, which is often disease specific (e.g., depression, congestive heart failure), whereby a behavioral health clinician (usually a nurse) provides assessment, intervention, care facilitation, and follow up (Belnap, et al., 2006)
Collaborative care	An overarching term describing ongoing relationships between primary care and behavioral health providers over time (Doherty, McDaniel & Baird, 1996); not a fixed model but a larger construct consisting of various components which when combined create models of collaborative care (Craven & Bland, 2006; Peek, 2007)
Co-located care	Primary care and behavioral health providers deliver care in the same location; co-location describes where services are provided rather than a specific type of service; typically includes an established process of referral from primary care to behavioral health (Blount, 2003)
Coordinated care	Primary care and behavioral health providers practice separately within their respective systems; information regarding mutual patients may be exchanged as needed; collaboration is limited outside of the initial referral (Blount, 2003)
Disease management	A system of coordinated health care interventions and communications, generally offered telephonically by a trained nursing professional, for populations with a specific chronic condition in which patient self-care efforts are significant; increasingly the industry has moved toward a whole person model in which all of a patient's conditions are managed by a single program (DMAA: The Care Continuum Alliance, 2009)
Medical home	A single-site, regular source of care for individuals seeking a broad range of medical and behavioral health care services (Starfield & Shi, 2004); initially developed to promote communication and collaborative treatment among care providers for children with chronic medical conditions (Sia, et al., 2004); subsequently expanded to provide accessible and accountable services in primary care settings for individuals with chronic medical conditions (Joint Principles of the Patient-Centered Medical Home, 2007)
Mental health home	A clinical setting that provides services for individuals with serious mental illness and incorporates medical home characteristics, including enhanced access and coordination of care, integration of primary and preventive care, use of evidence-based practices and continuous quality improvement, adoption of recovery principles, family and community outreach (Smith & Sederer, 2009)
Patient-centered care	Care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions (IOM, 2001)
Whole person health care	An integrated approach to health care that addresses physical, mental, and behavioral health issues at the same time and is optimally provided by a multidisciplinary team of providers (American Psychological Association, 2009)

Overview of Findings from the Literature

Interest in the integration of primary care and behavioral health has grown significantly over the past decade. This interest has been spurred in large part by numerous reports from the Surgeon General, the Institute of Medicine, the Substance Abuse and Mental Health Services Administration, and the President's New Freedom Commission on Mental Health, among others. These reports have cited problems related to the fragmentation of care and the enormous cost of untreated behavioral health conditions, as well as increasing evidence that integration makes sense on a number of levels, as summarized below.

The primary care setting is now widely recognized as the initial, and often only, opportunity for people in the broader community to access behavioral health services, with primary care physicians providing the majority of mental health care in the United States (Gallo & Coyne, 2000; Williams, 1998). Among the one in five adults who will experience a diagnosable mental health condition in any given year (U.S. Department of Health and Human Services, 1999), more than 40 percent initially seek help in primary care settings (Chapa, 2004). According to the American Academy of Family Physicians, 42 percent of patients diagnosed with clinical depression and 47 percent diagnosed with generalized anxiety disorder were first identified by a primary care physician (National Mental Health Association, 2000). Further, 32 percent of undiagnosed, asymptomatic adults indicate that they will first turn to their primary care physician for help with a mental health issue, while only 4 percent would approach a psychiatric professional (National Mental Health Association, 2000).

At the same time, barriers to accessing specialty behavioral health care have been widely cited. These barriers include shortages of behavioral health care providers/limited availability for consultation, health plan barriers, and lack of coverage or inadequate coverage. In a recent survey of primary care providers, about two-thirds reported that they could not get outpatient mental health services for patients—a rate that was at least twice as high as that for other services (Cunningham, 2009).

While concerns have been raised about the quality of behavioral health care that is available in primary care settings, overall, research has shown that the provision of appropriate behavioral health services in primary care settings can have positive impacts, including enhanced patient, practitioner, and provider satisfaction; improved clinical and functional outcomes over both the short- and long-term; and better adherence to regimens and treatment of behavioral health disorders. Receipt of behavioral health services in primary care settings also reduces stigma for some patients, who are no longer limited to accessing care through the specialty behavioral health setting, and avoids unnecessary consumption of care by "high utilizers" (Asarnow, et al., 2005; Gilbody, et al., 2006; Kessler, et al., 2001; Mauksch, et al., 2001; Nitzkin & Smith, 2004; Rost, et al., 2001; Simon, et al., 1998; Unutzer, et al., 2002).

The story regarding costs and so-called cost offsets of integrated care is a complex one and depends in large part upon the nature of the intervention/integration implemented, the patient population targeted, the time frame over which the costs are examined, and the perspective from which the costs are considered. Most of the recent economic research has focused on enhanced case management and collaborative care for depression in primary care settings. This research shows that improved clinical outcomes for depression are associated with modest to significant increases in direct health care costs over the short term (Von Korff, et al., 1998; Simon, et al., 2000; Simon, Katon, et al., 2001; Simon, Manning, et al., 2001; Simon, et al., 2002; Schoenbaum, et al., 2001; Liu, et al., 2003; Pyne, et al., 2003). In some cases, no discernible offsetting decrease in use of other health services has been observed (Simon, Katon, et al., 2001). However, for patients with depression and diabetes and depression and

panic disorder, there is evidence that the increase in mental health care costs associated with collaborative care is offset by greater savings in medical costs (Katon, 2008). Some researchers have concluded that the return on an investment in improved care for depression in primary care is comparable to that of many other widely accepted medical interventions (Simon, Katon, et al., 2001) and that such an investment is a prudent use of health care resources (Simon, et al., 2002). When the results of implementing collaborative care programs for depression are examined over time, there is some evidence that the direct costs of providing more effective treatment for depression appear to be balanced by decreases in the use of general medical services, especially for patients with comorbid chronic medical illness (Simon, 2009). The few studies that have examined the direct and indirect costs of collaborative care from a societal perspective have found that collaborative care was associated with overall cost savings (Katon, 2008). These findings are further substantiated by emerging evidence showing that unemployment is reduced and economic productivity increased as a consequence of case management approaches for depression (Schoenbaum, et al., 2001; Rost, Smith & Dickinson, 2004). In general, given that the added costs of collaborative care are incurred early and economic benefits appear slowly, successful implementation of collaborative care programs will depend on adequate funding and availability of dedicated staff (Simon, 2009). Moreover, the monetized benefits of integrated care will not necessarily accrue to those who spend the resources on integration interventions. Separate research on a collaborative care intervention for primary care patients with panic disorder showed a high probability that the intervention was associated with improved clinical outcomes and no significant differences in total outpatient costs compared to usual care (Katon, et al., 2002).

Related research focused on ways to increase and support the provision of behavioral health care in primary care settings has noted the need for better empirical data on the effects of physician payment on treatment of mental disorders in primary care (Pincus, 1990), policy advances to promote the full implementation of care management funding mechanisms (Bachman, et al., 2006), and other related changes with respect to organizational and financing arrangements, such as managed behavioral health carve-outs and risk-based provider payment mechanisms (Frank, Huskamp & Pincus, 2003).

Primary Care and Behavioral Health Integration Models and Components

A number of different models of primary care and behavioral health integration are described in the literature and employed to varying degrees in the field. These include:

(1) Usual care with a referral from primary care to specialty behavioral health care;
(2) Co-located care where primary care and behavioral health providers deliver care in the same practice setting and rely on an established referral process;
(3) Involvement of a behavioral health care manager (typically a master's level professional) in the primary care setting mainly for facilitating/coordinating patient treatment and often used in conjunction with patient referrals to co-located behavioral health care (Belnap, et al., 2006);
(4) A behavioral health therapist-on-staff in the primary care setting for evaluating, treating, and/or referring patients to specialty behavioral health care as necessary;
(5) A behavioral health professional consultant specifically trained to work directly with the primary care provider and the patient in a primary care setting (Blount, 1998; Blount & Bayona, 1994; Blount, DeGirolamo & Mariani, 2006).

Overall, the roles of behavioral health providers in primary care settings and/or the levels of behavioral health service provided in primary care settings appear to be increasingly more interconnected and seamless as practices move from (1) to (4) above, particularly from the patient's perspective. Primary care providers consistently prefer on-site behavioral health models over traditional outpatient referral models (Gallo, et al., 2004). In general, co-located behavioral health care, whether part of the same organization or not, increases collaboration as well as the percentage of patients that ultimately end up receiving treatment (Strosahl, 1997; Strosahl, et al., 1997). Consultant-based models (5) tend to cover a broader range of behavioral health issues that present in primary care settings, as opposed to any one specific behavioral health issue (Strosahl, et al., 1997), and, under certain circumstances, may be the least costly due to the lowering of specific costs in favor of shared costs. In addition, no show rates have been shown to significantly decrease with this level of service integration (Blount, 2003; Guck et al., 2007). On the other hand, consultant-based models have proven to be the most difficult to implement in real-world settings.

Although one can conceptualize these models as operating on a continuum of lesser to greater integration or being more or less focused on targeted/specialized services (i.e., vertical v. horizontal integration) (Strosahl, 1997; Strosahl, et al., 1997; Blount, 2003), the current consensus in the field is that the components of the model applied, and even more specifically, how they are applied (i.e., who is responsible for what, the exact nature of the relationship between the primary care practice and the behavioral health practice, etc.) are more important than the level of integration per se (Blount, et al., 2007; Butler, et al., 2008; Craven & Bland, 2006).

There are a number of specific components that have been identified as potentially relevant for advancing the integration of primary care and behavioral health. These include:

(1) Screening consumers to identify behavioral health issues;
(2) Systematic tracking, follow-up, and clinical monitoring of consumer health conditions and health outcomes;
(3) Providing care management support;
(4) Providing access to mental health care in the primary care setting;
(5) Developing a reimbursement strategy for paying the costs of establishing and maintaining connections between primary care and behavioral health;
(6) Establishing communication pathways and processes between primary care and behavioral health providers;
(7) Training primary care professionals to provide behavioral health care;
(8) Strategies to engage patients and their families in health self-management;
(9) Using information systems to promote improvements in connections between primary care and behavioral health.

In general, multidimensional efforts to improve care integration are most likely to achieve positive results (IOM, 2006). Such efforts typically include some combination of screening for co-occurring conditions; making a formal determination to either treat, or refer for treatment of, co-occurring conditions; implementing more effective mechanisms for linking providers of different services to enable joint planning and coordinated treatment; and providing organizational supports for collaboration between clinicians on- and off-site. Of critical importance is the extent to which accountability and responsibility are explicitly assigned among the multiple providers and delivery systems involved in the integrated care process. "When organizations or providers are reimbursed separately for the services they provide, each may perceive no responsibility for the services delivered

by others and, as a result, for any patient outcomes likely to be affected by those services. Unless providers' accountability for sharing information or collaborating with other providers is explicitly identified in their agreements with purchasers, they may reasonably believe that those other providers have primary responsibility for initiating and maintaining ongoing communication and collaboration" (Ibid.).

Frameworks for Thinking About and Advancing Primary Care-Behavioral Health Integration

In the 2006 report published by the Institute of Medicine, entitled *Improving the Quality of Health Care for Mental and Substance-Use Conditions*, a special Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders concluded that improving care delivery and health outcomes for either mental health, substance use, or general health conditions depends upon improving care delivery and outcomes for the others (IOM, 2006). The Committee made two overarching recommendations with respect to improving the quality of health care for mental and substance-use conditions: first, health care for general, mental, and substance-use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind/brain and the rest of the body; and second, the redesign set forth in *Crossing the Quality Chasm* should be applied throughout mental/substance use care on a day-to-day operational basis but tailored to reflect the characteristics that distinguish care for these problems and illnesses from general health care.

Generally speaking, the models and components described above for integrating primary care and behavioral health can be viewed as one way of attempting to operationalize the IOM Committee's recommendations. In many respects, they also align closely with and can be organized in frameworks similar to those of other widely accepted models for promoting high-quality chronic disease care and improving outcomes across a variety of health care settings.

In Peek's model of health care organization, the three worlds of health care (clinical, operational, and financial) must be considered and coordinated if the provision of care is to be sustainable and effective (Peek, 2008). The clinical world of health care organization asks "what care is called for?" and "is it high quality?"; the operational world asks "what will it take to accomplish such care?" and "is it well executed?"; and the financial work asks "is it a good value?"

The Chronic Care Model identifies six components of a health care system that promote effective change in provider groups to support evidence-based clinical and quality improvement at the community, organization, practice, and patient levels (Wagner, 1998; Wagner, et al., 2001). These components include: (1) providing chronic illness self-management support to patients and their families; (2) redesigning care delivery structures and operations; (3) linking patients and their care with community resources to support their management of their illness; (4) providing decision support to clinicians; (5) using computerized clinical information systems to support compliance with treatment protocols and monitor patient health indicators; and (6) aligning the health care organization's (or provider's) structures, goals, and values to support chronic care. The model's emphasis on the use of interdisciplinary structures and practices in which a clear division of the roles and responsibilities of the various team members fosters their collaboration is important to note, and may necessitate new roles and divisions of labor among clinicians with differing training and expertise (IOM, 2006). The Chronic Care Model has been applied successfully to the treatment of a wide variety of general chronic illnesses in primary care settings, such as diabetes, asthma, and heart failure, as well as to common mental illnesses such as depression. The model has also been theorized to have the potential for improving the quality of care for persons with alcohol use disorders (Watkins, Pincus & Tanielian, 2003).

The Patient-Centered Medical Home model endorses seven principles for providing comprehensive primary care for children, youth, and adults in a setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patient's family (Joint Principles of the Patient-Centered Medical Home, 2007). These principles are: (1) personal physician; (2) physician directed medical practice; (3) whole person orientation; (4) coordinated and/or integrated care across all elements of the complex health care system; (5) quality and safety; (6) enhanced access to care; (7) appropriate payment structures. Several organizations have developed strategies for measuring the effectiveness of medical home implementation projects, such as the published standards and guidelines of the National Committee for Quality Assurance (NCQA, 2008) and the Medical Home Index of the Center for Evaluative Clinical Services at Dartmouth College (Cooley, et al., 2003). Most recently, some of the key principles of this model have been considered for incorporation in a mental health home model, which targets a more limited population of individuals with serious mental illness and emphasizes a focused, chronic care-disease management approach that integrates medical and psychiatric care (Smith & Sederer, 2009).

The "6-P" Strategy is a multi-level approach for sustaining the use of evidence-based models for depression care in primary care settings, which can also serve as a template for improving care for multiple chronic conditions in real-world settings (Pincus, et al., 2001; Pincus, et al., 2003; Pincus, et al., 2006). This strategy recognizes and addresses the important clinical and systems barriers which can impede the provision of quality chronic care by considering the multiple perspectives of six key stakeholder groups (patients, providers, practice settings, health plans, public and private purchasers, and local populations/policies). The Robert Wood Johnson Foundation National Program on Depression Care (described in Table 2) has applied simultaneously both clinical and system strategies for financing and sustaining use of clinical best practices despite barriers created by economic and organizational structures that fragment behavioral and general health care (Pincus, et al., 2005).

Other comprehensive, integrated models of care that integrate screening, brief intervention, and referral to treatment (SBIRT) have been shown to be effective for individuals with or at risk for substance use disorders. Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment. Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change. Referral to treatment provides those identified as needing more extensive treatment with access to specialty care. A key aspect of SBIRT is the integration and coordination of screening and treatment components into a system of services. This system links a community's specialized treatment programs with a network of early intervention and referral activities that are conducted in medical and social service settings. SBIRT interventions have been found to decrease the frequency and severity of drug and alcohol use; reduce the risk of trauma; and increase the percentage of patients who enter specialized substance abuse treatment. In addition to decreases in substance abuse, screening and brief interventions have also been associated with fewer hospital days and fewer emergency department visits. Cost-benefit analyses and cost-effectiveness analyses have demonstrated net-cost savings from these interventions. More information about SBIRT services is available at sbirt.samhsa.gov, the SBIRT site of the federal Substance Abuse and Mental Health Services Administration and Center for Substance Abuse Treatment.

Testing and Implementing Models of Integration in Real-World Settings

The models and components described above have been employed in a number of large-scale clinical trials and interventions designed to test their efficacy in comparison with control or alternative models; several systematic reviews of these efforts have recently been published. They have also been used as the basis for broader initiatives and programs designed to promote the integration of primary care and behavioral health in real-world settings.

Large-Scale Clinical Trials and Service Programs

Between 1995 and 2000, RAND researchers conducted a real-world trial, entitled Partners in Care, which was designed to improve the quality of care for depression in managed, primary care practices (RAND, Partners in Care, 2008). The study involved more than 27,000 patients, 125 providers, and 46 primary care clinics within six nonacademic managed care practices in various locations across the United States. Two quality improvement programs based on previous successful collaborative care interventions were evaluated. Each program cost about the same amount to implement. One program directed quality improvement resources toward supporting medication treatment; the other directed resources toward supporting psychotherapy. However, both programs encouraged providers to consider patient treatment preferences in choosing a treatment plan. Interestingly, the two programs proved to be about equally successful. For patients: their mental health and daily functioning can be significantly improved by treatment their own doctors can initiate. For employers, managed care organizations, and insurers: good outcomes, including lower job-loss rates, can come through modest, practical programs in primary care settings.

In one of the largest treatment trials for depression to date, IMPACT (Improving Mood - Promoting Access to Collaborative Treatment for Late-Life Depression) followed 1,801 depressed, older adults from 18 diverse primary care clinics across the United States for two years (IMPACT: Evidence-based depression care, 2008). The 18 participating clinics were associated with eight health care organizations in Washington, California, Texas, Indiana, and North Carolina and included several health maintenance organizations, traditional fee-for-service clinics, an independent provider association, an inner-city public health clinic, and two Veteran's Administration clinics. Half of the enrolled study participants received IMPACT care (a collaborative/stepped care disease management program for depression in primary care offered for up to 12 months) and the other half received the care normally available in their primary care clinic (including referral to specialty mental health care). Researchers concluded that IMPACT doubles the effectiveness of usual care, is more cost effective, results in less physical pain, better overall functioning and quality of life for patients, and improved satisfaction for both patients and providers.

In the RESPECT (Re-Engineering Systems for the Primary Care Treatment of Depression) clinical trial conducted between February 2002 and February 2003 and involving five U.S. health care organizations (three large medical groups and two insurance plans) and 60 of their affiliated practices, researchers randomly assigned 400 patients diagnosed with depression to treatment using either the RESPECT-Depression approach or to usual care practices (Dietrich, et al., 2004). The RESPECT-Depression approach integrates work by primary care clinicians who manage patients, centralized care managers who provide telephone support, and psychiatrists who supervise the care managers and offer suggestions to clinicians about treatment and management. At each practice, these professionals were trained by internal staff, using materials developed by RESPECT-Depression researchers and customized to each setting by the organizations. After six months of treatment, 60 percent of RESPECT-Depression

patients had responded substantially to treatment, compared with 47 percent in usual care (a 28 percent increase). Remission rates for RESPECT-Depression patients were 37.3 percent versus 26.7 percent for usual care (a 40 percent increase), and 90 percent of RESPECT-Depression patients rated their depression care as either good or excellent versus 75 percent with usual care (a 20 percent increase). Researchers concluded that community practices are able to implement and sustain improvements for depression when offered a standardized care management program and adequate support.

Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT) compared the experiences of older patients (≥60 years) receiving usual care in primary care practices versus the PROSPECT intervention (Alexopoulos, et al., 2005). The intervention consisted of services of trained care managers, who offered algorithm-based recommendations to physicians and helped patients with treatment adherence over 18 months. The study found that first remission occurred earlier and was more common among patients receiving the intervention than among those receiving usual care, and patients experiencing hopelessness were more likely to achieve remission if treated in intervention practices. The intervention was also more effective in patients with low baseline anxiety. Researchers concluded that longitudinal assessment of depression, hopelessness, anxiety, and physical and emotional functional limitations in depressed older primary care patients is critical. Patients with prominent symptoms or impairment in these areas may be candidates for care management or mental health care, since they are at risk for remaining depressed and disabled.

We note that, for the most part, it has not yet been demonstrated that the models described above can be continued in any substantial way in the absence of continued support outside typical reimbursement systems.

Systematic Literature Reviews

The Canadian Collaborative Mental Health Initiative reviewed 38 randomized controlled trials and intervention studies (predominately focused on depression using care management and psychiatric service models) with outcome measures examining collaborative care (Craven & Bland, 2006). The group concluded that collaboration should encompass better communication, closer personal contacts, sharing of clinical care, joint educational programs, and joint program/system planning.

In a systematic review to determine the extent to which multifaceted interventions improve depression outcomes in primary care and to define key elements, patients who are likely to benefit, and resources required for these interventions, Williams and colleagues (2007) examined 28 randomized controlled trials that (1) involved primary care patients receiving acute-phased treatment; (2) tested a multi-component intervention involving a patient-directed component; and (3) reported effects on depression severity. Twenty of the 28 interventions improved depression outcomes over 3-12 months, although sustained improvements at 24-57 months were demonstrated in only three studies addressing acute-phase and continuation-phase treatments. All of the interventions involved care management and required additional resources or staff reassignment to implement. The most commonly used intervention features were patient education and self-management, monitoring of depressive symptoms and treatment adherence, decision support for medication management, a patient registry, and behavioral health supervision of care managers. The authors concluded that there is strong evidence supporting the short-term benefits of care management for depression and that critical elements of successful programs are now emerging.

A systematic review of 11 full economic evaluations (cost-effectiveness and cost-utility analyses) accompanying randomized controlled trials of enhanced care for depression was conducted by Gilbody and colleagues in 2006 (Gilbody, Bower & Whitty, 2006). Based on their analyses, the researchers determined that there is a substantial opportunity to improve the outcomes of depression and that primary care quality improvement strategies involving collaborative care and case management offer a strong candidate approach. Although improving depression outcomes will require a substantial investment of funds, the health benefit that might be expected within a certain cost threshold is comparable with other interventions that are funded from within healthcare systems.
The Minnesota Evidence-based Practice Center reviewed 33 randomized controlled trials and quasi-experimental design studies on models of integrated care in the United States for the Agency for Healthcare Research and Quality (Butler, et al., 2008). The review included 26 studies on depression care, four studies on anxiety disorders, one study on somatizing disorder, one study on attention deficit and hyperactivity disorder, and one study on depression and alcohol disorder. The reviewers concluded that while integrated care has positive outcomes, it is difficult to delineate between the added attention a disorder receives and the specific strategy used to address that disorder. Additionally, the authors note the need for further examination of specific elements of collaborative care and which elements are necessary to achieve desired outcomes. All reviews of the evidence conclude with the finding that integrating primary care and behavioral health is beneficial for depression.

Babor and colleagues at the University of Connecticut School of Medicine have conducted a review of research on the components of SBIRT conducted during the past 25 years, including efforts to provide an evidence base for alcohol screening and brief intervention in primary health care settings; more than a hundred clinical trials conducted to evaluate the efficacy and cost effectiveness of alcohol screening and brief intervention in primary care, emergency departments and trauma centers; and implementation research on alcohol SBIRT followed by trials of similar methods for other substances (e.g., illicit drugs, tobacco, prescription drugs) and national demonstration programs in the United States and other countries (Babor, et al., 2007). They conclude that while there is clear evidence of short-term improvements in individuals' health resulting from SBIRT, long-term effects on population health have yet to be demonstrated. However, simulation models suggest that the benefits could be substantial.

Broader Initiatives and Programs

A variety of national and state initiatives and programs for improving the integration of primary care and behavioral health are currently underway. These programs seek to operationalize one or more of the models presented above and/or to translate previous research findings into real world settings. In some cases they include training/networking/collaborative learning opportunities, technical assistance, and/or implementation and assessment tools. Nine programs and initiatives of potentially high relevance to the Collaborative are summarized in Table 2.

Table 2. National and State Programs/Initiatives for Improving Primary Care-Behavioral Health Integration				
Program	**Partners**	**Goals**	**Components**	**Implementation Strategies**
DIAMOND Initiative: Depression Improvement Across Minnesota Offering a New Direction ***www.icsi.org/ health_care_redesign_/ diamond_35953/***	All six health plans in Minnesota (Blue Cross Blue Shield, Health Partners, Medica, Metropolitan Health Plan, Preferred One, U-Care), the Department of Human Services, and several primary care groups in the Institute for Clinical System Improvement	Implement a new evidence-based best care management program for depression based on a collaborative care model focused on primary care, outpatient adults	Best practice program—care practice redesign; fair payment for new services—care management redesign	Use of PHQ-9 for assessment and ongoing management of depression; systematic follow-up, tracking, and monitoring; use of evidence-based guidelines and a stepped care treatment approach; relapse prevention; care manager role to educate, organize, and troubleshoot patient services; psychiatric consultation and formal caseload supervision; three-component payment model including (1) a funding option agreed to by all plans/payers that supports the best practice model components, (2) creation of a care management fee to be paid on periodic basis to the participating primary care clinics, and (3) a care management fee set up for adult patients identified, enrolled in the program, and managed in primary care with future linkages to payment based on outcomes
Health Resources and Service Administration (HRSA) Behavioral Health Service Expansion Funding ***www.grants.hrsa.gov***	Awarded 30 grants totaling $4.5 million in FY09 to 330-funded health centers seeking support to provide behavioral health services	Enhance access to behavioral health services for underserved Medicaid populations	Stakeholder engagement, enhanced communication, supportive funding structures for reimbursing behavioral health services, positive working relationships between primary care safety net providers and the specialty mental health sector	Applicants may propose to provide onsite or off-site (through a contractual agreement) behavioral health services
Hogg Foundation for Mental Health Integrated Health Care Initiative ***www.hogg.utexas.edu/programs_ihc.html***	$2.6 million distributed over three years through an RFP process to five grantee organizations including Texas primary care and pediatric clinics	Promote effective identification and treatment of mental health problems in primary care settings	Adoption of the collaborative care model in which primary care and mental health providers partner to manage the treatment of mental health problems in primary care or pediatric settings and to address implementation barriers	Assumes four essential elements must be present in some form: mental health assessment tool, clinical care manager, patient registry, psychiatric consultation
The ICARE Partnership ***www.icarenc.org/***	Southern Regional Area Health Education Center, North Carolina Academy of Family Physicians, North Carolina Pediatric Society, North Carolina Psychiatric Association, and local implementation partners, including Community Care of North Carolina networks, local management entities, primary care providers, mental health, developmental disabilities, and substance abuse service providers, and hospitals	Increase access to quality, evidence-based behavioral health care services for North Carolinians by forming partnerships to create a health care system that is **I**ntegrated, **C**ollaborative, **A**ccessible, **R**espectful and **E**vidence-Based	Improves patient outcomes by increasing (1) collaboration and communication between primary care and specialty providers; (2) capacity of primary care practices to provide appropriate, evidence-based behavioral health services and the capacity of specialty providers to screen and refer for physical illness	Three areas of focus: (1) statewide education and assistance—conduct focus groups to determine educational and technical assistance needs; develop a range of provider training opportunities to encourage capacity and relationship building (e.g., centralized and regional workshops; web-based conferences and resources; practice-based trainings and technical assistance); develop and implement a clinical consultation service; (2) local model development—develop integrated and coordinated local systems around the Four-Quadrant Model that will include improved care planning, communication, support (resource directories and consultation) and the development of evidenced-based programs to care for patients with targeted behavioral health problems; provide practice-based technical assistance to local providers to assure implementation of best practices; (3) process and policy change—study and report practice-based, community, regional, and statewide changes that are being recommended or implemented as a result of this initiative

Table 2. National and State Programs/Initiatives for Improving Primary Care-Behavioral Health Integration (cont.)				
Program	**Partners**	**Goals**	**Components**	**Implementation Strategies**
IMPACT: Evidence-Based Depression Care ***www.impact-uw.org***	Open to clinicians and organizations interested in bringing IMPACT depression care into their clinical practice	To adapt and implement the IMPACT program across diverse organizations and patient populations; implementation center provides a range of materials, training and technical assistance to aid the adaptation/implementation process	Collaborative care is the cornerstone of the model: the patient's primary care physician works with a care manager to develop and implement a treatment plan (medications and/or brief, evidence-based psychotherapy); the care manager and primary care provider consult with psychiatrist to change treatment plans if patients do not improve	Depression care manager (nurse, social worker or psychologist) educates the patient about depression, supports antidepressant therapy prescribed by the patient's primary care provider, coaches patients in behavioral activation; offers a brief course of counseling, monitors depression symptoms for treatment response, completes a relapse prevention plan with each patient who has improved; designated psychiatrist consults with care manager and primary care physician on the care of patients who do not respond to treatments as expected; care managers measure depressive symptoms at the start of treatment and regularly thereafter; stepped care is employed whereby treatment is adjusted based on clinical outcomes and according to an evidence-based algorithm
MacArthur Initiative on Depression and Primary Care at Dartmouth and Duke ***www.depression-primarycare.org/***	Open to primary care clinicians, medical groups, specialty societies, health plans, and other organizations committed to high quality depression care	Improve care and outcomes nation wide for patients with depressive disorders treated in primary care practices; center provides educational programs and tools for use in primary care	Uses three components of the RESPECT-Depression study: (1) prepared primary care clinicians and their practices; (2) care management; (3) closer relationships between mental health and primary care clinicians	Process of change is guided by a manualized, widely applicable, easily transported set of implementation strategies and materials; process of care is based on a structured approach to diagnostic assessment; initial steps in care, including promotion of self management; and quantitative monitoring of the response modifying treatment as needed
New Orleans Primary Care-Behavioral Health Integration Project ***www.lphi.org/home2/section/generic-165/***	Includes primary health care and mental health treatment providers in the four-parish Greater New Orleans area	Overcome organizational barriers and produce enduring change by building capacity to combine best practice treatment of depression and mental illness with financial and non-financial incentives for changing systems of care	Site improvement collaboration; financial sustainability planning	Establish/implement behavioral health integration of services in primary care clinics consistent with principles of the Chronic Care Model; conduct learning collaborative among the sites for mutual assistance in development of implementation of these models; develop a standard reporting process for monitoring the implementation at each site; convene a work group that will strategize financial sustainability of behavioral health services by bringing local and state stakeholders together to work toward policy changes that support sustained use of integrated models of care; develop recommendations to insure financial sustainability for adoption by Louisiana Medicaid and other relevant purchasers/ payers as well as by the local sites
RAND Partners in Care ***www.rand.org/health/projects/pic***	Open to any organization committed to implementing the program, with a dedicated team of expert leaders, led by a primary care clinician	An integrated approach to improving care for depression in primary care	Consists of two quality improvement programs — one focusing on medication, the other on psychotherapy; both are appropriate for socioeconomically and ethnically diverse populations; practices can choose either model and add elements of the one not chosen	Recognizes and addresses several key challenges, including need for proactive case detection; need for proactive case management and patient activation; need for time to conduct a thorough clinical assessment; need for collaboration with mental health specialists; key characteristics of the approach include collaboration between specialists and generalists, active case management, and patient empowerment
RWJF Depression in Primary Care National Program ***www.lphi.org/dppc/***	Incentive grants provided to eight partnerships including at least two organizations representing health insurance plans, managed behavioral health organizations, pharmacy benefit managers, health practice/delivery systems, and academic institutions	Increase use of effective models for treating depression in primary care settings	A program to determine feasible and effective ways to (1) realign financial and other systems incentives to enhance implementation of proven clinical care models; (2) strengthen the business case for providing quality care for depression; and (3) develop primary care leadership	Partnerships use an economic/systems approach to ensure that the key components of a chronic care framework for depression treatment will be implemented and sustained and a clinical framework for treating depression in primary care that is based upon the Chronic Care Model

PART 2: ADAPTING THE ROADMAP TO PENNSYLANIA

Summary of Primary Data Collection Methodology

The RAND project team worked with the Collaborative to identify 57 key stakeholders in the Commonwealth to be interviewed and/or surveyed with regard to the desired scope of the initiative, including primary care practice leaders/providers, behavioral health practice leaders/providers, county-level officials, payers, and state-level officials (Appendix A). A standard survey instrument (Appendix B) was sent by email to 38 primary care and behavioral health providers across the Commonwealth; 23 surveys were completed (response rate=61 percent). The RAND project team also conducted 20 telephone interviews. For most of the telephone interviews (15), a standard interview protocol was used (Appendix C). These interviews were one-hour in duration; one project team member conducted the interview and one project team member took notes. Some of the interviews (5), were conducted as informal follow-up inquiries to acquire more detailed information about a program or initiative reported to the project team in a survey or interview. These interviews were typically conducted by one project team member and did not follow the standard interview protocol. The survey and interview results were aggregated and synthesized by each key domain of the protocol.

Overview of Stakeholders' Responses by Protocol Domain

Ideal Working Relationship Between Primary Care and Behavioral Health

Most stakeholders described the ideal working relationship between primary care and behavioral health as involving co-location of care, where integrated care is delivered by a joint primary care provider and behavioral health consultant team. One stakeholder noted that this model should be "invisible" to patients, that "services from both sides of the model could be provided as needed to fit the needs of the patient at the time of the visit or intervention." This ideal model would include integrated treatment planning, open communication between primary care and behavioral health providers (through a shared medical record and/or other format), and institutional incentives (i.e., time and reimbursement) for providers to see and take care of patients with complicated behavioral and physical health needs. One stakeholder cautioned that formal processes and protocols are essential: "good intentions will not get us there."

Assessing Effectiveness: Important Outcomes for the Consumer and the System

When evaluating integrated care models, stakeholders reported that the most important consumer outcomes to focus on are: adequacy of mental health assessment (screening) and diagnosis, clinical outcomes (both behavioral and physical health), quality of life, social functioning, reduced stigma, access to care (i.e., convenience, timeliness of treatment, attendance at follow-up appointments), receipt of evidence-based treatment, patient satisfaction, and engagement in self care. Stakeholders reported that the most important system outcomes to focus on are: cost effectiveness, including cost savings resulting from increased collaboration, ease of communication (i.e., consolidation of information, shared documentation), provider satisfaction, productivity, consistency and quality of documentation, degree of integrated treatment planning, evaluation capability, and quality of care.

Importance of Primary Care–Behavioral Health Integration as a Policy Issue

The majority of stakeholders identified this issue as "extremely important" in the broader context of Pennsylvania's health policy, saying that "it is critical that these connections/linkages be an articulated, mandated policy at highest levels", "it's highly critical", and it is a "top priority, especially with health care reform … it is critical that we get a model as part of the greater health reform efforts."

Components of an Integrated Care Model

Stakeholders were asked to rate the importance of nine key components of an integrated care model on a scale of 1 to 10. Table 3 presents the mean ratings for these components across all stakeholder groups.

Table 3. Stakeholders' Mean Ratings of the Importance of Various Components of an Integrated Primary Care-Behavioral Health Model

Component	Importance (1-10) (Average)
1. Screening consumers to identify behavioral health issues	8.6
2. Systematic tracking, follow-up, and clinical monitoring of consumer health conditions and health outcomes	8.9
3. Providing care management support	8.7
4. Providing access to specialty mental health care in the primary care setting	8.7
5. Developing a reimbursement strategy for paying the costs of establishing and maintaining connections between primary care and behavioral health	9.6
6. Establishing communication pathways and processes between primary care and behavioral health providers	9.5
7. Training primary care professionals to provide behavioral health care	7.7
8. Strategies to engage patients and their families in health self-management	9.3
9. Using information systems to promote improvements in connections between primary care and behavioral health	8.4

The component rated most important was "developing a reimbursement strategy for paying for the costs of establishing and maintaining connections between primary care and behavioral health." Stakeholders commented that payers (both public and private) "prevent these types of connections" as they "only pay for treatment, not family conferences or talking with case managers, etc." Stakeholders also noted that most primary care services are paid through capitation, which does not include mental health. One insurer is now providing primary care practices with a "bill above" number (using a Current Procedural Terminology [CPT] code) so that practitioners can bill for case management work—time that is usually not considered to be included in the capitation rate. Some stakeholders pointed out that reimbursement is easier for providers who serve the Medicaid population because they "can use fee for service to cover consultation costs" and that "it's more problematic for the uninsured."

The component rated least important was “training primary care professionals to provide behavioral health care.” Overall, stakeholders did not consider this an efficient strategy, since “most primary care providers are too busy trying to take care of physical health issues; although there are some conditions can be handled fine by a primary care practitioner, this is probably not true for the majority of people needing behavioral health services.” One stakeholder noted, “we have a 30-year history of this kind of training in family medicine and internal medicine; it doesn’t work; people aren’t interested in learning to provide behavioral health care.”

Stakeholders also rated as less important “using information systems to promote improvements in connections between primary care and behavioral health.” Many believe that there are too many legal and regulatory barriers to realize information systems integration. As one stakeholder commented, “this is important but current Pennsylvania legislation prevents the free flow of information, and these barriers are further aggravated by Health Insurance Portability and Accountability Act (HIPAA) requirements and probably also the new health-information technology (HIT) funding under the stimulus package. In an ideal world, all primary care and behavioral health records would be integrated so that all providers would have the information they need to provide patients with high quality care. Legislation will need to be changed to make this a reality.” In addition, some stakeholders observed that many primary care practices in Pennsylvania are one- or two-physician operations and “do not use computers at all, nor do they want to.”

Barriers to Implementation of an Integrated Model

Stakeholders described numerous barriers to implementing a working model of integrated primary and behavioral health care. Several stakeholders identified the lack of organized leadership as a major barrier, noting that is necesssary to identify “a champion who will develop the integrated plan and lead the effort.” Another reported barrier is real or perceived provider resistance to integration. Primary care providers tended to report that behavioral health providers are resistant to integration, while behavioral health providers reported that primary care providers are resistant. Some stakeholders noted that “primary care doctors don't like dealing with the seriously mentally ill - they seem to find them a time-consuming nuisance” and that “primary care providers are busy and overwhelmed…They are generally anxious about getting involved with behavioral health, though they are desperate for the assistance.” One stakeholder commented that “providers have also said that individuals who are in the throes of symptomatic mental illness cause disturbances in their facilities that upset other people and can even at worst hurt other people.” Stakeholders also reported that primary care providers “do not feel qualified” to treat mental health conditions. Patient factors were also reported as a barrier, specifically “patients do not want to go to speciality mental health and there is poor follow up” and, importantly, that “it is a mistake to assume that everyone would want this type of integration, as many people have issues around privacy… Not everyone wants their primary care practitioner to know that they have a drug or alcohol problem, etc.”

One of the most common barriers reported by stakeholders is the lack of health insurance reimbursement for integrated care. Many stakeholders noted “there is no reimbursement to my knowledge”or that “reimbursement of behavioral health issues for family medicine is a joke… It is such a large part of the practice and the payment is horrible.” In particular, stakeholders reported that time for communication between providers, “either direct communication by phone or in person, or attendance at team meetings where cases could be discussed by

behavioral health professionals and the primary care practitioner," is not reimbursable. In addition, "absence from work to attend training is not usually reimbursed so provider agencies are reluctant to free staff to attend trainings that last longer than a lunch period because they lose billable hours." On the other hand, the payers we interviewed did not consider reimbursement to be an issue: "rates for outpatient care [are] very high and very reasonable." One state official commented that "in my experience, health plans do pay for mental health in primary care." They did, however, point out a general lack of understanding about how to develop a cost and reimbursement structure in an integrated model.

Stakeholders also reported that due to Pennsylvania's privacy laws, sharing patient information between providers is difficult or impossible: "the obstacles are tremendous trying to share patient information across the physical health/behavioral health wall." One stakeholder described "at least three different levels of security (i.e., addictions regulations, mental health regulations, and physical health regulations)… Add HIPPA, and people's confusion about that makes it even more difficult." Others pointed to a "widespread lack of understanding about confidentiality regulations and laws and privacy laws" and clarified that the laws about information sharing are only restrictive on the drug and alcohol side. Pennsylvania law does not allow sharing of information about drug and alcohol services, even with patient consent. A state official explained that her office has "made inroads [to clarify the privacy regulations] recently. People do hide behind the rules. Consent is not impossible to obtain. Information that is pertinent (e.g., pharmacy) is worthy of being shared, and drug and alcohol rules will not be an issue."

Most Pennsylvania health purchasers or insurers "carve-out" mental health care to a managed behavioral health care organization through contractual arrangements including specified reimbursement and incentive structures. These carve-out arrangements are perceived by many stakeholders as a significant barrier to integrated care because they create "two payors, one for physical health and one for behavioral health" and because they "encourage the silo mentality." The incentives of a behavioral health carve-out approach are viewed as a "reimbursement system that limits care, limits interactions of mental health professionals and primary care." One primary care practitioner stated that the carve-out system limits "[my] ability to speak to the behavioral person (or to even know who it is!!), limits [my] ability to refer to a specific provider, and is not user friendly….I am often not impressed with whom my patients get to see."

Use of Care Coordinators

Stakeholders are generally supportive of the use of care coordinators to enhance primary care and mental health integration, believing that these professionals can help to reduce stigma, that "primary care providers do not have time to do this and consumers need a lot of support to maintain a commitment to behavioral health treatment," and that "patients would have advocates to help them navigate systems…these professionals would be able to understand the financial and program requirements of both primary care and behavioral health." However, stakeholders worry about the availability of funding mechanisms to cover the costs of care coordination, since "care managers are often not reimbursable personnel," and are concerned about patient confidentiality issues and information sharing barriers. In addition, stakeholders reported that only large primary care practices would be able to generate the volume required

to support a care coordinator, observing that most primary care in Pennsylvania is delivered in small practices.

Importance of Health-Information Technology

Stakeholders are enthusiastic about using HIT to integrate primary care and mental health care, especially in the form of an integrated electronic health record (EHR), feeling that "it would be great if practitioners could look at one screen and see holistically what is happening with a person—this would be tremendously helpful in being able to treat the whole person…With greater access to the complete picture of a person's health, practitioners might begin to think differently about how they treat them." Many stakeholders described this strategy as "critical," and one stakeholder shared his experience that "an EHR shared by behavioral health specialists and primary care practitioners has been absolutely essential in sustaining collaboration." Several benefits of a shared EHR were identified: "it tends to force clarity, it makes for measurable outcomes, it can be accessed at any time rather than confined to between session minutes, [and] it reduces duplication and time to access materials."

At the same time, stakeholders identified a number of barriers to a shared EHR: confidentiality/ privacy, cost, and logistical (e.g., primary care providers may work for a different entity than a behavioral health provider, with different EHR systems). Worries about breaching confidentiality regulations are the most prevalent barrier identified, with stakeholders reporting that "people have fears of putting these mental health issues in writing," "many mental health services are deemed to be too private to be kept on a HIT record without some kind of secure access above and beyond the typical chart," although "if you have the appropriate releases signed, you are okay." A state official recognized these challenges and stated that "we may need to revisit things around the EHR as it is an artifact of licensing that requires separate records. There is nothing in the regulations that would preclude use of a common EHR." One stakeholder commented that although "HIT can be extremely helpful for integrating documentation, tracking progress, and facilitating co-management of patients, … the practice change involved in provision of integrated care can occur without HIT."

Concept of a Medical Home

The majority of stakeholders supported the concept of a medical home, where a patient's care is coordinated and managed by a personal physician, especially when the definition of a medical home includes mental health care. Stakeholders commented that this model "does not ask the patient to take their mind one place and their body another" and that "all patients need one place to go where they can get all of their health care issues/questions answered." One stakeholder observed that "any setting that moves toward becoming a medical home will move toward readiness to establish collaborative or integrated care models."

Concerns about the medical home model include skepticism about whether the model is "realistic," that it is "easier to describe in theory than to implement in practice" and that it is a "marketing concept." In addition, stakeholders noted that there "is no standard definition and many practices may call themselves a medical home" and that "there is a fine line between coordinating care and limiting access as in the gatekeeper model." In terms of operationalizing the medical home concept, stakeholders identified issues around large practices, where a patient may not see the same physician each time, and for patients whose primary physician

(most frequently seen) is a specialist, rather than a primary care provider. In the latter situation, one stakeholder commented that "the medical home locus could be in a specialty setting… I would not try to impose [the primary care medical home] model across the entire population. [It's important to] look at who is primary for the person, who they have relationships with, etc."

How Resources for Care Integration Should Be Used

Stakeholders were asked to rank four possible strategies for advancing and sustaining working relationships between primary care and behavioral health, particularly in terms of the payback that would be achieved through an investment of resources in these areas. Table 4 presents the mean ratings for these four strategies across all stakeholder groups.

Table 4. Stakeholders' Mean Ratings of the Importance of Various Strategies for Establishing and Sustaining Working Relationships Between Primary Care and Behavioral Health

Strategies	Mean Importance(1-10)
1. Broad based technical assistance	7.6
2. Financial incentives or direct financial support	9.3
3. Creation of a quality improvement collaborative	6.8
4. Implementation of a state-wide demonstration program	7.4

Stakeholders were also asked to recommend additional strategies for investments focused on advancing primary care-behavioral health integration. Their recommendations can be organized into five main thematic areas:

(1) Alignment with ongoing efforts: Stakeholders suggested that the Collaborative partner with ongoing integration intiatives across the state, such as those sponsored by the Office of Healthcare Reform or the Chronic Care Commission.

(2) Demonstration projects: Stakeholders expressed interest in demonstration projects organized around the identification and implementation of an integration model that would include ongoing education and technical support as well as established and approved reimbursement mechanisms for sustaining the projects beyond the funding period. One stakeholder suggested: "it would be great if [the Collaborative] could do something in a rural area, as most of the work is in Philadelphia and Allegheny County."

(3) Payment reform: Several stakeholders noted the need for education and policy reform related to paying for integrated care, including establishing pathways for reimburement for communication, collaboration, "from integrated intake to team treatment review to team care management," noting that "paid time is a recognition of the value of that process."

(4) Workforce development: Stakeholders noted a lack of behavioral health professionals willing and able to work in primary care and suggested that resources be used to establish a new workforce of behavioral health professionals trained to work in primary care settings. This might include providing technical support to the new workforce for at

least five years, and creating a new set of guidelines/regulations to define documentation criteria, billing and diagnostic coding, and professional standards.

(5) Learning networks/collaboratives: Many stakeholders supported the creation of regional learning networks/collaboratives. One stakeholder explained: "If you could get collaboration to happen on a small scale, then other providers would see how it could work to their benefit and would want to be a part of it. You need to make integrated primary care-behavioral health the established way of doing business and show that it works. The convening component is essential. Most providers do not have the time to do it their own, but if you could facilitate the convening and collaboration across small 'pods' working together across the state, the idea could take off." Another stakeholder recommended bringing stakeholders together in a retreat-type setting with a facilitator so that they can get to know each other and work on shared problems together.

Additional Stakeholder Recommendations

At the end of both the survey and the interviews, stakeholders were asked to comment on additional issues of potential importance for informing the Collaborative's efforts. Many stakeholders responded. Below is a representative sample of their advice:

- "This is a complex process. You must have the buy-in and leadership of medical directors. Integration does not work if it is seen as a hand off of care from one professional (the primary care practitioner) to another (the behavioral health provider). The only way it truly works is if the team sees the patient as their mutual responsibility and the primary care practitioners as the team leader."

- "Educating physicians who have practiced one way for a long time is very difficult; change comes slow, if at all, unless it is mandated."

- "The great resistence of primary care providers is important to recognize. Emergency room staff talk about people with mental illness as though they are an inconvenience to be gotten rid of as quickly as possible—not recognizing the strength of this aversion would be a mistake."

- "There should be an emphasis on behavioral health care for those who do not speak English either by providing translators or training behavioral health professionals in other languages, especially Spanish. There should also be an emphasis on subtance abuse treatment with expanded access for medications that improve patient outcomes."

- "It is critical to address those with serious mental illness…these people have a terrible time accessing primary care…having all the consumers with just mild or occasional behavioral health issues served in the primary care system leaves only the sickest for behavioral health. From a funding and management perspective, you need to have the healthier and the sick in the pool."

- "To get people excited about this idea you have to paint a picture of where you will take them (e.g., patients getting the care they need when they need it, total elimination of the stigma associated with receiving behavioral health services, complete coordination across

providers and systems, unhindered flow of information, providers working together for the benefit of their patients). You may know what's happening behind the scenes, but the people you are trying to get excited about this won't. You have to make the vision real and underscore that the reality of today is simply not acceptable."

Existing Initiatives and Programs Across the Commonwealth for Integrating Primary Care and Behavioral Health

In reviewing the survey responses and conducting the interviews, the RAND project team identified a number of ongoing efforts to integrate primary care and behavioral health across the Commonwealth. These efforts are summarized in Table 5. The first four programs, which appear particularly relevant to the Collaborative's goals, are described in greater detail below.

Table 5. Existing Initiatives/Programs for Integrating Primary Care and Behavioral Health Across the Commonwealth

What	Where	Setting/Populations	Model
Health Federation of Pennsylvania: Integrating Primary Care and Behavioral Health in FQHCs	**Philadelphia**	**Six FQHCs, with plans for expansion**	**Primary Care/Behavioral Health Consultation Model**
Pennsylvania Chronic Care Commission Demonstration	**First regional rollout: five-county Phila. area; additional rollouts planned**	**First regional rollout: 32 practices, 150 physicians, 250 patients**	**Chronic Care Model and Patient-Centered Medical Home**
Integrating Treatment in Primary Care (ITPC)	**Southwestern Pennsylvania**	**Five primary care clinics**	**IMPACT, SBIRT, Chronic Care Model**
Center for Health Care Strategies Rethinking Care Program	**Allegheny, Bucks, Montgomery, and Delaware Counties**	**Medicaid enrollees with serious mental illness, 20 percent at high risk for other physical/behavioral health conditions**	**Coordinated assessment, medical home, consumer engagement, information exchange, substance abuse screening, evaluation**
Creative Health Services, Inc.	Montgomery, Berks, and Chester Counties	New all-in-one clinic that includes behavioral health, community health, and dental health services, and a full-service pharmacy; applying for FQHC status	"No wrong door" approach to care; emphasizes stability and sustainability, personal health and balance, recovery, partnership, fiscal responsibility, growth, community, interdependence
Allegheny County Maternal and Child Health Care Collaborative	Allegheny County	Originally FQHCs, expanded to OB/GYN, pediatrics, and family medicine residency practices; managed care organizations; behavioral health providers; and community-based service providers	Three phases: (1) planning; (2) pilot testing quality-improvement strategies in community-based settings; (3) county-wide demonstration to improve screening, referral, and engagement in treatment for maternal depression
Medicaid Pilot Projects	Allegheny County (UPMC for You)	New Kensington Family Health Center and Family Services of Western Pennsylvania	Coordination and consultation between physical and behavioral health through co-location and reimbursement changes
		East Liberty Family Health Care Center	Co-located psychiatrist and social worker
		Latterman Family Health Center and Mon Yough Community Services	Emergency Department diversion strategy through enhanced primary care, staff sharing, and cooperation
		Western Psychiatric Institute and Clinic and University of Pittsburgh Medical Center Family Medicine Residency Program	Co-location of primary care in schizophrenia clinic

Health Federation of Pennsylvania: Integrating Primary Care and Behavioral Health in FQHCs

Background. Five years ago, the Health Federation of Pennsylvania (HFP) was approached by Community Behavioral Health (CBH, a managed behavioral health care organization) and the Philadelphia Department of Health to determine if its affiliated FQHCs could provide behavioral health services, as the existing behavioral health system could not meet the demand. HFP and the City conducted a series of dialogues and work groups aiming to simplify the administrative requirements for primary care practices to provide behavioral health services. HFP then applied for funding from the Aetna Foundation to train primary care and behavioral health providers on a brief therapy model. A technical assistance consultant for the Health Resources and Services Administration reviewed the plan and concluded that it was a recipe for disaster: the number of required per patient hours was too high and the FQHCs would be overwhelmed immediately. He recommended training on the Primary Care/Behavioral Health Consultation Model. The Aetna Foundation funding has been used for training, technical assistance, convening participating practices, and for advocating with CBH. The original three-year grant has been stretched to four years, and will run through June 2010; the model is now well established.

Model components. In this model, behavioral health consultants (a master's level clinical social workers or licensed therapists) adapt their work to the primary care setting, providing support to the primary care providers, seeing more patients (8-12) in shorter visits (10-30 minutes), flexing their schedules to allow for same-day immediate consults, and referring to the specialty care sector when needed and when the patient is amenable. The behavioral health services provided are practically focused and include problem assessment/identification, consultation with the patient on specific behavioral changes required to alleviate symptoms, and enhanced patient self-management, with the overall goal of improving patient functioning. HFP organizes monthly clinical team meetings for peer support, sharing best practices, and ongoing training. CBH has created a behavioral health event code and a reimbursement code to pay for services provided by the behavioral health consultant.

Experience with implementation. It was reported that access to behavioral health services has improved for several reasons: (1) the behavioral health consultants can see more patients per day than in traditional behavioral health settings; (2) there is no down time since no-show appointments can be filled by other patients who are already there; and (3) the need to involve behavioral health consultants in follow-up appointments is limited. It was also reported that primary care practitioners have embraced the model because it makes their work easier and more effective.

Privacy issues/information sharing between primary care and behavioral health have not been a problem since, under this model, there is no separate case load for the behavioral health specialists and no separate patient charts; all of the information is put into one patient chart that is accessible by everyone working in the practice which operates as a single HIPAA entity.

There were several barriers identified on the both the primary care and behavioral health sides. First, primary care practitioners initially feared that taking more time to deal with the mental/behavioral health issues of patients would slow down their productivity. They were also concerned about practicing outside their area of competence and expressed some initial insecurity, especially around psychopharmacology. These concerns were addressed through training for both primary care practitioners and behavioral health consultants and having

behavioral health consultants available to make recommendations as needed. Barriers for behavioral health consultants included the learning curve for acquiring skills of rapid assessment and intervention planning, focused problem solving, uniform documentation, and dealing with payer-related issues/requirements.

Pennsylvania Chronic Care Commission: Chronic Care/Medical Home Demonstration Project

Background. The Pennsylvania Chronic Care Management, Reimbursement and Cost Commission was formed under Governor Rendell's Prescription for Pennsylvania in 2007 and charged with developing a strategic plan to implement the Chronic Care Model region-by-region across the state. The Commission decided to begin with a focus on diabetes and its related co-morbidities, and then to proceed to childhood asthma. The first regional roll-out of the project started in May 2008 and included 32 practices (i.e., FQHCs, internal medicine, pediatrics, and family medicine), 150 physicians, and about 250 patients in the five-county Philadelphia area. Each region will have a learning collaborative made up of providers and insurers (at least two for each collaborative) to share knowledge and practices, and providers will utilize a common registry. Insurers and providers must agree to participate for the three-year period of the demonstration and to be involved in measurement and evaluation.

Model components. The Commission considered the Chronic Care Model and the Patient-Centered Medical Home and decided to include components of both: care coordination, integration with community resources, the team approach for patient management, use of a registry to track and measure individual and population health, support for patient self-management, and open access scheduling. The Commission requires that participating insurers provide either enhanced payments or infrastructure to support the implementation of the model. It also requires insurers to pay performance bonuses for high quality care.

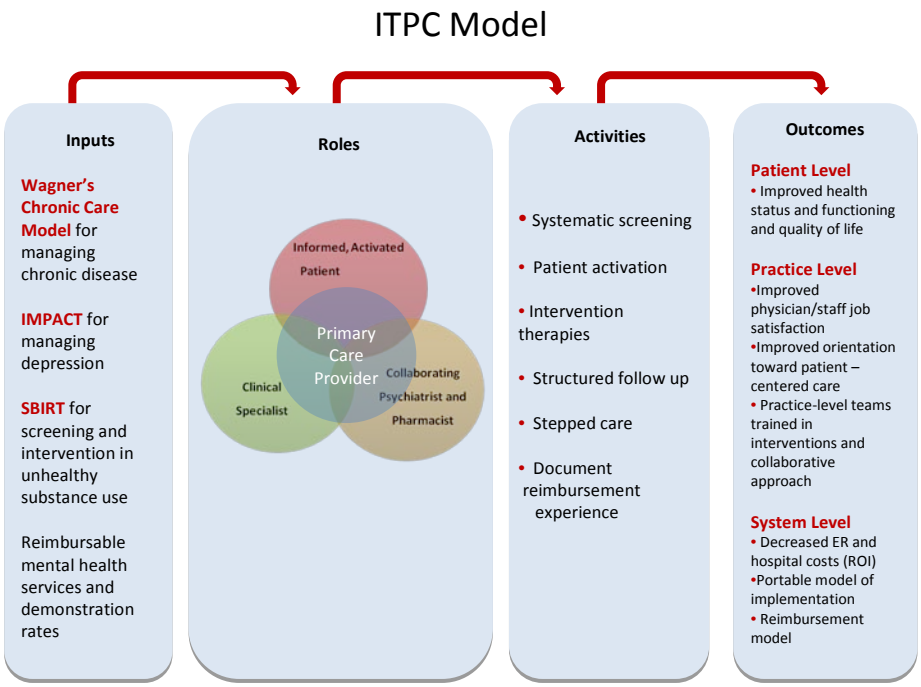
Experience with implementation. Once members identified the necessary components of the model, the Philadelphia-area collaborative focused on facilitating relationships among the 32 practices and the behavioral health providers that were geographically proximate to them. They organized meetings with payers, the managed behavioral health organization for each payer, the Pennsylvania Department of Welfare, and primary care providers. Together they identified the barriers to good integration: patients not being able to get timely appointments, lack of communication across systems, patients not wanting to go to behavioral health offices, primary care practitioners saying that they do not get paid to deal with behavioral health issues and they are not allowed to refer to behavioral health providers because payers have their own networks, etc. Strategies were adopted to address each of the barriers. It was reported that: (1) practices have eliminated the need for referrals; (2) payers allowed practices to hire any behavioral health providers that agreed to contract with them; (3) payers made it possible for behavioral health providers to be located in a primary care setting (i.e., providers worked out the rental arrangements and payers agreed to pay them); and (4) the collaborative facilitated face-to-face working relationships among the primary care practices and the behavioral health providers.

Integrating Treatment in Primary Care (ITPC)

Background. This 18-month demonstration was recently launched at five southwest Pennsylvania health centers by the Pittsburgh Regional Health Initiative with support from the Jewish Healthcare Foundation, the Fine Foundation, and the Staunton Farm Foundation. The target population is adult patients with one or more of four chronic conditions including diabetes, asthma, congestive obstructive pulmonary disease, and congestive heart failure as well as co-morbid depression or unhealthy substance use. An independent evaluation will be conducted by an investigator at the Institute for Evaluation Science in Community Health, University of Pittsburgh.

Model components. The model, developed by PRHI and the University of Washington's IMPACT Training and Implementation Center, integrates the IMPACT, SBIRT and Chronic Care Models with the goal of effectively and efficiently managing chronic disease. The components include an expanded, collaborative care team, standardized screening, a focus on patient activation, evidence-based brief interventions, and structured follow up to determine whether patients are making progress toward treatment goals.

The care team involves the patient, a primary care practitioner, a clinical specialist, a consulting psychiatrist, and a consulting pharmacist. The clinical specialist is a master's level mental health professional who has regular phone and face-to-face contact with the patient and consults weekly with the psychiatrist and primary care practitioner. This position will be fully supported by foundation funding at each of the five locations. Clinical decision making, collaboration, and follow-up will be supported by a web-based registry developed, customized, and maintained by the University of Washington.



Center for Health Care Strategies, Inc. (CHCS): **Rethinking Care** ***Program***

Background. Pennsylvania is one of four states with pilot projects to design and test new care management interventions as part of CHCS' *Rethinking Care for Medicaid's Highest Need Highest Cost Populations* program. Within the state, there are three regional pilots working to integrate physical and behavioral health services for adults with serious mental illness and physical health co-morbidities. A pilot located in Allegheny County is working with UPMC for You members, while a pilot in Southeast Pennsylvania is working with Keystone, Mercy, and Magellan members. A third pilot will link the state's ACCESS Plus (enhanced primary care case management program) vendor with additional county behavioral health partners.

Model components. The basic premise of the project is that individuals with serious mental illness are underserved by both the behavioral and physical health systems and that outcomes could be improved through a joint approach. Components of the two-year pilot project include: coordination of hospital discharge and appropriate follow-up, a pharmacy management program, a co-location demonstration project, focus on appropriate Emergency Department use for behavioral health treatment, focus on alcohol and substance abuse treatment/care coordination, and consumer engagement. Critical outcomes to be measured include: behavioral and physical health-related hospital admission rates, behavioral and physical health-related hospital readmission rates, Emergency Department visit rates, consumer satisfaction (CAHPS survey), appropriate prescribing patterns (e.g., use of two or more atypical anti-psychotics or benzodiazepines), and identified behavioral or physical health care gaps.

PART 3: NEXT STEPS FOR IMPLEMENTING THE ROADMAP

Based on our previous discussions with Collaborative leaders, our understanding is that the Collaborative seeks to design and implement a statewide demonstration project that would document the value of primary care-behavioral health integration at the local, regional, and state levels. Ideally, the project would test best practice models at various stages of integration, and demonstrate to providers that "if they do it right, it's worth the investment." An additional related goal is to develop and implement a community assessment tool that would help communities understand where they are in terms of readiness for integration, best practices for moving along the continuum, and the likely impact of continued investments in integration.

Important Issues for the Collaborative's Consideration

The results of our primary and secondary data collection effort reveal several important issues that should be considered when thinking about next steps for the Collaborative.

First, while there is increasing evidence that integrated care achieves positive outcomes, "it is not possible to distinguish the effects of increased attention to mental health problems from the effects of specific strategies, evidenced by the lack of correlation between measures of integration or a systematic approach to care processes and the various outcomes" (Butler, et al., 2008). The strongest evidence supports "the benefits of care management, specifically, and multifaceted interventions, generally, on depression outcomes" (Williams, et al., 2007).

Second, there is no one "right" integration model; the appropriate selection of which model to implement depends upon the needs and circumstances of the relevant patient and provider populations. "Without evidence for a clearly superior model, there is legitimate reason to worry about premature orthodoxy" (Butler, et al., 2008).

Third, no matter what integration model is chosen, successful translation of that model into practice will ultimately require the creation of specific provisions for ensuring accountability and incentives to support sustainability across all relevant stakeholder groups.

Fourth, there is significant related work currently underway in the Southeast Pennsylvania region (Philadelphia five-county area) and the Southwest Pennsylvania region (Pittsburgh/ Allegheny County) that could be usefully expanded to other counties represented by the Collaborative, specifically areas in the Central region (Harrisburg, Cumberland County, Adams County, Perry County) and/or more rural areas where access to behavioral health care is a notable challenge. Efforts to monitor and/or evaluate these programs vary by program; there is currently no comprehensive, systematic effort to share lessons learned or to examine outcomes across programs.

Fifth, while the momentum for integration appears to be strong among all key stakeholder groups across the state, overcoming the systems-level barriers which prevent integrated primary care-behavioral models from moving into mainstream health care will require organized, collaborative action beyond the practice and community levels.

Strategies for Moving Forward with Primary Care-Behavioral Health Implementation in Pennsylvania

Below we describe four broad types of initiatives/activities for the Collaborative to consider when thinking about how it might work with key stakeholders across the state to improve population health through the integration of primary care and behavioral health. For each type of initiative/activity, we also offer some brief commentary on the relative advantages, disadvantages, and costs of implementation. These comments are based on available information regarding experiences with implementing these types of strategies in similar contexts, as well as the comments of the stakeholders who were interviewed as part of this study.

We note that the strategies can be implemented individually, in any combination, or in their totality. In fact, some strategies are more likely to be effective when combined with at least one other strategy (e.g., shared learning collaboratives and demonstration/pilot projects; workforce development and targeted policy reform efforts; shared learning collaboratives, targeted policy reform efforts, and demonstration/pilot projects). In each case, the scale (i.e., within several communities or counties versus within/across regions or statewide) and procedural/ methodological rigor of the implementation may vary. Ultimately, both the selection of strategies and the approach for implementing them will depend upon the goals of the Collaborative and the resources available to it.

Learning Networks/Collaboratives

Statewide or regional learning networks/collaboratives would create a forum for key stakeholders (providers, payers, and policy makers) to systematically assess current practices, disseminate lessons learned from related state or regional efforts, develop strategies for overcoming barriers to sustainability, and expand/strengthen existing programs and initiatives through ongoing monitoring/data collection, training, and technical assistance. Many different types of collaboratives have been used in different clinical areas and organizational contexts and have been adopted by numerous large and small health care systems for the purpose of improving care delivery and accelerating better outcomes. The Allegheny County Maternal and Child Health Care Collaborative, which has been in operation since 2002, has been able to use learning collaborative forums as an effective means for strengthening, monitoring, and expanding "home-grown" community-based quality improvement efforts focused on care coordination and consumer engagement. These forums can also provide a useful setting for "getting the record straight" on important issues related to the generalizability and sustainability of integrated care models. For example, from the interviews and surveys, we discovered a prevailing perception, particularly among practitioners, that it is not possible to share patients' behavioral health information. However, state officials point out that this perception is incorrect, that indeed information sharing is permitted by state regulations. Learning networks/collaboratives would provide a setting where policy makers could clarify the regulations, stakeholders would have the opportunity to ask questions, and guidelines on information sharing could be developed for statewide dissemination. These groups could also develop and disseminate policy briefs, operational and/or evaluation aides/instruments, webinars, and toolkits for supporting and expanding existing integration efforts.

The major advantage of this strategy is that the Collaborative could build on the work of existing programs, rather than having to create new programs from scratch. In this respect, it would be relatively easy to draw all key stakeholders to the table and to build strong, effective linkages among them. Also, because it represents an additional allocation of resources on top of existing substantial investments, this strategy is likely to be less resource intensive than large-scale Demonstration Projects (see below).

Targeted Policy Reform Efforts

The Collaborative could convene statewide or regional forums, conferences, or workshops to develop strategies for reforming state or federal policies that inhibit the integration of primary and behavioral health care. For example, Pennsylvania state policy currently prohibits the sharing of information about drug and alcohol use and treatment, even if patients give consent, which stakeholders identified as a significant barrier to integration. State policies governing Medicaid payment rules, especially those regarding "carving out" mental health care from medical care, may also be a target for policy reform efforts (e.g., building in specific accountability provisions/incentives for enhancing coordination and integration). Additional modifications related to incentives for ongoing quality improvement, use of HIT, etc. might also be proposed.

Leadership from and collaboration with state-level officials would be essential for the success of this strategy and, based on the results of our interviews, should not be too difficult to obtain. Reforms could be developed and proposed in a relatively short period of time and for a relatively modest investment.

Workforce Development

Stakeholders reported that one of the challenges of integrating primary care and behavioral health care is securing funding for training. Training and workforce development needs are multifold: primary care providers need training on appropriate screening, diagnosing, and referral; individuals identified as care coordinators need training on the chosen coordination or care management models; and behavioral health specialists need training on how to adapt behavioral health care to the primary care setting. One option may be for the Collaborative to create an integration training institute, where primary care providers, behavioral health specialists and/or care coordinators could learn about a particular integration model, be trained in their respective roles, and receive certification. Another option may be to collaborate with health professions schools in the state to develop curriculum on the recognition and treatment of behavioral health conditions in primary care settings.

It is likely that incentivizing providers to participate in trainings that occur separately from their formal training and career development will prove challenging, and that collaborating with health professions schools may be a more viable strategy. In both cases, efforts to provide training will be limited in their effectiveness if not combined with related provisions for accountability and incentives in clinical settings. Although this strategy will take longer to implement than the others, and the ability to measure its impact on population health outcomes will be limited, the required level of investment would be relatively low.

Demonstration Projects

Demonstration projects could be created and implemented through statewide, cross-regional, or regional Requests for Proposals. In this case, the Collaborative would need to define the parameters of the project and the components of the models to be used, select the participating sites, and ensure that critical program components (e.g., incentives, provisions for accountability, training, monitoring, and evaluation) are incorporated. It would also most likely be responsible for direct reimbursement of clinical expenses incurred by the participating practices/providers.

Based on the experiences of related national, state, and regional initiatives and programs, the success of this strategy would be greatly enhanced if undertaken simultaneously with activities as described above under Learning Networks/Collaboratives and Targeted Policy Reform Efforts that will help to create linkages among new and existing programs and ensure sustainability beyond the funding period. The ability to generalize the demonstration outcomes to broader settings/populations and the overall cost of undertaking such a strategy will depend upon the scale and scope of the demonstration.

Concluding Observations

The RAND project team was tasked with collecting and synthesizing primary and secondary information that would be useful for the Collaborative's decision making regarding how to improve population health through the integration of primary care and behavioral health in a coordinated, high-impact way across the Commonwealth. In conducting this task, we were instructed to focus on a specific population of interest (i.e., adults with a chronic physical health condition that is managed by their primary care physician but who also have behavioral health issues that commonly present in primary care settings) and a specific type of setting (i.e., family medicine and general internal medicine practices). Therefore, the information presented in this report does not encompass all of the issues related to integration, particularly those that pertain to other types of populations and settings (e.g., populations with serious mental illness, populations at high risk for conditions that frequently result in hospitalization, high-cost users of health care, etc.).

Regardless of the population or setting of interest, there are a number of general prescriptions for advancing and sustaining integration that warrant special note. First, while there is no "silver bullet" that will magically transform a fragmented system of care into one that is integrated, collaboration among all stakeholders (e.g., patients, providers, plans/payers, and policy makers) will be essential to any successful transformation. This collaboration must include not only the explicit recognition that each group has a role to play and what that role is, but that each group will be supported, monitored, and held accountable for its performance as appropriate. Second, in the current fiscal environment, enhancing the overall appeal of integration will require a strong emphasis on the promise that integration can help improve overall health outcomes in a more efficient way than usual care. In this sense, rigorous approaches to evaluating specific process and outcome measures of integration and disseminating that knowledge to inform new efforts could yield tremendous payoffs. Finally, while there is sufficient current activity around integration, both in Pennsylvania and elsewhere, to warrant careful consideration of expansionary, supportive, and sustaining (as opposed to *de nouveau*) strategies for advancing these efforts, the key to success with respect to any strategy undertaken will be the extent to which measures of accountability and related and supportive systems changes are implemented to ensure sustainability over time.

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APPENDIX A. PENNSYLVANIA STAKEHOLDERS IDENTIFIED, SURVEYED AND/OR INTERVIEWED

(1) Primary Care Practice Leader/Provider					
Name	**Organization**	**Community/ County**	**Emailed Survey**	**Completed Survey**	**Interviewed**
1. Krys Sipple, Executive Director	The Clinic	Phoenixville /Chester County	**X**		
2. Maureen Tomaschuk	Community Volunteers In Medicine	Chester County	**X**		
3. Tracy Shantz, Program Director	Phoenixville Healthcare Access Foundation	Phoenixville / Chester County	**X**	**X**	
4. Kathleen A. Fitzgerald, RN	North Penn Visiting Nurse Association	Lansdale/ Montgomery County	**X**		
5. Diane Crown	HealthLink Medical Center	Southampton /Bucks County	**X**	**X**	
6. Patti Deitsch	Delaware Valley Community Health, Inc.*	Philadelphia County	**X**	**X**	
7. William Fife, MD, Medical Director	SouthEast Lancaster Health Services*	Lancaster County	**X**	**X**	
8. Jonathan Han, MD	New Kensington Family Health Center	Westmoreland County	**X**	**X**	**X**
9. Rekha Yagnik, MD, Medical Director	ChesPenn Health Services*	Chester County	**X**		
10. Elaine Herstek, Director	Sadler Health Center Corporation*	Cumberland and Perry Counties	**X**	**X**	
11. Jeannine Peterson, CEO	Hamilton Health Center, Inc.*	Dauphin County	**X**	**X**	
12. Joanne Cochran, Director	Keystone Community Health Center*	Franklin County	**X**	**X**	
13. Donna Torrisi, Executive Director	Family Practice and Counseling Network*	Philadelphia County	**X**		
14. Patty Gerrity, RN, PhD, FAAN, Director	11th Street Family Health Services Center of Drexel University*	Philadelphia County	**X**	**X**	
15. Natalie Levkovich, MD, MPH, Executive Director	Health Federation of Philadelphia	Philadelphia County	**X**	**X**	**X**
16. Wil Payne, Director	Primary Care Health Services Inc*	Allegheny County	**X**		
17. Jeanette South-Paul, MD, Chair	UPMC Department of Family Medicine	Allegheny County	**X**	**X**	
18. Marjorie A. Bowman, MD, MPA, Chair	University of Pennsylvania Department of Family Medicine and Community Health	Philadelphia	**X**	**X**	
19. James M. Herman, MD, MSPH, Chair	Penn State Department of Family and Community Medicine	Hershey	**X**		
20. Linda Kanzleiter, MD, Vice Chair	Penn State Department of Family and Community Medicine	Hershey			**X**
21. Richard Wender, MD, Chair	Jefferson University Hospitals Department of Family and Community Medicine	Philadelphia	**X**	**X**	
22. David Berkson, MD, Program Director	Drexel University College of Medicine Department of Family Medicine	Philadelphia	**X**	**X**	
23. Dennis Torretti, MD, Chair	Geisinger Internal Medicine Department	Danville	**X**		

* Indicates Federally Qualified Health Center (FQHC)

(2) Behavioral Health Practice Leader/Provider					
Name	**Organization**	**Community/County**	**Emailed Survey**	**Completed Survey**	**Interviewed**
1. Richard Graziano	Fellowship Health Resources	Phoenixville / Chester County	**X**		
2. Burroughs Mack, MSS	Family Services of Chester County	Chester County	**X**		
3. Caroline Smith, MD, Deputy Administrator for Mental Health	Chester County Mental Health Services	Chester County	**X**	**X**	
4. Sharon Testa, PsyD	Northwestern Human Services	Lansdale / Montgomery County	**X**	**X**	
5. John Goshow	Penn Foundation, Inc.	Sellersville / Bucks County	**X**	**X**	
6. Mary S. Gruber, MA	Philhaven	Mt Gretna / Lebanon County (Lancaster County)	**X**		
7. Timothy Merlin, MA	Southwest Behavioral Care, Inc.		**X**		
8. Kathleen Yarzebinski, Director Behavioral Health Services	Family Services of Western Pennsylvania	New Kensington / Westmoreland County	**X**	**X**	
9. Ken Thompson, MD	CMHS, SAMHSA *also serves as consulting psychiatrist UPMC McKeesport and Squirrel Hill FQHC 1 day/ week*		**X**	**X**	**X**
10. Andrew Kind-Rubin, MD, Clinical Director	Child Guidance Resource Centers	Chester County	**X**	**X**	
11. Bill Niles, CEO	Roxbury Treatment Center	Franklin County	**X**		
12. John Thomas, Director	NHS/The Stevens Center	Cumberland/ Perry Counties	**X**	**X**	
13. David Stockton, MHS, Central Region Director	Gaudenzia, Inc.	Chester, Cumberland, Dauphin, Lancaster, Montgomery, Northumberland, Philadelphia and Schuykill Counties	**X**		
14. Suzanne Daub, MSW, LCSW, Director of Behavioral Health	Delaware Valley Community Health	Philadelphia/ Montgomery County	**X**	**X**	
15. Neftali Serrano, PsyD, Clinical Psychologist	Primary Care Behavioral Health Model	Southeastern Pennsylvania	**X**	**X**	
16. Kenneth Nash, MD, Chief of Clinical Services	Western Psychiatric Institute and Clinic	Allegheny County	**X**		
17. P. Andrew Trentacoste, PsyD, MBA, Executive Director	Creative Health Services, Inc.	Montgomery/Berks/ Chester Counties			**X**

(3) County-Level Officials					
Name	**Organization**	**Community/County**	**Sent Survey**	**Completed Survey**	**Interviewed**
1. Donna Carlson, Deputy Human Services Director	Chester County Department of Human Services	Chester County			**X**
2. Pat Valentine, Deputy Director	Allegheny County Department of Human Services	Allegheny County			**X**
3. Eric Goldstein, Administrator Leeann Moyer, Deputy Administrator	Montgomery County Behavioral Health and Developmental Disabilities	Norristown / Montgomery County			**X** **X**
4. Arthur Evans, PhD, Director	Department of Behavioral Health, City of Philadelphia	Philadelphia			**X**

(4) Payers					
Name	**Organization**	**Community/County**	**Sent Survey**	**Completed Survey**	**Interviewed**
1. Richard Snyder, MD, Sr. VP Health Services	Independence Blue Cross *Also a key player in the Eastern Region's Governor's Office of Health Care Reform learning collaborative*	Mid Atlantic Region			**X**
2. Donald Fischer, MD, MBA, Medical Director	Highmark	Western PA			**X**
3. Angie Sarneso, LSW, MPM, Clinical Director *Or Mark Fuller, MD, Medical Director*	Value Behavioral Health of Pennsylvania	Erie, Crawford, Mercer, Venango, Cambria, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Washington, Westmoreland Counties			
4. Bryce McLaulin, MD, Chief Medical Officer	Community Behavioral Health DBH-MRS	Philadelphia			**X**
5. Mike Blackwood, CEO Renee Miskimmin, Acting Chief Medical Officer Mona Hawkins, Director, Care Management	Gateway Health Plan	Allegheny County			**X** **X** **X**
6. John Lovelace, Program Director; President	Community Care Behavioral Health, UPMC for You				**X**

(5) State-Level Officials					
Name	**Organization**	**Community/County**	**Sent Survey**	**Completed Survey**	**Interviewed**
1. Estelle Richman, Secretary Stefani Pashman	PA DPW				**X** **X**
2. Ann Torregrossa Director	Office of Health Care Reform				
3.Joan Erney Deputy Secretary	Office of Mental Health and Substance Abuse				**X**

Total Stakeholders Identified: 57
Total Surveys Fielded: 38
Total Surveys Received: 23 (response rate=61 percent)
Total Interviews Completed: 20

APPENDIX B. STAKEHOLDER SURVEY INSTRUMENT

We are interested in your perspective on several issues related to optimizing the working relationship between primary care and behavioral health care.

The population of interest is adults with a chronic physical health condition that is managed by their primary care physician (for example, diabetes, asthma) but who also have behavioral health issues that commonly present in primary care settings (for example, depression, anxiety, alcoholism).

We are gathering this information from you and other stakeholders as a first step towards possibly developing a statewide initiative that would enhance and improve the provision of behavioral health care in primary care settings for the population of interest. Your comments will be summarized in a report that we will provide to the PA Health Funders Collaborative who is funding this data collection effort. Your comments will not be linked directly to your name or identity in any way.

Name

Name of Organization

Type of Organization (please check)
☐ FQHC ☐ Primary Care Practice ☐ Behavioral Health Practice
☐ Other (specify)

1. What is your vision for the ideal working relationship between primary care and behavioral health, particularly for the population of interest?

2. What outcomes do you think are most important to focus on when working to establish connections or linkages between primary care and behavioral health?
    a) For the consumer?

    b) For the system?

3. How important is it, in the broader context of Pennsylvania health care policy, to strengthen connections or linkages between primary care and behavioral health, particularly for the population of interest (please check)?

☐ Not important
☐ Somewhat important
☐ Very important
☐ Extremely important

4. Have you or your organization undertaken any efforts to establish or improve connections between primary care and behavioral health (please check)?

☐Yes
☐No

If yes, please describe:

5. There are a number of components that have been identified as potentially relevant for establishing and sustaining effective working relationships between primary care and behavioral health.

   For each component, please indicate:
   - Whether you're familiar with/have heard of the concept;
   - How important you think it is for establishing and sustaining effective working relationships between primary care and behavioral health on a scale from 1 to 10 (where 10 is "most important"); and
   - If you or your organization have undertaken any efforts to implement the component/strategy

Component	**Familiar? (Y/N)**	**Importance (1-10)**	**Implement ? (Y/N)**
Screening consumers to identify behavioral health issues			
Systematic tracking, follow-up, and clinical monitoring of consumer health conditions and health outcomes			
Providing care management support			
Providing access to specialty mental health care in the primary care setting			
Developing a reimbursement strategy for paying the costs of establishing and maintaining connections between primary care and behavioral health			
Establishing communication pathways and processes between primary care and behavioral health providers			
Training primary care professionals to provide behavioral health care			
Strategies to engage patients and their families in health self-management			
Using information systems to promote improvements in connections between primary care and behavioral health			
Other strategy identified by interviewee:			

6a. For any of the strategies above that you or your organization has attempted to implement, what types of barriers did you encounter?

If you or your organization has not attempted to implement any of these strategies, are you aware of efforts in your county or in the Commonwealth to implement them?

☐ Yes
☐ No

If yes, please describe:

6b. There are several models for establishing relationships between primary care and behavioral health (e.g., ENHANCE; IMPACT; the Chronic Care Model). Have you or your organization undertaken any efforts to implement a specific model to connect primary care to behavioral health?

☐ Yes
☐ No

If yes, please describe:

6c. Have you or your organization undertaken any efforts specifically to co-locate behavioral health services in the primary care setting?

☐ Yes
☐ No

If yes, please describe:

7a. GENERALLY, what are some barriers to effectively establishing and maintaining connections between primary care and behavioral health?

7b. What are some barriers to effectively establishing and maintaining connections between primary care and behavioral health related to *cost, reimbursement, and payment issues*?

7c. What are some barriers to effectively establishing and maintaining connections between primary care and behavioral health related to *providing effective and appropriate clinical care*?

8. A couple of strategies identified in the literature as helpful to establishing and maintaining effective working relationships between primary care and behavioral health are: (a) the use of specific professionals to coordinate physical and behavioral health care (sometimes called care managers; case managers; integrated care specialists) and (b) the use of health information technology (HIT) (such as electronic medical records).

8a. The professionals who serve to coordinate physical and behavioral health care can serve several functions, including communication and coordination of care; direct education and support to consumers; monitor consumer symptoms and adherence; provide consumers with self-management support; and provide behavioral health interventions (e.g., brief psychotherapy). **Do you think this would be an effective**

strategy for establishing and maintaining a behavioral health presence in primary care? Why?

8b. HIT is increasingly talked about as a useful tool for increasing communication between and among health care providers and health care consumers which may help to enhance care coordination across primary care and behavioral health. **Do you think HIT is important for establishing and maintaining a behavioral health presence in primary care? Why?**

9. The idea of a "medical home" has been recently discussed as a way to improve the quality of health care. A medical home is the concept of continual care, managed and coordinated by a patient's personal physician. Characteristics of a medical home include timely access to medical services, a "whole person" orientation to medical care, enhanced communication between patients and their health care team, coordination and continuity of care, and an intensive focus on quality and safety. **Do you think the medical home concept would have any impact on establishing and maintaining connections between primary care and behavioral health?**

9a. In current definitions of a medical home, there is no explicit recognition of the need for an established relationship between primary care and behavioral health. **Would emphasizing this connection in the definition of a medical home make it more likely that these connections would occur?**

10. If there was an investment of resources to improve connections between primary care and behavioral health here in Pennsylvania or in your county, what strategies do you think would afford the greatest "payback" with regard to successfully establishing and maintaining those connections?

For each strategy below, please indicate how important you think it is for establishing and sustaining effective working relationships between primary care and behavioral health on a scale from 1 to 10 (where 10 is "most important")

Strategies	**Importance (1-10)**
Broad based technical assistance	
Financial incentives or direct financial support	
Creation of a quality improvement collaborative	
Implementation of a state-wide demonstration program	
Other (specify)	

11. Is there anything else that you think it is important for us to know as we work to identify the best strategies for improving connections between primary care and behavioral health in Pennsylvania?

Appendix C: STAKEHOLDER INTERVIEW INSTRUMENT

Name of Interviewee:_____

Date:_____

Stakeholder Group (circle one):

Potential funder	PH Practice	BH practice	County-level official	State-level official	Employer	Insurer/Payer	Other:

To read at the commencement of all interviews:

Thank you for taking the time to talk with us today. We are interested in your perspective on several issues related to optimizing the working relationship between primary care and behavioral health care. The population of interest is adults with a chronic physical health condition that is managed by their primary care physician (for example, diabetes, asthma) but who also have behavioral health issues that commonly present in primary care settings (for example, depression, anxiety, alcoholism).

We're gathering this information from you and other stakeholders as a first step towards possibly developing a statewide initiative that would enhance and improve the provision of behavioral health care in primary care settings for the population of interest. Your comments will be summarized in a report that we will provide to the PA Health Funders Collaborative, which includes approximately 13 foundations who are funding this data collection effort. Your comments will not be linked directly to your name or identity in any way.

1. What is your vision for the ideal working relationship between primary care and behavioral health, particularly for the population of interest?
2. What outcomes do you think are most important to focus on when working to establish connections or linkages between primary care and behavioral health? *PROBE*: What outcomes are important for the health care consumer (e.g., symptom severity, treatment response, adherence)? What outcomes are important for the system (e.g., costs)?
3. How critical is it, in the broader context of Pennsylvania health care policy, to strengthen connections or linkages between primary care and behavioral health, particularly for the population of interest? *PROBE*: Tell me more about why you think the connection between primary care and behavioral health (is/isn't) a priority.
4. Have you or your organization undertaken any efforts to establish or improve connections between primary care and behavioral health? *If YES*: Would you tell me a little bit about that? *If YES or NO*: Are you aware of any (other) initiatives like this in your county? In the Commonwealth?
5. I'd like to ask you about a number of components that have been identified as potentially relevant for establishing and sustaining effective working relationships between primary care and behavioral health.

For each component, please tell me:

- Whether you're familiar with/have heard of the concept;
- How important you think it is for establishing and sustaining effective working relationships between primary care and behavioral health on a scale from 1 to 10 (where 10 is "most important"); and
- If you or your organization have undertaken any efforts to implement the component/strategy

Component	**Familiar? (Y/N)**	**Importance (1-10)**	**Implement? (Y/N)**
o *Screening consumers to identify behavioral health issues*			
o *Systematic tracking, follow-up, and clinical monitoring of consumer health conditions and health outcomes*			
o *Providing care management support*			
o *Providing access to specialty mental health care in the primary care setting*			
o *Developing a reimbursement strategy for paying the costs of establishing and maintaining connections between primary care and behavioral health*			
o *Establishing communication pathways and processes between primary care and behavioral health providers*			
o *Training primary care professionals to provide behavioral health care*			
o *Strategies to engage patients and their families in health self-management*			
o *Using information systems to promote improvements in connections between primary care and behavioral health*			
o *Other strategy identified by interviewee:*			

6a. *If interviewee has attempted to implement strategies above:* For the strategies above that you or your organization have attempted to implement:
PROBE: Would you tell me a little bit about that?
PROBE: What barriers have you encountered?

If interviewee has NOT attempted to implement strategies above: For the strategies above that you identified as important (query about top 3 choices):
PROBE: Are you aware of any work to address these issues in your county? In the Commonwealth?
PROBE: What barriers are likely to be encountered?

6b. There are several models for establishing relationships between primary care and behavioral health (e.g., ENHANCE; IMPACT; the Chronic Care Model). Have you or your organization undertaken any efforts to implement a specific model to connect primary care to behavioral health:

If YES: Would you tell me a little bit about that? Which model did you choose? Why did you choose that model?
If NO: Are you familiar with any specific models of care? Do you prefer one model of others? Why?

6c. Have you or your organization undertaken any efforts specifically to co-locate behavioral health services in the primary care setting?
If YES: Would you tell me a little bit about that (e.g., what does co-location "mean," how has it been established)?
If YES or NO: What do you think are the primary barriers to establishing co-located services?

7a. GENERALLY, what are some barriers to effectively establishing and maintaining connections between primary care and behavioral health?
PROBE: What are barriers for you or your organization? What are barriers at the state level?

7b. What are some barriers to effectively establishing and maintaining connections between primary care and behavioral health related to *cost, reimbursement, and payment issues*?
PROBE: What are barriers for you or your organization? What are barriers at the state level?

7c. What are some barriers to effectively establishing and maintaining connections between primary care and behavioral health related to *providing effective and appropriate clinical care*?
PROBE: What are barriers for you or your organization? What are barriers at the state level?

8. (*If care management and/or HIT are not mentioned previously):* A couple of strategies identified in the literature as helpful to establishing and maintaining effective working relationships between primary care and behavioral health are the use of specific professionals to coordinate physical and behavioral health care (sometimes called care managers; case managers; integrated care specialists) and use of health information technology (HIT).

8a. The professionals who serve to coordinate physical and behavioral health care can serve several functions, including communication and coordination of care; direct education and support to consumers; monitor consumer symptoms and adherence; provide consumers with self-management support; and provide behavioral health interventions (e.g., brief psychotherapy).
PROBE: Do you think this would be an effective strategy for establishing and maintaining a behavioral health presence in primary care? Do you think it is feasible? Why or why not?

8b. HIT is increasingly talked about as a useful tool for increasing communication between and among health care providers and health care consumers which may help to enhance care coordination across primary care and behavioral health.
PROBE: Do you think HIT is important for establishing and maintaining a behavioral health presence in primary care? How would it be important? Do you think it is feasible? Why or why not?
PROBE: What is the potential impact of rules about information sharing on the benefits of HIT? What is the impact of information sharing restrictions at the practice-level? At the systems-level?

9. Are you familiar with the concept of a "patient-centered medical home?"
IF YES: As you may know, there is a common set of principles describing the characteristics of a medical home, including timely access to medical services, a "whole person" orientation to medical care, enhanced communication between patients and their health care team, coordination and continuity of care, and an intensive focus on quality and safety.
PROBE: Do you think the medical home would have any impact on establishing and maintaining connections between primary care and behavioral health?
PROBE: Currently, there is no explicit recognition of the need for an established relationship between primary care and behavioral health in order to qualify as a medical home. What do you think about this? Would emphasizing this connection in the definition of a medical home make it more likely that these connections would occur?
IF NO: The medical home concept refers to primary care that emphasizes a common set of

principles, including timely access to medical services, a "whole person" orientation to medical care, enhanced communication between patients and their health care team, coordination and continuity of care, and an intensive focus on quality and safety.

PROBE: Do you think the medical home would have any impact on establishing and maintaining connections between primary care and behavioral health?

PROBE: Currently, there is no explicit recognition of the need for an established relationship between primary care and behavioral health in order to qualify as a medical home. What do you think about this? Would emphasizing this connection in the definition of a medical home make it more likely that these connections would occur?

OTHER POTENTIAL PROBES: (For practices): Does your practice espouse the principles of patient-centered medical home? Is this important to you? Will you pursue it? (For payers): Would you like to see a partnership between primary care and behavioral health be explicitly recognized as among the common principles of a medical home?

10. If there was an investment of resources to improve connections between primary care and behavioral health here in Pennsylvania or in your county, what strategies do you think would afford the greatest "payback" with regard to successfully establishing and maintaining those connections?

PROBE: If interviewee has trouble thinking of strategies, can suggest the following:

- Broad based technical assistance
- Financial incentives or direct financial support
- Creation of a quality improvement collaborative
- Implementation of a state-wide demonstration program

11. Is there anything else that you think it is important for us to know as we work to identify the best strategies for improving connections between primary care and behavioral health in Pennsylvania?