

TABLE 12: SUMMARY OF PRIMARY CARE—BEHAVIORAL HEALTH INTEGRATION MODELS

	COORDINATED		CO-LOCATED				INTEGRATED	
Model	Practice Model 1: Improving Collaboration between Separate Providers	Practice Model 2: Medical-Provided Behavioral Health Care	Practice Model 3: Co-location	Practice Model 4: Disease Management	Practice Model 5: Reverse Co-location	Practice Model 6: Unified Primary Care and Behavioral Health	Practice Model 7: Primary Care Behavioral Health	Practice Model 8: Collaborative System of Care
Level of Integration	Minimal collaboration—mental health providers and primary care providers work in separate facilities, have separate systems, and communicate sporadically	Basic collaboration at a distance—providers have separate systems at separate sites but now engage in periodic communication about shared patients	Basic collaboration on-site—mental health and primary care professionals have separate systems but share the same facility, allowing for more communication	Close collaboration in a partly integrated system—mental health professionals and primary care providers share the same facility and have some systems in common, such as scheduling appointments or medical records; physical proximity allows for regular face-to-face communication among behavioral health and physical health providers	Close collaboration in a partly integrated system—mental health professionals and primary care providers share the same facility and have some systems in common, such as scheduling appointments or medical records; physical proximity allows for regular face-to-face communication among behavioral health and physical health providers	Close collaboration in a fully integrated system—the behavioral health provider and primary care provider are part of the same team	Close collaboration in a fully integrated system—the behavioral health provider and primary care provider are part of the same team	Close collaboration—the specialty mental health services are integrated with the primary care services; may be partly or fully integrated depending on degree of collaboration
Type of Setting/ Provider of Behavioral Health Care	<ul style="list-style-type: none"> Private practices; settings with active referral linkages Care managers and behavioral health specialty providers 	<ul style="list-style-type: none"> Private practices; settings with active referral linkages Physician or other medical professional with consultative support from a psychiatrist or other behavioral health professional 	<ul style="list-style-type: none"> HMO settings; medical clinics that employ therapists or care managers Therapists and specialty mental health clinicians 	<ul style="list-style-type: none"> HMO settings; medical clinics that employ therapists or care managers Care managers 	<ul style="list-style-type: none"> HMO settings; medical clinics that employ therapists or care managers Traditional mental health team members and a medical professional (nurse, nurse practitioner, or physician) 	<ul style="list-style-type: none"> Large practices and medical systems Psychiatrists and therapist 	<ul style="list-style-type: none"> Large practices and medical systems Mental health professional 	<ul style="list-style-type: none"> HMO settings; medical clinics that employ therapists or care managers Care managers (though this may vary) with close collaboration among partner agencies
Populations Best Served	<ul style="list-style-type: none"> Quadrants I and III (Low behavioral health needs) Applicable to all ages 	<ul style="list-style-type: none"> Quadrants I and III (Low behavioral health needs) Applicable to all ages 	<ul style="list-style-type: none"> Quadrants I–III (Low and high behavioral health needs) Applicable to all ages with adaptations 	<ul style="list-style-type: none"> Quadrants I–III (Low and high behavioral health needs) Applicable to all ages with adaptations 	<ul style="list-style-type: none"> Quadrants II and IV (High behavioral health needs) Applicable to all ages with adaptations 	<ul style="list-style-type: none"> Quadrants I–IV (Low and high behavioral health needs, especially patients with both high behavioral and high physical health needs) Applicable to all ages with adaptations 	<ul style="list-style-type: none"> Quadrants I–IV (Low and high behavioral health needs, especially patients with both high behavioral and high physical health needs) Applicable to all ages with adaptations 	<ul style="list-style-type: none"> Quadrants II and IV (High behavioral health needs) Applicable to all ages with adaptations
Barriers to Implementation	<ul style="list-style-type: none"> Significant cultural barriers between primary care and behavioral health providers Records are in separate locations Consent/privacy laws restrict sharing of clinical information No or few providers to which to refer Patient does not follow through on the referral Coordination of care among providers is generally not a funded activity 	<ul style="list-style-type: none"> Resistance from medical providers about time constraints and necessary skills for screening for behavioral health Records are in separate locations Consent/privacy laws No or few providers to which to refer Patient does not follow through on the referral Need to substantially increase billing and coding knowledge Telephone-based activities generally are not covered services Coordination of care among providers is generally not a funded activity 	<ul style="list-style-type: none"> Records may remain in separate sections Issues of consent and privacy may need to be addressed If two agencies are involved, differing intake, paperwork policy, and culture will exist Same-day billing Patients have different benefit packages for medical and mental health coverage Lack of parity means that payment can be vastly different If a new appointment is required, issues with no-show can increase Uncompensated informal consultations will occur for both primary and behavioral health providers 	<ul style="list-style-type: none"> Records may remain in separate sections Issues of consent and privacy may need to be addressed If two agencies are involved, differing intake, paperwork policy, and culture will exist Same-day billing Patients have different benefit packages for medical and mental health coverage Lack of parity means that payment can be vastly different If a new appointment is required, issues with no-show can increase 	<ul style="list-style-type: none"> Records may remain in separate sections Issues of consent and privacy may need to be addressed If two agencies are involved, differing intake, paperwork policy, and culture will exist Same-day billing Patients have different benefit packages for medical and mental health coverage Lack of parity means that payment can be vastly different If a new appointment is required, issues with no-show can increase 	<ul style="list-style-type: none"> Cross-discipline education and training needs are substantial Office systems needs are substantial Coordination of care among providers is generally not a funded activity Same-day billing Patients have different benefit packages for medical and mental health coverage Lack of parity means that payment can be vastly different If a new appointment is required, issues with no-show can increase Sufficient funds to cover cost of employees needed New codes for tobacco, substance, and behavior interventions may not be covered by various payers 	<ul style="list-style-type: none"> Cross-discipline education and training needs are substantial Office systems needs are substantial Coordination of care among providers is generally not a funded activity Same-day billing Patients have different benefit packages for medical and mental health coverage Lack of parity means that payment can be vastly different If a new appointment is required, issues with no-show can increase Sufficient funds to cover cost of employees needed New codes for tobacco, substance, and behavior interventions may not be covered by various payers 	<ul style="list-style-type: none"> Records may remain in separate sections Issues of consent and privacy may need to be addressed If two agencies are involved, differing intake, paperwork policy, and culture will exist Same-day billing Patients have different benefit packages for medical and mental health coverage Lack of parity means that payment can be vastly different If a new appointment is required, issues with no-show can increase
Economic Outcomes*	<ul style="list-style-type: none"> May generate savings because of more cost-effective treatment Cost-offset savings possible 	<ul style="list-style-type: none"> May generate savings because of more cost-effective treatment Cost-offset savings possible 	<ul style="list-style-type: none"> Generates savings because of leveraging Generates savings because of cost-effectiveness May generate cost-offset savings 	<ul style="list-style-type: none"> Generates savings because of leveraging Generates savings because of cost-effectiveness May generate cost-offset savings 	<ul style="list-style-type: none"> Generates savings because of leveraging Generates savings because of cost-effectiveness May generate cost-offset savings 	<ul style="list-style-type: none"> Generates savings because of cost-effectiveness Generates savings because of leveraging Greatest potential for substantial cost-offset savings 	<ul style="list-style-type: none"> Generates savings because of cost-effectiveness Generates savings because of leveraging Greatest potential for substantial cost-offset savings 	<ul style="list-style-type: none"> Generates savings because of cost-effectiveness Generates savings because of leveraging May generate cost-offset savings
Health Outcomes	<ul style="list-style-type: none"> No evidence-based studies 	<ul style="list-style-type: none"> Considerable evidence base for the effectiveness of SBI for substance abuse in primary care settings, as well as for many common problems such as pain, smoking, and depression 	<ul style="list-style-type: none"> Patients have better outcomes, with the greatest improvement for those with poor physical health Diagnosis and treatment may significantly improve due to behavioral health clinicians taking an active role in teaching and coaching primary care providers 	<ul style="list-style-type: none"> Considerable potential to positively impact clinical and cost-effectiveness Analyses indicate that there is a cost offset of 20–40 percent for primary care patients who receive behavioral health services (Blount et al. 2007) 	<ul style="list-style-type: none"> Considerable potential to reduce lifestyle risk factors RCT of Massachusetts program demonstrated a 42 percent reduction of ER visits and dramatic increases in screening of hypertension and diabetes (Boardman 2006) 	<ul style="list-style-type: none"> Patients less likely to have ER visits Patients less likely to report a problem with continuity of care 	<ul style="list-style-type: none"> Brief interventions have been found to be effective with depression, generalized anxiety disorder, smoking and snuff cessation, pain, panic disorder, alcohol abuse, and childhood conduct 	<ul style="list-style-type: none"> Evaluations are highly variable in this model Potential for improved outcomes demonstrated in some studies
Why Choose This Model?	<ul style="list-style-type: none"> When reimbursement structure does not support behavioral health in primary care or primary care in specialty mental health 	<ul style="list-style-type: none"> When reimbursement structure does not support behavioral health in primary care or primary care in specialty mental health 	<ul style="list-style-type: none"> When provider, either through billing or partnership, is able to sustain a more integrated model between primary care and specialty mental health 	<ul style="list-style-type: none"> When provider, either through billing or partnership, is able to sustain a more integrated model between primary care and specialty mental health 	<ul style="list-style-type: none"> When provider, either through billing or partnership, is able to sustain a more integrated model between primary care and specialty mental health 	<ul style="list-style-type: none"> When per member per month (PMPM) or capitation financing systems are available When a provider can access the codes necessary to fund all of the key elements in a fully integrated model 	<ul style="list-style-type: none"> When per member per month (PMPM) or capitation financing systems are available When a provider can access the codes necessary to fund all of the key elements in a fully integrated model 	<ul style="list-style-type: none"> When provider, either through billing or partnership, is able to sustain a more integrated model between primary care and specialty mental health

*Cost-effectiveness: savings accrued by more effectively treating the physical problem because behavioral health is addressed or by treating behavioral health issues that otherwise might not be addressed. For example, cost-effectiveness is achieved when patients who receive counseling for substance use show marked improvement with their medical conditions.

Leveraging: savings accrued by freeing up physician time when behavioral health staff pick up some responsibilities for the patient. For example, leveraging occurs when a primary care physician's time can be freed up when patients with psychosocially complex needs can access behavioral health services.

Cost offset: savings accrued by preventing additional health care costs, such as ER visits, hospitalizations, and high utilization. For example, cost-offset savings results with the reduction in the duplication of screenings and unnecessary services, such as an MRI for a headache.