Milbank Memorial Fund

Evolving Models of Behavioral Health Integration in Primary Care

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FOREWORD

The U.S. mental health system fails to reach and/or adequately treat the millions of Americans suffering from mental illness and substance abuse. This report offers an approach to meeting these unmet needs: the integration of primary care and behavioral health care. The report summarizes the available evidence and states' experiences around integration as a means for delivering quality, effective physical and mental health care. For those interested in integrating care, it provides eight models that represent qualitatively different ways of integrating/coordinating care across a continuum—from minimal collaboration to partial integration to full integration—according to stakeholder needs, resources, and practice patterns.

The Milbank Memorial Fund commissioned this report to provide policymakers with a primer on integrated care that includes both a description of the various models along the continuum and a useful planning guide for those seeking to successfully implement an integrated care model in their jurisdiction.

The Milbank Memorial Fund is an endowed operating foundation that works to improve health by helping decision makers in the public and private sectors acquire and use the best available evidence to inform policy for health care and population health.

Policymakers, consultants, academicians, and practitioners knowledgeable in the field reviewed successive drafts of this report. As a result of these reviews and the authors' subsequent revisions, we believe that the information in this report is timely and accurate. We thank all who participated in this project.

Carmen Hooker Odom
President

Samuel L. Milbank
Chairman

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EXECUTIVE SUMMARY

Mental illness impacts all age groups. The National Institute of Mental Health (NIMH) states in a 2008 report that an estimated 26.2 percent of Americans ages eighteen and older—about one in four adults—suffer from a diagnosable mental disorder in a given year, which translates into 57.7 million people. Furthermore, researchers supported by NIMH have found that mental illness begins very early in life (2005). Half of all lifetime cases begin by age fourteen, and three-quarters have begun by age twenty-four. Thus, mental disorders are really the chronic diseases of the young. Unfortunately, evidence also shows that the mental health system fails to reach a significant number of people with mental illness, and those it does reach often drop out or get insufficient, uncoordinated care.

The good news is that research has improved our ability to recognize, diagnose, and treat conditions effectively. In fact, many studies over the past twenty-five years have found correlations between physical and mental health-related problems. Individuals with serious physical health problems often have co-morbid mental health problems, and nearly half of those with any mental disorder meet the criteria for two or more disorders, with severity strongly linked to co-morbidity (Kessler et al. 2005). As cited in Robinson and Reiter (2007), as many as 70 percent of primary care visits stem from psychosocial issues. While patients typically present with a physical health complaint, data suggest that underlying mental health or substance abuse issues are often triggering these visits. Unfortunately, most primary care doctors are ill-equipped or lack the time to fully address the wide range of psychosocial issues that are presented by the patients.

These realities explain why policymakers, planners, and providers of physical and behavioral health care across the United States continue to grapple with how to deliver quality, effective mental health services within the context of individual well-being and improved community health status.

Over the past several decades, examples of coordinated care service delivery models—*those that connect behavioral and physical health*—have led to promising approaches of integration and collaboration. Emerging evidence from a variety of care models has stimulated the interest of policymakers in both the public and private sectors to better understand the evidence underpinning these models.

Improving the screening and treatment of mental health and substance abuse problems in primary care settings and improving the medical care of individuals with serious mental health problems and substance abuse in behavioral health settings are two growing areas of practice and study. Generally, this combination of care is called *integration* or *collaboration*.

Integrating mental health services into a primary care setting offers a promising, viable, and efficient way of ensuring that people have access to needed mental health services. Additionally, mental health care delivered in an integrated setting can help to minimize stigma and discrimination, while increasing opportunities to improve overall health outcomes. Successful integration requires the support of a strengthened primary care delivery system as well as a long-term commitment from policymakers at the federal, state, and private levels. This report assesses models of integration in their applicability to primary care settings and, in particular, to the

"medical home." Many of the challenges and barriers to integration stem from differing clinical cultures, a fragmented delivery system, and varying reimbursement mechanisms.

This report also provides an orientation to the field and, hopefully, a compelling case for integrated or collaborative care. It provides a concise summary of the various models and concepts and describes, in further detail, eight models that represent qualitatively different ways of integrating and coordinating care across a continuum—from minimal collaboration to partial integration to full integration. Each model is defined and includes examples and successes, any evidence-based research, and potential implementation and financial considerations. Also provided is guidance in choosing a model as well as specific information on how a state or jurisdiction could approach integrated care through steps or tiers. Issues such as model complexity and cost are provided to assist planners in assessing integration opportunities based on available resources and funding. The report culminates with specific recommendations on how to support the successful development of integrated care.

Extensive research and literature exist about models of integration. A resource section at the end of this report provides a list of websites, toolkits, and other references.

INTRODUCTION—MAKING THE CASE FOR INTEGRATED CARE

Despite positive changes and advancement in the treatment, support, and understanding of mental illness over the past fifty years, there is still need for improvement in the U.S. mental health care system. Richard Frank and Sherry Glied demonstrate this need in their seminal work *Better But Not Well* (2006). They acknowledge that even though progress has been made in behavioral health care, many people affected by mental illness are still very disadvantaged and not getting appropriate care.

There is increasing acknowledgment that mental health disorders are as disabling as cancer or heart disease in terms of lost productivity and premature death. A 2006, eight-state report by Colton and Manderscheid documented that individuals with the most serious mental illnesses will die twenty-five years earlier than the average American. When mental illness is left untreated, adults may experience lost productivity, unsuccessful relationships, significant distress and dysfunction, and/or an adverse impact in caring for children.

A comprehensive health care system must support mental health integration that treats the patient at the point of care where the patient is most comfortable and applies a patient-centered approach to treatment. Integration is also important for positively impacting disparities in health care in minority populations.

A 2008 report by Funk and Ivbijaro cited seven reasons for integrating mental health into primary care. Each must be considered in any effort to design or implement a collaborative approach, partial integration, or a fully integrated model.

1. *The burden of mental disorders is great.* Mental disorders are prevalent in all societies and create a substantial personal burden for affected individuals and their families. They produce significant economic and social hardships that affect society as a whole.
2. *Mental and physical health problems are interwoven.* Many people suffer from both physical and mental health problems. Integrated primary care helps to ensure that people are treated in a holistic manner, meeting the mental health needs of people with physical disorders, as well as the physical health needs of people with mental disorders.
3. *The treatment gap for mental disorders is enormous.* In all countries, there is a significant gap between the prevalence of mental disorders and the number of people receiving treatment and care. Coordinating primary care and mental health helps close this divide.
4. *Primary care settings for mental health services enhance access.* When mental health is integrated into primary care, people can access mental health services closer to their homes, thus keeping families together and allowing them to maintain daily activities. Integration also facilitates community outreach and mental health promotion, as well as long-term monitoring and management of affected individuals.
5. *Delivering mental health services in primary care settings reduces stigma and discrimination.*
6. *Treating common mental disorders in primary care settings is cost-effective.*
7. *The majority of people with mental disorders treated in collaborative primary care have good outcomes,* particularly when linked to a network of services at a specialty care level and in the community.

While there is growing awareness of the need for improved collaboration and integration, the barriers to achieving them are substantial. Chief among these challenges are the following:

- Behavioral and physical health providers have long operated in their separate silos.
- Sharing of information rarely occurs.
- Confidentiality laws pertaining to substance abuse (federal and state) and mental health (state) are generally more restrictive than those pertaining to physical health. While HIPAA is often cited as a barrier to sharing information between primary care and mental health practitioners, this is not accurate: sharing information for the purposes of care coordination is a permitted activity under HIPAA, not requiring formal consents. However, many states have mental health laws that are more restrictive and need to be reassessed. In regard to federal regulation CFR 42, which restricts information sharing regarding substance abuse services, there is currently a discussion under way to allow information sharing for the purposes of treatment coordination. If this becomes new federal law, state laws will also need to be changed to align with the new intent.
- Payment and parity issues are prevalent.

ORIENTATION TO THE FIELD

This report does not attempt to address the totality of issues in the field of collaborative and integrated care. Rather, it reflects a robust and maturing literature that has been burgeoning in recent years, including seminal work by more than a dozen prominent leaders, such as Alexander Blount, Nicholas Cummings, Wayne Katon, Barbara Mauer, William O'Donohue, C.J. Peek, Patricia Robinson, and Kirk Strosahl.

In 2005, the Canadian Collaborative Mental Health Initiative (CCMHI) published a comprehensive review of the literature (Pautler and Gagne). The CCMHI monograph analyzes the entire research literature and includes a specific emphasis on randomized clinical trials (Craven and Bland 2006). For states and jurisdictions seeking specific guidelines to implement integrated programs, CCMHI, the Patient-Centered Primary Care Collaborative, and the New Zealand Ministry of Health have published toolkits that offer practical advice on establishing integrated initiatives (see the resources section). There are numerous technical review papers as well, covering topics such as financing and reimbursement, integrated models, rural integrated care, and assessment tools for state-level policymakers and others interested in integrating care.

Historically, innovative programs in collaboration and integration were first developed in settings like the Veterans Health Administration, federally qualified health centers (such as the Cherokee Health Systems in East Tennessee), and health maintenance organizations (HMOs), such as Kaiser Permanente. The Bureau of Primary Health Care within the U.S. Health Resources and Services Administration (HRSA) has also supported a number of initiatives around the country. Foundations such as the John A. Hartford Foundation, the John D. and Catherine T. MacArthur Foundation, the Robert Wood Johnson Foundation, and the Hogg Foundation for Mental Health have also funded projects that have helped define the field. Many of the projects have focused on the treatment of depression in primary care—an obvious choice because of depression's ubiquity in the population. As of the writing of this report, there are at least two large-scale implementations of integrated care: one in the U.S. Air Force and the other, the California Integrated Behavioral Health Project. All of these integration efforts have contributed and continue to add significantly to the knowledge base in the field.

While hundreds of integrated care initiatives are under way in the United States, there is not a complete list or inventory of programs. A partial list, however, was compiled by the U.S. government and is titled *Compendium of Primary Care and Mental Health Integration Activities across Various Participating Federal Agencies* (Weaver 2008). There are also numerous comprehensive clinical practice manuals that have been published, which offer suggestions on the "how to do it" part of implementation, as well as websites with integrated care resources, two journals covering the field, and a national membership organization on the subject. Finally, there are more than half a dozen influential books that now document the basic concepts in the field. All of these documents and resources are cited in the resources section.

With such a vast amount of information in the field, this report makes no effort to synthesize it all. Rather, the report draws on some salient themes from the field—with an eye to identifying

practical implications for policymakers, planners, and providers of physical health and behavioral health care.

DIFFERENCES BETWEEN COLLABORATIVE AND INTEGRATED CARE

Primary care is described as the medical setting in which patients receive most of their medical care and, therefore, is typically their first source for treatment (Byrd, O'Donohue, and Cummings 2005). Primary care includes family medicine, general internal medicine, pediatrics, and sometimes obstetrics-gynecology. *Behavioral health care* includes both mental health and substance abuse services. In the United States, the predominant behavioral health delivery model is *specialty* behavioral health care, and it is delivered in separate behavioral health clinics. It is also common in the United States to find mental health and substance abuse services delivered in separate facilities.

Collaborative care and *integrated care* are the two terms most often used to describe the interface of primary care and behavioral health care. Unfortunately, the terms *collaborative care* and *integrated care* are not used consistently in the field, and this has led to confusion. Strosahl (1998) has proposed a basic distinction that is useful. Namely, collaborative care involves behavioral health working *with* primary care; integrated care involves behavioral health working *within* and as a part of primary care.

In collaborative care, patients perceive that they are getting a separate service from a specialist, albeit one who collaborates closely with their physician. In integrated models, behavioral health care is part of the primary care and patients perceive it as a routine part of their health care. Integrated practice approaches are highly diverse; however, there are a number of broad concepts that underlie the field of collaborative and integrated care.

The "granddaddy" of theoretical viewpoints in the field of collaborative and integrated care is the *biopsychosocial model* enunciated by Engel (1977). Simply stated, this model acknowledges that biological, psychological, and social factors all play a significant role in human functioning in the context of disease. This model is endorsed by most medical professionals yet seldom practiced. However, it is the theory at the root of collaborative and integrated care and is universally embraced as a "best practice."

CONCEPTS COMMON TO ALL MODELS OF INTEGRATED CARE

There are four concepts common to all models of integrated care. Those concepts are the medical home, the health care team, stepped care, and the four-quadrant clinical integration.

The first of the four concepts, the *medical home*, or *health care home*, has become a mainstream theory in primary care. It has also recently gained national attention in recognition of its importance in caring for the chronically ill. The medical home concept is also one of the centerpieces in the current national health care reform efforts (Rittenhouse and Shortell 2009).

The National Committee for Quality Assurance (NCQA) has defined criteria for a medical home—the patient-centered medical home—which includes standards that apply to disease and case management activities that are beneficial to both physical and mental health (2008). These criteria include, but are not limited, to the following:

- patient tracking and registry functions
- use of nonphysician staff for case management
- the adoption of evidence-based guidelines
- patient self-management support and tests (screenings)
- referral tracking

Most medical homes are compensated by a "per-member-per-month" (PMPM) fee, and this fee could be enhanced if integrated physical–behavioral health care is incorporated. (See discussion of the Minnesota DIAMOND project in table 7.) While the concept of a medical home is not specifically an integrated behavioral health model, it clearly encompasses the philosophy of integration. Though not commonplace, a more dynamic role for behavioral health in the patient-centered health care home has been recently defined (Mauer 2009).

The second concept common to all models of integrated care, the *health care team*, is deeply seated in the field. In this approach, the doctor-patient relationship is replaced with a team-patient relationship (Strosahl 2005). Applied to integrated care, members of the health care team share responsibility for a patient's care, and the message to the patient is that the team is responsible. A visit is choreographed with various members of the team: physician, mid-level (nurse practitioner or physician's assistant), nurse, care coordinator, behavioral health consultant, and other health professionals. Blount (1998) notes that in a health care team each provider learns what the other does and, in some cases, can fill in for one another.

The third concept, *stepped care*, is widely used in integrated care models. This concept holds that, except for acutely ill patients, health care providers should offer care that (1) causes the least disruption in the person's life; (2) is the least extensive needed for positive results; (3) is the least intensive needed for positive results; (4) is the least expensive needed for positive results; and (5) is the least expensive in terms of staff training required to provide effective service. In stepped care, if the patient's functioning does not improve through the usual course of care, the intensity of service is customized according to the patient's response. The first step of behavioral care involves basic educational efforts, such as sharing information and referral to self-help groups. The second level "steps up" the care to involve clinicians who provide psycho-educational interventions and make follow-up phone calls. The third level involves more highly trained behavioral health care professionals who use specific practice algorithms. If a patient does not respond to these progressions of care (or if specialized treatment is needed), the patient is then referred to the specialty mental health system (Strosahl 2005). When referral to specialty care is necessary, there is

acceptance that responsibility for some aspects of care should be retained by the primary care team, which in turn will work collaboratively with the mental health provider. Sometimes, the patient's care can be transitioned back (or stepped down) fully to primary care after adequate specialty mental health treatment/intervention has been provided.

The final concept is referred to as *four quadrant clinical integration*, which identifies populations to be served in primary care versus specialty behavioral health. Different types of services and organizational models are used depending on the needs of the population in each quadrant (Mauer 2006; National Council for Community Behavioral Healthcare 2009; Parks et al. 2005). This concept may also be used as a template for planning local health care systems. Table 1 summarizes the settings where an individual receives care—based on the complexity of his or her physical and behavioral health needs.

TABLE 1: FOUR QUADRANTS OF CLINICAL INTEGRATION BASED ON PATIENT NEEDS

BEHAVIORAL HEALTH RISK/COMPLEXITY	PHYSICAL HEALTH RISK/COMPLEXITY: LOW	PHYSICAL HEALTH RISK/COMPLEXITY: HIGH
HIGH	**QUADRANT II** Patients with high behavioral health and low physical health needs Served in primary care and specialty mental health settings (Example: patients with bipolar disorder and chronic pain) Note: when mental health needs are stable, often mental health care can be transitioned back to primary care.	**QUADRANT IV** Patients with high behavioral health and high physical health needs Served in primary care and specialty mental health settings (Example: patients with schizophrenia and metabolic syndrome or hepatitis C)
LOW	**QUADRANT I** Patients with low behavioral health and low physical health needs Served in primary care setting (Example: patients with moderate alcohol abuse and fibromyalgia)	**QUADRANT III** Patients with low behavioral health and high physical health needs Served in primary care setting (Example: patients with moderate depression and uncontrolled diabetes)

Source: Adapted from Mauer 2006.

Patients in Quadrant I have low behavioral health needs and low physical needs and are typically served in primary care. The physician may serve low-need patients with on-site behavioral health staff serving those with low-to-moderate behavioral health needs. Quadrant II patients have high behavioral health needs and low physical needs and are typically served in specialty behavioral health programs with linkages to primary care. Patients in Quadrant III have low behavioral health needs and high physical needs, and they are served in primary care or in the medical specialty system. While this group is sometimes referred for specialty behavioral health care, such care is usually short term. Ultimately, the responsibility for behavioral health care returns to the primary care setting and is provided by behavioral health staff or disease case managers. Quadrant IV patients have both high behavioral health needs and high physical needs. These patients are typically served in both specialty behavioral health settings and primary care, with a strong need for collaboration between the two. Patients in this quadrant have recently become a targeted population given their predisposition to metabolic syndrome, particularly those patients who are taking long-term psychoactive medications. (Metabolic syndrome includes elevated blood pressure and cholesterol, obesity, and hyperglycemia.) Mauer (2006) has summarized some of the characteristics of the Quadrant IV population:

- lower medication adherence
- higher incidence of co-occurring chronic medical conditions
- high incidence of co-occurring alcohol and drug abuse problems
- lack of a stable medical home
- more complex medical plans

INFORMATION TECHNOLOGY

The use of information technology has great potential for designing and facilitating integration efforts. Such technology can serve to support medical homes and providers in managing their target populations and providing meaningful information that supports the best possible health care for patients and their families. It can also provide client-level information that is relevant across providers and delivery settings and can identify gaps in care as well as evidence-based best practice guidelines.

Table 2 illustrates half a dozen likely barriers to integration that can be resolved by using information technology.

TABLE 2: USING INFORMATION TECHNOLOGY TO INTEGRATE CARE

INTEGRATION PROBLEM	TECHNOLOGY SOLUTION
1. A primary care practice desires to make psychiatric consultation available, but psychiatric resources are scarce and expensive.	Numerous sites around the country are using telepsychiatry, in which a psychiatrist uses remote computer technology to interview and assess patients directly and either directly provides treatment or provides consultation to the patient's primary care physician (Hilty et al. 2004).
2. A rural primary care practice wants to have psychiatric consultation available.	An initiative in Canada pairs a primary care physician and a psychiatrist, who share an email mentoring relationship. The primary care physician exchanges emails about patients with complex behavioral health needs, and the psychiatrist provides advice. The ongoing consultation builds the skills of the primary care physician (Pauze and Gagne 2005).
3. A pediatric practice wants to screen for mental health issues and make accurate diagnoses and referrals.	The Cleveland Coalition for Pediatric Mental Health has developed a Web-based mental health resource guide, accessible to local primary care providers, to enable physicians to link families to appropriate resources. The project includes a computerized interview to be completed by parents and teenagers, which is then reviewed by the physician to make a provisional diagnosis. The diagnosis links to clinical guidelines and handouts/resources to share with families (Edwards, Garcia, and Smith 2007).

(continued)

TABLE 2 *(CONTINUED)*

INTEGRATION PROBLEM	TECHNOLOGY SOLUTION
4. Patient education handouts for common psychological issues are not effective.	Educational programs for a number of behavioral health issues can be played on a patient's iPod (see www.ipsyc.com).
5. A primary care practice serves a large indigent population that struggles with adherence to treatment and attendance at follow-up appointments.	The Health Buddy System gives patients a mini-computer-like apparatus that connects to their telephone at home. Each day, the Health Buddy displays questions about the patient's condition. The patient inputs his or her responses, which are monitored by the primary care office via the Internet. The Health Buddy can remind patients to take medication and suggest self-management techniques. Programs have been developed for a number of behavioral health issues (see www.healthbuddy.com).
6. A primary care practice wants to screen patients for psychological issues with limited staff.	A computer-administered telephone version of PRIME-MD (Primary Care Evaluation of Mental Disorders) provides diagnostic information over the telephone through the use of interactive voice response technology (Kobak et al. 1997).

PRACTICE MODELS OF INTEGRATION

This report describes eight models of integration across a variety of settings. These models are improved collaboration, medically provided behavioral health care, co-location, disease management, reverse co-location, unified primary care and behavioral health, primary care behavioral health, and collaborative system of care.

According to the Canadian Collaborative Mental Health Initiative (CCMHI), "there are almost as many ways of 'doing' collaborative mental health care as there are people writing about it" (Macfarlane 2005, p. 11). As such, those who would like to integrate medical and behavioral health care are confronted with a vast number of disparate interventions under the rubric of collaborative care. This complexity is further compounded because most models are implemented as hybrids and often blend together one or more elements of different models. And depending on the specific implementation, a model may represent partial or full integration. Table 3 summarizes three basic distinctions among collaborative models: coordinated, co-located, and integrated (Blount 2003).

Behavioral health care may be *coordinated* with primary care, but the actual delivery of services may occur in different settings. As such, treatment (or the delivery of services) can be *co-located* (where behavioral health and primary care are provided in the same location) or *integrated*, which means that behavioral health and medical services are provided in one treatment plan. Integrated treatment plans can occur in co-location and/or in separate treatment locations aided by Web-based health information technology. Generally speaking, co-located care includes the elements of coordinated care, and integrated care includes the elements of both coordinated care and co-located care.

TABLE 3: COLLABORATIVE CARE CATEGORIZATIONS AT A GLANCE

COORDINATED	CO-LOCATED	INTEGRATED
• Routine screening for behavioral health problems conducted in primary care setting • Referral relationship between primary care and behavioral health settings • Routine exchange of information between both treatment settings to bridge cultural differences	• Medical services and behavioral health services located in the same facility • Referral process for medical cases to be seen by behavioral specialists • Enhanced informal communication between the primary care provider and the behavioral health provider due to proximity	• Medical services and behavioral health services located either in the same facility or in separate locations • One treatment plan with behavioral and medical elements • Typically, a team working together to deliver care, using a prearranged protocol

(continued)

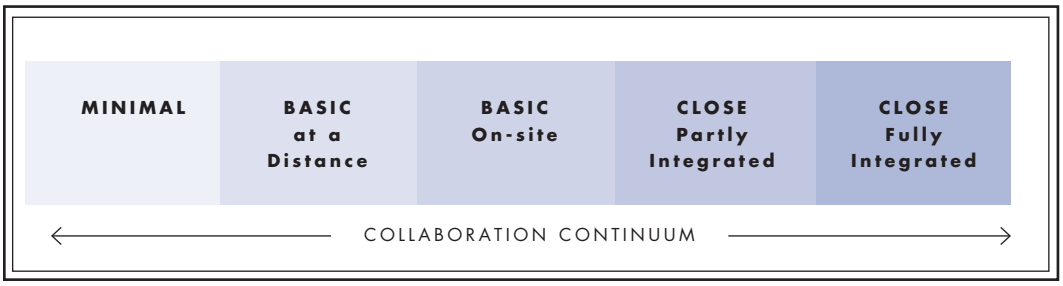
TABLE 3 *(CONTINUED)*

COORDINATED	CO-LOCATED	INTEGRATED
• Primary care provider to deliver behavioral health interventions using brief algorithms • Connections made between the patient and resources in the community	• Consultation between the behavioral health and medical providers to increase the skills of both groups • Increase in the level and quality of behavioral health services offered • Significant reduction of "no-shows" for behavioral health treatment	• Teams composed of a physician and one or more of the following: physician's assistant, nurse practitioner, nurse, case manager, family advocate, behavioral health therapist • Use of a database to track the care of patients who are screened into behavioral health services

Source: Adapted from Blount 2003.

This report identifies eight practice models that represent qualitatively different ways of integrating care. Following each model are examples of specific programs that illustrate these differing approaches to care, and the descriptions of those programs can be found in tables 4 through 11. The descriptions are gleaned from reviews by Edwards, Garcia, and Smith (2007), Koyanagi (2004), Lopez and colleagues (2008), and the National Council for Community Behavioral Healthcare (2009). Readers are encouraged to consult these sources for a more in-depth analysis of the programs. Also provided is a brief analysis of the evidence base for the model, but policymakers and other planners might refer to the federal Agency for Healthcare Research and Quality's (AHRQ) comprehensive review of randomized controlled trial (RCT) studies of integrated care for further information (Butler et al. 2008). Where available, additional information is provided on implementation issues and challenges as well as financial costs and considerations.

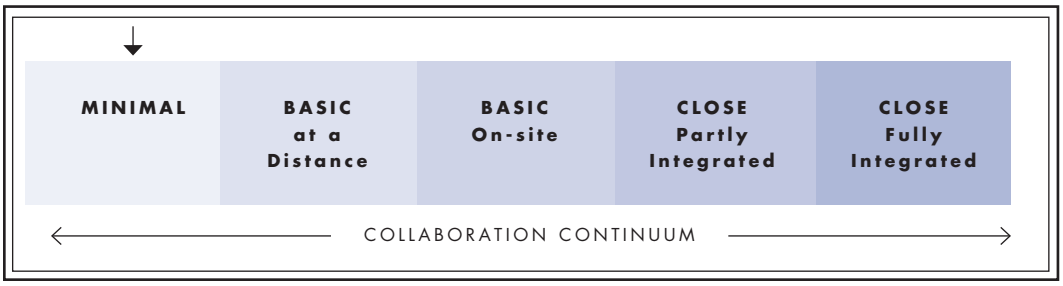
A helpful way to organize practice models is to look at the degree of integration along a continuum. Doherty (1995) outlines a range of five levels for mental health providers and primary care to work together—from the least to the highest degree of integration. A common level has been assigned to each model in this report; however, depending on the specific implementation of a model, the degree of collaboration varies. The five levels are of integration are as follows:



- *Minimal collaboration.* Mental health providers and primary care providers work in separate facilities, have separate systems, and communicate sporadically.
- *Basic collaboration at a distance.* Primary care and behavioral health providers have separate systems at separate sites, but now engage in periodic communication about shared patients. Communication occurs typically by telephone or letter. Improved coordination is a step forward compared to completely disconnected systems.
- *Basic collaboration on-site.* Mental health and primary care professionals have separate systems but share the same facility. Proximity allows for more communication, but each provider remains in his or her own professional culture.
- *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. There is a sense of being part of a larger team in which each professional appreciates his or her role in working together to treat a shared patient.
- *Close collaboration in a fully integrated system.* The mental health provider and primary care provider are part of the same team. The patient experiences the mental health treatment as part of his or her regular primary care.

As noted, many integrated programs around the country have combined elements of two or more of the models. These blended programs are becoming more common than pure replications of the models described because programs are often designed for a particular set of local or statewide circumstances, such as target population, provider and service capacity, funding issues, and regulatory restrictions.

PRACTICE MODEL 1: IMPROVING COLLABORATION BETWEEN SEPARATE PROVIDERS



In this model, providers practice separately and have separate administrative structures and financing/reimbursement systems. This model requires the least amount of change to traditional practice, and, in many circumstances, it may be the only option available in the short run (Koyanagi 2004).

A number of common strategies are used in this practice model. Case managers may be assigned to coordinate health care for patients with complex physical health issues. A behavioral health agency may offer psychiatric consultation via telephone to one or more primary care practices that serve patients with complex medical issues. Information-sharing practices may be formalized, such as adopting forms to share basic information (for example, a patient's medication), so that voluminous treatment records do not have to be sent.

EVIDENCE BASE

There are no randomized controlled trials using this model, and while anecdotal reports are mixed, these kinds of approaches to improving collaboration may be useful first steps as behavioral health and primary care providers consider other integration opportunities.

IMPLEMENTATION CONSIDERATIONS

The cultural barriers in this practice model are significant. Most primary care providers have not developed the same relationships with community behavioral health providers as they have with other specialty health providers, such as surgeons, cardiologists, or endocrinologists. Efforts need to be made to develop those relationships so that providers can agree on communication and/or care management strategies.

Privacy laws contribute to this isolated approach. To protect themselves from liability, mental health agencies tend to default to the most restrictive state or federal law and apply that criterion to all patients. This can make the sharing of clinical information very difficult.

Primary care providers often have limited knowledge about community agencies that can provide valuable behavioral health services for their patients. Their willingness to invest time in coordinating care will be influenced by their past ability to access and communicate with specialty

mental health agencies. Primary care providers who are not systematically screening patients for mental health and substance use have not developed a systematic approach to referral.

FINANCIAL CONSIDERATIONS

As long as state and federal confidentiality laws remain restrictive, agencies must have the staff and the systems (paper or electronic) to track who provided consent, for what agency, for what purpose, and for what length of time. Currently these tasks impose a significant financial burden with no return to the agency or practice. Mental health and primary care providers generally do not have the funding or resources required for the coordination of care, including providing consultations. Options for consideration include the following:

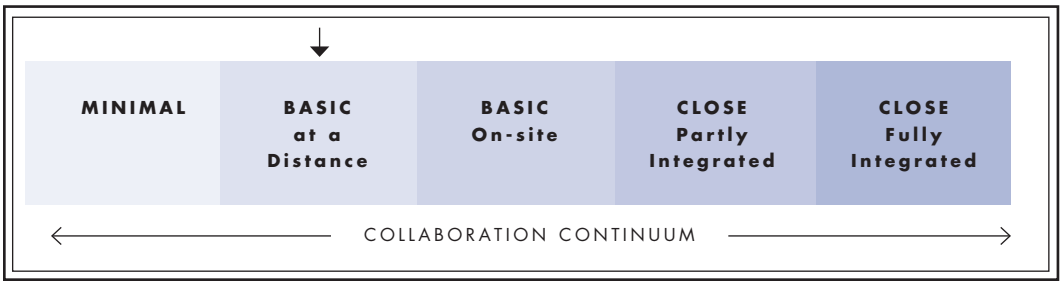
- Mental health case manager's policy guidelines could be expanded to explicitly state that activities involving coordination of care with primary care providers allow for a billable case management unit.

TABLE 4: EXAMPLES OF PRACTICE MODEL 1—IMPROVING COLLABORATION BETWEEN SEPARATE PROVIDERS

PROGRAM	STATE	DESCRIPTION
LifeWays	Michigan	LifeWays, a nonprofit behavioral health agency, has mental health case managers who often transport patients to primary care appointments. LifeWays has a formal policy stating that mental health providers must contact referring primary care providers. Administrative staff also meet annually with large primary care practices to discuss ways to enhance communication and address concerns (Koyanagi 2004).
Washington Medicaid Integration Partnership	Washington	Molina Healthcare is an HMO that receives a capitated payment to provide physical and behavioral health care to SSI clients. Molina provides care coordination across all health care needs, including various mental health agencies, which submit written care plans. Care coordination teams are led by RNs who also have access to psychiatric consultation and mental health clinicians.

- As outlined in at least one state Medicaid program billing guide, the majority of Medicaid recipients are assigned a primary care provider (a medical home) through a primary care case management (PCCM) model; an enhanced per member per month payment for the coordination of care across the continuum is funded (North Carolina Division of Medical Assistance 2009). This payment could be further enhanced to include the coordination for specialty mental health and substance abuse (see the discussion of the Minnesota DIAMOND project in table 7).

PRACTICE MODEL 2: MEDICAL-PROVIDED BEHAVIORAL HEALTH CARE



Medical-provided behavioral health care is a delivery model in which only the medical providers are *directly* involved in service delivery. For example, there are simple things that physicians can do to address behavioral health issues, such as discussing an exercise routine with depressed patients, having patients use a daily log to plan some activities, or perhaps having a nurse to follow up with the patient via a telephone call to ensure (or improve) medication compliance.

In this model, often *consultation-liaison* is used—the primary care provider delivers the behavioral health service while receiving consultative support from a psychiatrist or other behavioral health professional. The goal is to enhance the primary health care provider's ability to treat patients with behavioral health issues within a primary care setting. The psychiatrist works solely as a consultant to the primary care provider, seeing patients with the physician or more commonly advising via telephone, but not co-managing the patient.

To diagnose a behavioral health issue in a patient, primary care providers often use evidence-based behavioral health screening tools. One such screening tool is the "Patient Health Questionnaire" (PHQ-9) that is used to identify adults with depression (Kroenke and Spitzer 2002). This nine-item questionnaire can be quickly completed, usually in one to two minutes. Ideally, the physician confirms the depressive symptomology (by talking with patient, talking with other providers, reviewing PHQ-9 scores, etc.) and then uses brief intervention algorithms for treatment. Such practice is called *screening and brief intervention (SBI)*. Many medical homes have begun to integrate the screening of depression as a routine practice in caring for individuals with chronic illnesses. This process may begin with a brief two-question screening, using the first two questions of the PHQ-9. Additionally, a growing number of primary care sites screen for multiple issues, such as panic disorder, substance abuse, and even bipolar disorder. For children and adolescents, many practices use the "Pediatric Symptom Checklist" as their global behavioral health screening tool (Jellinek et al. 1988).

Brief intervention guidelines have been developed for most behavioral health issues that are seen in primary care (for example, see Hunter et al. 2009). In many cases, brief interventions can be delivered directly by primary care physicians with minimal training. The American Academy of Family Physicians (AAFP) has developed a number of algorithms for various disorders. Similarly, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office of National Drug Control Policy have implemented Screening, Brief Intervention, Referral and

Treatment (SBIRT) programs. SBIRT interventions have been found to be effective in reducing both the severity of mental health problems and the number of unnecessary emergency department visits and hospitalizations (National Council for Community Behavioral Healthcare 2009).

EVIDENCE BASE

There is a considerable evidence base for the effectiveness of SBI for substance abuse in primary care settings (Trick and Nardini 2006), as well as for many common problems, including pain, smoking, panic disorder, generalized anxiety, and depression (see sample studies in the resources section). Nonetheless, primary care providers are more likely to screen for depression than for substance abuse. This fact may reflect their comfort level in the diagnostic and treatment process for substance abuse.

IMPLEMENTATION CONSIDERATIONS

In implementing an SBI program, resistance may come from medical providers who voice concerns about screening for behavioral health conditions in an already time-stretched medical appointment. Concerns may also be based on discomfort with the skills needed to integrate mental health services, particularly substance abuse services, into the practice. Resistance to screening may occur when providers are unable to ensure access to behavioral health services and/or are unaware of the local behavioral health resources available in the community. Consultation services will need to be available, but those alone will not be sufficient to meet the needs of the patient. Primary care providers may be reluctant to contact a psychiatrist with whom they have no prior professional relationship. Opportunities to build those relationships, such as "meet and greets," on-site lectures, or clinical training (on how to get the most out of a consultation and/or staffing for patients with complex conditions), can serve to increase comfort levels among primary care providers.

Patients identified through SBI as having complex mental health conditions are best treated in specialty mental health and substance abuse agencies, not the primary care setting. So that the primary care providers' experiences in referring and coordinating care with these specialty agencies are positive, there must be sufficient capacity within the community to support an easy transition and coordination of care of the large variety of patients who are seen within the primary care setting.

FINANCIAL CONSIDERATIONS

To obtain financial viability, practices will need to substantially increase their billing and coding knowledge. Detailed coding information from the *Current Procedural Terminology (CPT)* of the American Medical Association (AMA) (2009) is contained within the financial considerations and resources sections in this report. Often, providers are not aware of billing opportunities, are unable to bill for two services on the same day, and find reimbursement policy rules confusing. For

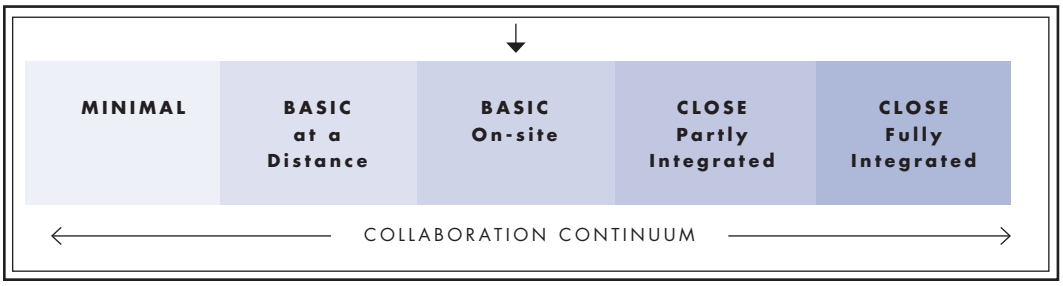
TABLE 5: EXAMPLES OF PRACTICE MODEL 2—MEDICAL-PROVIDED BEHAVIORAL HEALTH CARE

PROGRAM	STATE	DESCRIPTION
National Institute on Alcohol Abuse and Alcoholism	Nationwide	The National Institute on Alcohol Abuse and Alcoholism's brief intervention model has been sponsored in seventeen states. SBI (screening and brief intervention) for substance abuse in health care settings includes: (1) use of a screening instrument to identify the problem; (2) brief intervention, including motivational discussion and cognitive-behavioral strategies; and (3) arrangements for follow-up care if needed. The approach may be used by a primary care physician, nurse practitioner, or other trained medical staff. Typically, only a few hours of training are needed to deliver the interventions successfully. A simple pocket guide is available at http://pubs.niaaa.nih.gov/publications/Practitioner/PocketGuide/pocket.pdf.
Child Psychiatry Access Project	Massachusetts	The University of Massachusetts has created a statewide consultation model for primary care practices whereby real-time telephone consultation is available from a child psychiatrist or nurse specialist. The primary care physician may also refer the patient for psychiatric evaluation and assistance with treatment planning. A team composed of a case manager, social worker, and psychiatrist provides consultation and training for primary care physicians. The team also helps families to access specialty care and offers direct services if the family is put on a waiting list for specialty services.

example, Medicare authorizes brief interventions for alcohol and/or other substance abuse that can be billed on the same day as E/M (evaluation and management) codes, but providers must know that a Medicare alpha code ("G" code) should be used for these services rather than the codes created for and used by private insurance.

Telephone-based activities, including psychiatric consultations and brief patient follow-up interventions, are generally not covered services. However, payment for telephone calls by a physician to a patient for coordinating medical management with other health professionals may be allowable when the calls have an impact on the medical treatment plan (AMA 2009 CPT codes 99371–99373). Only the primary care provider can receive funding for the call. This means the behavioral health provider has no existing payment mechanism for providing consultations. Some state Medicaid programs are exploring the costs and benefits of reimbursing for telephonic consultation, and some jurisdictions have funded centralized phone consultations.

PRACTICE MODEL 3: CO-LOCATION



Collaboration between mental health professionals and primary care providers is likely to be more effective when the clinicians are co-located and the location is familiar and nonstigmatizing for patients. The co-location model uses specialty mental health clinicians who provide services at the same site as primary care. This approach shares space but is run as a separate service. Patients who present to a primary care provider with a medical complaint and are subsequently referred to a mental health provider may resist the referral because it "feels" like therapy. Such resistance could be due to the lingering stigma associated with needing therapy, and because traditional counseling approaches are typically used, the interventions "feel" more like specialty care. Also, when a behavioral health service is in a separate wing of the primary care site, there are fewer opportunities for spontaneous contact with physicians, which may decrease patient willingness to talk to a therapist. While co-location models are not fully integrated, physicians like them because specialty mental health services are often difficult to access and having the service on-site is a significant step forward (Strosahl 2005). Co-located services do not guarantee integration, but they are an important first step.

Co-location models usually serve persons with less severe mental illnesses as compared to specialty mental health settings. For example, persons with schizophrenia often require services from an Assertive Community Treatment Team (ACTT) or a day rehabilitation program. However, this practice model is effective with persons with serious but stable mental illness—providing a kind of mental health backup. The degree of collaboration varies widely in co-location models. Opportunities for collaboration increase when there is the timely availability of a behavioral health specialist to follow up on the primary care referral (Koyanagi 2004).

Positive implications of co-location include earlier identification, greater acceptance of referral, and improved communication and care coordination. Shared plans of care can also significantly enhance the quality of care, prevent duplication of services, and reduce risk of adverse events.

EVIDENCE BASE

Delivering specialty mental health in primary care settings produces greater engagement of patients in mental health care, which is a prerequisite for better patient outcomes. Emerging literature on co-located substance abuse treatment and primary care has shown that patients have better outcomes,

with the greatest improvement for those with poorer health (Craven and Bland 2006). Medical cost offset may occur when patients use less medical care because they are receiving mental health services. The reduced physical health care cost offsets the cost of the mental health care (Strosahl and Sobel 1996). And diagnosis and treatment may significantly improve in co-located models. This is attributed to behavioral health clinicians taking an active role in teaching and coaching primary care providers (Koyanagi 2004).

IMPLEMENTATION CONSIDERATIONS

The initial implementation issues are centered on the basic logistics of creating a successful co-location model. The providers will need to address office space, consent forms, maintenance of separate records, and staff roles and responsibilities in a co-located site. Behavioral health providers who work in fifty-minute windows may not be accessible to assist the primary care provider who is working in a faster paced fifteen-to-thirty-minute environment. When demand quickly exceeds capacity, both organizations may experience frustration.

This practice model is primarily a referral-based process with providers working more closely and with improved communications. As a general rule, patients must still migrate through a new organization that could include separate appointment and intake processes. Having the mental health service on-site will increase the primary care provider's understanding of the referral process; however, it may not improve the traditionally high patient no-show rates seen in mental health without other support.

FINANCIAL CONSIDERATIONS

One of the strengths of this model is the physical proximity of providers. Medical providers are encouraged to introduce the patient to the behavioral health provider at the time of the medical appointment. These "warm handoffs" will work to decrease the number of no-shows but are themselves not billable interactions. Once both providers have established a treatment relationship and issues of consent have been addressed, the proximity can increase the exchange of relevant clinical information; however, neither provider will be compensated for such informal consultations. Each agency will, for financial viability, need to limit and define the scope of uncompensated services that can be provided.

Patients may have limits on the number or cost of visits within both their physical and behavioral health benefit packages. In this model, a psychiatrist may use an evaluation and management (E/M) code under a medical group number. If the payer's billing system does not correctly apply the visit, the primary care provider and psychiatrist can find themselves competing for a limited number of E/M visits under the medical health benefits.

TABLE 6: EXAMPLES OF PRACTICE MODEL 3—CO-LOCATION

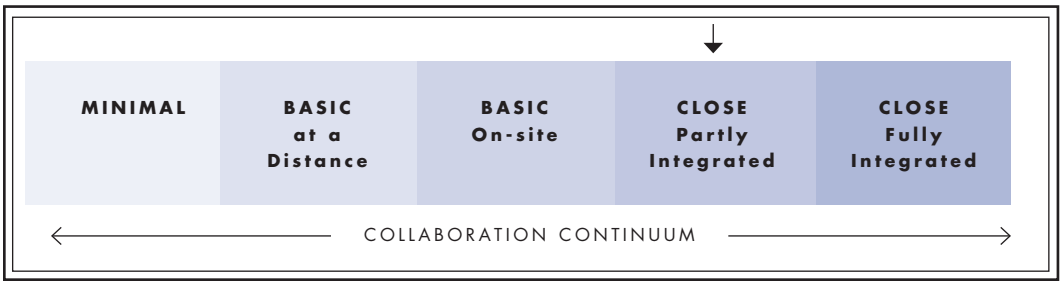
PROGRAM	STATE	DESCRIPTION
Family Medicine Residencies	Nationwide	The American Academy of Family Physicians has required family medicine residencies to include behavioral health training since the late 1960s. Since then, training sites around the country have employed psychologists and social workers to train physicians about the psychosocial aspects of health care. Peek and Heinrich (1998) use the term *ecology of care* to refer to the broader arena in which care must be managed and collaboration must take place. The patient is viewed within a family and life context. Behavioral health clinicians are co-located at the primary care clinic. Behavioral health and primary care providers have staff reviews of shared patients and may conduct joint therapy sessions. This model increases collaboration, but specialty mental health usually remains the model of service delivery. The behavioral health provider is typically viewed as an in-house specialist (Strosahl 2005).
Armstrong Pediatrics	Pennsylvania	Armstrong Pediatrics, a large rural primary care practice, works with the nearby Western Psychiatric Institute and Clinic in Pittsburgh to provide a range of mental health services to youth. Children are screened for mental health problems, and a nurse practitioner conducts assessments. A social worker is available to provide on-site counseling, and a psychiatrist is available for psychiatric evaluations and consultations. About two-thirds of identified children need treatment by only the physician or nurse practitioner. About 19 percent of identified children receive care from the social worker or psychiatrist. Only 13 percent of identified children require referral for specialty mental health care.

(continued)

TABLE 6 *(CONTINUED)*

PROGRAM	STATE	DESCRIPTION
Washtenaw Community Health Organization	Michigan	The Washtenaw Community Health Organization is a partnership between the county public mental health system and the University of Michigan Health System. The partnership allows for pooling of funds across systems and shared risk. Mental health clinicians from the community mental health center are out-stationed to primary care practices to provide direct treatment. A psychiatrist provides consultation to local public health clinics. The project has added a reverse co-location initiative (see discussion of Practice Model 5) by having a nurse practitioner visit community mental health clinics to provide primary care as well as to coordinate with the patient's physician if there is one.

PRACTICE MODEL 4: DISEASE MANAGEMENT



Psychological stress and disability accompany many chronic illnesses. The disease management (or chronic care) model is an integrated system of interventions to optimize functioning of patients and to impact the overall cost of the disease burden. The disease management model was developed by Edward Wagner and his colleagues (2001). This practice model emphasizes both the early identification in primary care of populations that are at risk for costly chronic disease (for example, depression, diabetes, asthma) and the provision of educational orientation and evidence-based algorithms (Mauer 2003). It is estimated that 60 percent of patients with chronic disorders do not adhere to treatment regimens (Dunbar-Jacob and Mortimer-Stephens 2001), and this is especially true for patients who live in poverty or in abusive families—all circumstances that increase the difficulty of caring for patients with chronic diseases.

A care manager provides follow-up care by monitoring the patient's response and adherence to treatment. The care manager also provides education to the patient about his or her disorder and self-management strategies. Disease management models have an organized approach to assisting lifestyle modification. Care managers may be nurses or master's-level social workers. These professionals may provide brief psychotherapy if needed. Paraprofessionals, such as bachelor's-level staff and LPNs, may provide these services as well (following appropriate training).

The disease management model shares many similarities with the co-location model. The distinction is that behavioral health interventions used in pure co-location models are typically specialty mental health interventions that are brought into primary care. The emphasis in co-location is using physical proximity to facilitate integration. The disease management model also involves co-location, but the clinical interventions are typically modified for the primary care setting.

Another hallmark of the disease management model is the use of a patient registry, for example, one that identifies all patients with chronic pain and depression. Special programming is targeted for this population and patients are routinely monitored by a care manager to ensure that defined interventions are completed.

As noted earlier, the specific implementation of a model can change the level of integration, and the disease management model in particular seems to roam across levels. Some programs operate at either a basic level of collaboration (on-site) or at a close level of collaboration (partly integrated), while others are similar to a close and fully integrated level (such as Practice Model 7, which is discussed later) in which the care manager functions like a consultant/therapist.

Three major philanthropic-funded initiatives have informed many disease management programs around the country. In fact, these foundations have been responsible for much of the development of integrated approaches over the past decade and, thus, are the reason that this practice model may be the most prominent at the present time. These initiatives share numerous similarities but also have unique implementations. Each has excellent websites and curriculum materials, and the IMPACT program site (funded by the John A. Hartford Foundation) has a particularly impressive Web-based training program. A brief synopsis of each initiative (gleaned from their respective websites) is outlined below:

1. *John A. Hartford Foundation Initiative–Improving Mood: Promoting Access to Collaborative Treatment (IMPACT).* This program, developed at the University of Washington, is a depression management program based on a randomized controlled trial with a focus on older adults. The patient's primary care physician works with a care manager to develop and implement a treatment plan (medications and/or brief, evidence-based therapy). The care manager and primary care provider consult with a psychiatrist to change treatment plans if patients do not improve. The care manager may be a nurse, social worker, or psychologist and may be supported by a medical assistant or other paraprofessional. The model has recently been expanded to include adolescents and the general adult population and to manage anxiety, substance abuse, and other disorders in addition to depression.
2. *MacArthur Foundation Initiative on Depression and Primary Care.* This initiative uses a "Three Component Model": a trained physician and practice, a care manager, and a mental health clinician, using a team-based approach. The care manager conducts regular telephone follow-up calls to patients and keeps the physician informed about the patient's progress. A standardized assessment of depression severity is used. Psychiatric consultation is available to physicians.
3. *Robert Wood Johnson Foundation (RWJF) Initiative–Depression in Primary Care: Linking Clinical and System Strategies.* The RWJF program is based on Edward Wagner and his colleagues' chronic care model and has many similarities to the MacArthur initiative. Additionally, the project developed strategies to remove financial and structural barriers to integration. Primary care providers were reimbursed to identify and manage depressed patients. The care management function was funded to support physicians, as was a mental health clinician to provide consultation.

EVIDENCE BASE

Randomized controlled trials (RCTs) show that disease management models using care managers are both clinically effective and cost-effective. Meta-analyses indicate that there is a cost offset of 20 to 40 percent for primary care patients who receive behavioral health services. Notably, fewer hospitalizations result in significant cost reductions for patients with chronic physical illness and those with psychiatric diagnoses (Blount et al. 2007).

IMPLEMENTATION CONSIDERATIONS

Disease management programs provide an opportunity to begin integrating the screening and treatment or referral for behavioral health conditions. For implementing a disease management model, the following considerations are noteworthy:

- When implementing depression screening, providers need to understand that the depression algorithm is very aggressive over the first twelve weeks. The care manager/therapist providing the service will need to be able to respond quickly to the referral and work in an integrated fashion to support the primary care provider in the implementation of that algorithm.
- Provider engagement and buy-in are essential, especially with the implementation of new clinical guidelines for mental health conditions.
- Practices engaged in disease management programs generally maintain a registry or database to enable the identification of patients and the management of their disease. These systems need to be able to support information and data for behavioral health processes as well. A comprehensive disease management model should focus beyond single disease states of either physical or behavioral health. A first step in that process would be to integrate behavioral health into the existing medical disease management processes.

FINANCIAL CONSIDERATIONS

Medical disease management programs that incorporate new behavioral health screenings and clinical pathways will require some additional resources. Options at the state level to provide needed funding might include the following:

- Expanding an existing medical home or primary care case management (PCCM) program to include patients with mental health and substance abuse disorders.
- Expanding the role and funding for existing disease management programs. If providers are reimbursed on a fee-for-service basis, then consider that the following key disease management activities are generally not reimbursed:
  - psychiatric consultations
  - outbound phone monitoring
  - coordination of care across the continuum
- Reimbursing telephone-based interventions. Telephonic evaluation and management services can be reimbursed when meeting certain guidelines—when provided by a physician (AMA 2009 CPT codes 99441–99443) or when provided by a qualified non-physician health care professional (AMA 2009 CPT codes 98966–98968).

As primary care providers adopt clinical pathways that are common within disease management programs, the parity issue will be highlighted and begin to have a direct negative impact on their reimbursement. Primary care providers who provide medical visits with mental health/substance

abuse codes listed as the chief diagnosis may discover that the visit has a significantly higher patient co-payment or may not be reimbursed at all. By 2014, the Medicare Improvements for Patients and Providers Act (MIPPA) will require parity with co-payments. However, at the time this report is being written, a publication by the Centers for Medicare and Medicaid Services, titled *Medicare and Your Mental Health Benefits* (2007), states that approximately a 50 percent reduction in reimbursement applies to outpatient treatment of a mental health condition.

TABLE 7: EXAMPLES OF PRACTICE MODEL 4—DISEASE MANAGEMENT

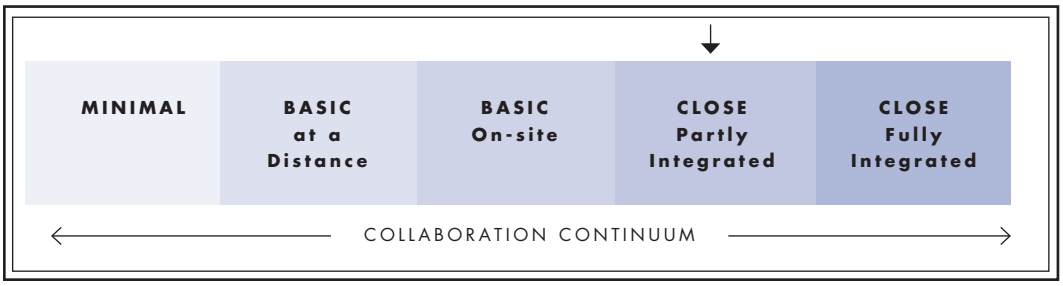
PROGRAM	STATE	DESCRIPTION
Veterans Health Administration (VHA) Primary Care–Mental Health Integration Initiative	Nationwide	The VHA is using two care management models in its health clinics. One model uses a nurse care manager to provide telephone monitoring to individuals with depression and referral to specialty care when needed. The other model uses a software-based assessment to determine three interventions: watchful waiting, treatment by the primary physician, and referral to specialty care. The VHA also is co-locating behavioral health clinicians in health clinics. The blending of both co-location and care management has become the preferred model.
Aetna	Nationwide	The Aetna Insurance Company is using a care management model with persons with co-morbid conditions. Early screening is used, and telephone psychiatric consultation is available to primary care physicians. Care managers monitor patients by telephone and refer patients to behavioral health services as needed.

(continued)

TABLE 7 *(CONTINUED)*

PROGRAM	STATE	DESCRIPTION
Depression Improvement Across Minnesota—Offering a New Direction (DIAMOND)	Minnesota	This groundbreaking project is a partnership of medical groups, health plans, the Department of Human Services, and employer groups. The Hartford Foundation's IMPACT model is being used, featuring a care manager who provides ongoing assessment, a patient registry, use of self-management techniques, and the provision of psychiatric consultation. Patient outcomes are far superior to results seen under the usual care given currently to patients with depression in primary care. The project is applying the concept of a case rate payment for depression care. Minnesota health plans are paying a monthly PMPM to participating clinics for a bundle of services—including the care manager and consulting psychiatrist roles—under a single billing code (Jaeckels 2009).
Inter-mountain Healthcare	Utah and Idaho	Intermountain Healthcare is a nonprofit system that includes outpatient clinics, hospitals, and health plans. Its Mental Health Integration project began with the RWJF depression initiative and has been expanded to include a focus on evidence-based treatment algorithms. The program serves both children and adults. After a comprehensive assessment, patients are assigned to low care, which is managed by a physician with support from a care manager, or moderate care, which includes the entire team (mental health clinician and psychiatric consultant). High-need patients are referred to specialty care—with tools to facilitate communication and follow-up with the mental health agency.

PRACTICE MODEL 5: REVERSE CO-LOCATION



Typically, integration is considered from the perspective of integrating behavioral health care into primary care (Pincus 2004). However, the *reversed* approach is also possible. The reverse co-location model seeks to improve health care for persons with severe and persistent mental illness. Persons with serious mental illness have high levels of medical co-morbidity compared to the general population, as well as increased risk for diabetes, obesity, and high cholesterol due to the use of some second-generation antipsychotic medications. Physical health care should be an essential service for persons with serious mental illness. In the reverse co-location model, a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) may be out-stationed part- or full-time in a psychiatric specialty setting to monitor the physical health of patients. Typical settings are rehabilitation or day treatment programs, though services may also be viable in an outpatient mental health clinic program. One variation of the model gives psychiatrists in mental health settings additional medical training to monitor and treat common physical problems (Mauer and Druss 2007).

When a primary care provider is on-site at a facility that treats the severe and persistent mentally ill, more time is available to address complex medical issues. Because they work in physical proximity, primary care providers and behavioral health professionals develop strong collaborative relationships. The primary care provider gains important experience with serious mental illness and may develop a keen ability to sort out physical and behavioral symptoms. Finally, having primary care appointments and behavioral health appointments on the same day in the same facility helps patients comply with treatment (Koyanagi 2004).

EVIDENCE BASE

Studies of reverse co-location models are still in their infancy but have demonstrated the model's considerable potential to reduce lifestyle risk factors (Mauer and Druss 2007). For example, the Massachusetts reverse co-location model described in table 8 lowered emergency room (ER) visits by 42 percent and dramatically increased screenings for hypertension and diabetes (Boardman 2006).

IMPLEMENTATION CONSIDERATIONS

When a primary care provider is placed on-site at a mental health agency, some of the implementation issues for reverse co-location will be similar to those of co-location. Providers will

have to address the issues regarding space, consents of treatment, maintenance of medical records, and referral processes.

Mental health agencies traditionally have case managers whose responsibilities include working with patients on developing plans of care. This service has the potential to be an important resource for incorporating preventive and primary care treatment goals. Mental health case managers will, however, need to build skills with regard to medical conditions. They can play a key role in assisting patients in developing self-management goals, managing chronic conditions, and promoting wellness by supporting tobacco cessation, nutrition, and exercise.

As with co-location, there are cultural, medical, and mental health terminology and disease states that will require additional orientation and training for providers and staffs. However, the core of their work remains relatively unchanged with both groups continuing to practice their respective disciplines. If the practice chooses to employ a nurse experienced in primary care, there exists an opportunity for nursing notes with key medical information to be provided to the psychiatrist prior to the appointment, thus enhancing the psychiatrist's ability to address a medical concern such as hypertension.

FINANCIAL CONSIDERATIONS

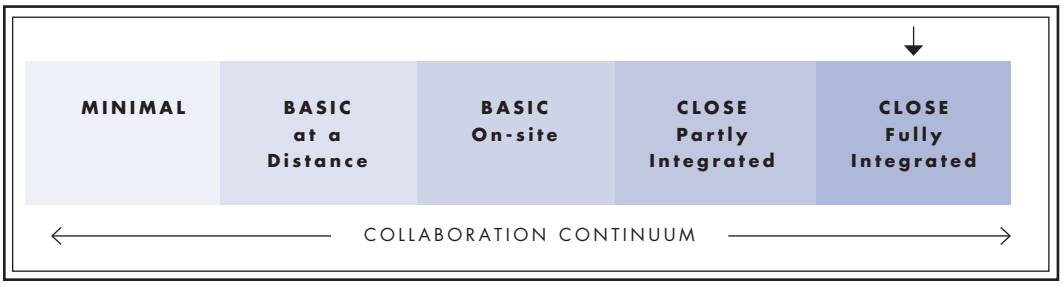
As with the disease management model, much will depend on the level of integration. Cherokee Health Systems, a community mental health agency located in Tennessee, sought credentialing to become a licensed medical provider. It is possible that mental health agencies may experience difficulty in locating primary care providers, particularly for uninsured and Medicaid patients with multiple co-morbid conditions.

Frequently, no payment exists for consultation between providers. Codes for the administration and interpretation of health risk assessments are generally not funded. State and private payers often have different policies and codes based on the specialty type of the provider. Mental health agencies may be unable to gain access to E/M codes to bill for medical visits. These codes cover an office or other outpatient visit for the evaluation and management of a new patient (99201–99205) or an established patient (AMA 2009 CPT codes 99211–99215). Payment is linked to the American Medical Association's CPT codes, which reflect the complexity of the visit and are used to establish reimbursement rates.

TABLE 8: EXAMPLES OF PRACTICE MODEL 5—REVERSE CO-LOCATION

PROGRAM	STATE	DESCRIPTION
Health and Education Services	Massachusetts	Health and Education Services (HES) is a nonprofit, full-service mental health organization in the North Shore area. HES is focused on improving the physical health care of its Latino population. A Spanish-speaking nurse practitioner, who has expertise in both primary care and psychiatry, regularly visits three clinics. The nurse is available on a walk-in basis to see patients with a range of medical issues.
Horizon Health Services	New York	Horizon Health Services is a provider of comprehensive substance dependence and mental health services in Buffalo. Three of Horizon's sites have medical units, where patients are offered an appointment if they do not have a primary care physician. The medical staff includes a family physician, registered nurse, nurse practitioner, LPNs, and HIV counselors.
Community Support Services	Ohio	Akron, Ohio's Community Support Services Center serves adults with severe mental illness in Summit County. The center opened its doors to an integrated primary care clinic and pharmacy in 2008. Clinic staff includes a nurse practitioner and a primary care physician. The center has developed an electronic record for primary care, aiming to establish a totally integrated electronic medical record.

PRACTICE MODEL 6: UNIFIED PRIMARY CARE AND BEHAVIORAL HEALTH



Another approach that targets persons with serious mental illness is the unified primary care and behavioral health model, in which psychiatric services are part of a larger primary care practice. The hallmark of the model is the integration of clinical services combined with the integration of administration and financing. Integration is an organization-wide effort. At the clinical level, primary care and behavioral health staff interact regularly and typically have an integrated medical record and single treatment plan.

This model has been implemented in some federally qualified health centers (FQHCs) and Veterans Health Administration outpatient programs. The model typically offers full-service primary care and full-service psychiatric care in one place. Patients require outside referral only when intensive specialty mental health services are needed (for example, an Assertive Community Treatment Team—ACTT—which makes regular home visits to patients). Unified programs usually serve a broader population of patients with mental health needs, not only patients with severe mental illnesses, as is the case in reverse co-location programs.

EVIDENCE BASE

There are few RCT studies of this model. Using an RCT, Druss and colleagues (2001) studied the impact of taking primary care into a VHA mental health clinic. Outcomes were positive: patients were less likely to have ER visits, reported better physical health status, and were less likely to report a problem with continuity of care.

IMPLEMENTATION CONSIDERATIONS

Integrating full-service mental health in the primary care setting has a multitude of implementation considerations. A substantial number of care processes will need to be designed or redesigned, in such areas as credentialing, paneling, funding sources for uninsured, coding/billing, policy requirements, IT systems, education, after-hours coverage, supervision, and liability.

If a community mental health agency is the primary mental health provider, it may choose to go through the credentialing process to become a licensed medical provider, as was the case with Cherokee Health Systems. In the event a mental health agency retains its mental health focus but

wishes to integrate components of physical health, it will have many of the same barriers as the primary care provider in securing reimbursement from carriers for mental health services. When mental health services are carved out from medical benefits, the lack of parity results in lower payments, tighter limits, and higher co-payments.

Mission and vision statements will need to be addressed along with issues of governance. Agencies will have to become credentialed, and the providers will need to be paneled for medical and mental health services. Office systems, including medical records and billing systems, will need to be able to accommodate both disciplines. Careful consideration and clear guidance about roles and responsibilities for all members of the team will be needed. New laws and standards of ethics will apply.

Policy barriers include confidentiality as it pertains to state laws and federal substance abuse standards and how these policies are interpreted. Mental health agencies have a long and ingrained culture of requiring patient consent. Issues and concerns arise not only when care is coordinated across the continuum but also within the integrated agency. The tendencies to secure separate consents and to maintain separate medical records clearly have implications for all models and remain barriers to effective integration. Confidentiality must be carefully balanced with the need to provide services in a way that does not separate and stigmatize mental health and substance abuse conditions. Most providers do not have the staff or infrastructure to maintain and coordinate multiple consents.

FINANCIAL CONSIDERATIONS

Unlike prior models where the primary financial barriers are the lack of codes or alternative payment methodologies, the financial barriers in this model incorporate much larger system issues. This model will need to support a behavioral health team that is employed by the primary care site.

Many private carriers have closed provider panels, or providers experience difficulty accessing the existing panels. The impact of the lack of parity carries over into the medical setting. Public and private carriers have wide variations in mental health and substance abuse coverage, codes, co-payments, and prior authorization requirements. Carriers may prevent therapy codes from being billed on the same day as an E/M code. Medicare, for example, does not allow the majority of the therapy codes to be billed on the same day.

In part due to federal Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements in Medicaid, the age of the recipient may result in significantly different coverage for a child compared to an adult patient. In some states, a significant co-payment for mental health services also applies to the most vulnerable dually eligible population (those eligible for both Medicaid and Medicare). Such variability leads to significant confusion for the patients, providers, coders, and administrators.

Claims processing systems may present additional challenges, as edits developed for mental health services conflict with the edits for physical health services. The location of the service may also impact the payment amount.

TABLE 9: EXAMPLES OF PRACTICE MODEL 6—UNIFIED PRIMARY CARE AND BEHAVIORAL HEALTH

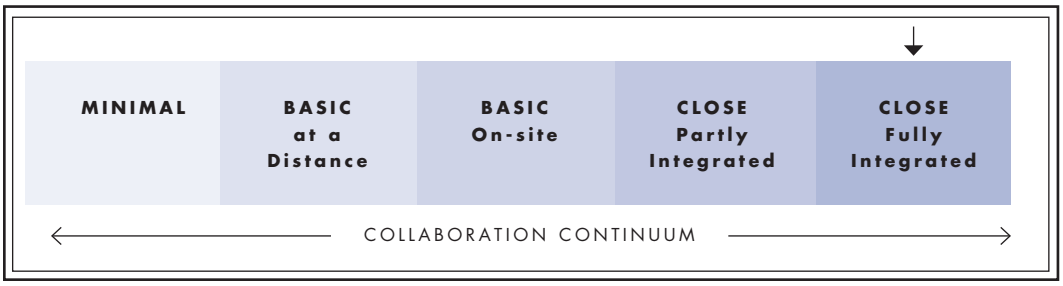
PROGRAM	STATE	DESCRIPTION
Cherokee Health Systems	Tennessee	Cherokee Health Systems in eastern Tennessee was originally a community mental health center that expanded to become a federally qualified health center (FQHC). The program provides integrated behavioral health and primary care at twenty-two sites. In addition to comprehensive primary care, specialized services for persons with serious mental illness are available, including case management, day programs, and substance abuse services. Cherokee receives a Medicaid capitated rate for providing both medical and mental health services. Case managers work with adults and children with serious mental illness, as well as patients with chronic physical health problems. Cherokee is an effective model for underserved areas, where there is a lack of providers. As an FQHC, it is able to access special federal financial support. Co-location of services enables Cherokee providers to collaborate informally. Cherokee uses an integrated paper medical record. Treatment team meetings are held monthly for patients with complex mental and physical health needs, and sometimes primary care and behavioral health staff see patients together. Cherokee also uses the brief interventions that are described in the next section in the primary care behavioral health model.

(continued)

TABLE 9 *(CONTINUED)*

PROGRAM	STATE	DESCRIPTION
Community Health Center, Inc.	Connecticut	Community Health Center, Inc., is a multi-site FQHC with four sites providing co-located primary care and behavioral health services, which are embedded into the center's operational framework. The interdisciplinary team shares work space and meets daily for a "morning huddle" to review patient treatment plans. All patients are screened using the PHQ-9. The "warm handoff," in which the physician directly introduces the patient to the behavioral health clinician in the exam room, is used to transition patients from primary care staff to behavioral health clinicians.

PRACTICE MODEL 7: PRIMARY CARE BEHAVIORAL HEALTH



In this fully integrated model, behavioral health is a routine part of the medical care. Strosahl (1998) notes that a patient is just as likely to see a behavioral health clinician as a nurse during a routine office visit in this model. The behavioral health clinician is part of the primary care team, not part of specialty mental health. The patient's primary care physician is the principal "provider" in the model. The behavioral health clinician does not take over responsibility for treating the patient, but rather temporarily co-manages the patient with the physician, who makes the initial referral.

Strosahl (2001) is adamant that integrating behavioral health care in the primary care system cannot involve simply taking specialty mental health approaches and dropping them into primary care. He says that the sheer volume of behavioral health needs would quickly outstrip the capacity of traditional mental health approaches. The answer is to convert evidence-based knowledge into condensed "bite-size" interventions with a psycho-educational format, with emphasis on skill building and home-based practice (Strosahl 2005).

A hallmark of the primary care behavioral health model is its focus on an epidemiological, public health view of service delivery. In specialty behavioral health care, the focus is on the individual. In population-based care, the entire primary care population is the target. The goal is not just to address the needs of sick patients but also to target those who may be at risk or who are sick and do not seek care (Strosahl 1997). The primary care behavioral health model uses a "wide-net" approach aimed at serving the entire primary care population with emphasis on brief, focused interventions. (Some unified programs, such as FQHCs, share this perspective.)

According to Strosahl (2005), the goal of the brief intervention is to educate patients about their condition and to discuss different types of self-management strategies that patients can implement in their daily environments. The aim is to get patients doing something different. Strosahl says that a patient's problem is not causing the dysfunction, but rather the solutions being used to solve the problem cause the dysfunction.

Strosahl (2005, p. 36) notes that "to routinely accomplish fifteen-to-thirty-minute sessions, the behavioral health provider must reduce the emphasis on rapport building, eliminate unneeded, time-consuming assessments, limit the problem focus, and stick with functional interventions." Strosahl says that the standard of care for primary care behavioral health should not be defined by the practice of specialty mental health care. Just as a primary care provider who treats a patient for

heart disease is not expected to practice the standard of care of a cardiologist, practice standards for primary care behavioral health should be derived from primary care.

Interestingly, according to Robinson (2005), primary care patients will tolerate only about three hours of "treatment" over a three-month period for conditions like depression. For example, a cognitive behavioral approach to panic disorder can be done in three to four brief contacts, when supported with educational materials, home practice, and telephone follow-up. Clearly, this is an effective approach to reach the large percentage of patients who will not follow through with a referral for traditional mental health counseling.

Key features of the primary care behavioral health model include "warm handoffs" in which the physician introduces the behavioral health clinician directly to the patient and "curbside" consultations in which the physician and behavioral health clinician have frequent informal interactions to discuss patients. Service delivery consists of multiple formats: patient education, case management, telephone monitoring, and skill coaching.

EVIDENCE BASE

The primary care behavioral health model has not yet been systematically evaluated. While brief interventions are not unique to this model, the research literature on brief intervention is increasing and highly encouraging. For example, meeting with a counselor just once at the time of a routine doctor visit and receiving a follow-up telephone call can motivate abusers of cocaine and heroin to reduce their drug use (Bernstein et al. 2005). 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. (See the resources section for a list of studies on brief interventions in primary care.)

IMPLEMENTATION CONSIDERATIONS

The greatest challenge for this model is the need for a complete redesign of the role of behavioral health within primary care. The learning curve for existing behavioral health providers who wish to work in this fully integrated setting should not be underestimated. The new model of care will require a commitment to significant change. Change is built around developing the knowledge and skills to effectively implement validated screening tools, motivational interviewing, self-management, focused brief interventions/therapy, consultations, chronic disease models, clinical algorithms, disease management processes, medications, substance abuse screenings and interventions, recovery models, and cultural competencies. The therapist who has practiced in a highly structured fifty-minute appointment schedule will find a much faster paced environment in the primary care setting where practitioners work in fifteen-to-thirty-minute increments with frequent interruptions, consultations, and handoffs. The primary care provider will need to implement new clinical pathways requiring

active engagement in the treatment of mental health and substance abuse. Care that is provided through a team-based approach with shared responsibilities for outcomes will be a significant shift.

The existing system will be the default system, unless work is done to aggressively remove any barriers for the provision of new services. The resources section includes a recommended list of websites that contain detailed information with regards to staff roles and responsibilities, quality measures, evidence-based practices, tools for implementation, and provider cultural competency.

Educational training programs will be key in providing a properly trained behavioral health provider workforce that can meet the demands the new integrated model will require. At the National Naval Medical Center in Bethesda, Maryland, psychology interns are being trained to do the following tasks: start an integrated service; provide secondary prevention, population health intervention, and chronic care assessment; and manage acute assessments and interventions for general mental health and substance use (for example, anxiety and depression and alcohol and prescription medication problems) and for problems falling in the health psychology domain (for example, diabetes, cardiovascular disease, and chronic pain conditions) (Weaver 2008).

This practice model should not require the behavioral health provider to complete the extensive paperwork generally required for targeted populations receiving ongoing complex services. The time to complete the paperwork should not be longer than the time to provide the brief intervention.

National and state codes of ethics that were previously developed in the specialty mental health setting may conflict with the integrated model. Issues around informed consent, brief interventions absent a comprehensive psychiatric diagnostic interview examination, sharing of medical records, and scope of practice with regards to medication monitoring may need to be discussed in the context of integrated care.

As this model focuses on brief interventions for a large number of patients, practices will have to build the infrastructure and develop the relationships needed to transfer and accept patients across the continuum of care.

FINANCIAL CONSIDERATIONS

This model lays out a new vision for the role of the behavioral health provider that involves significant integration into a practice. This paradigm shift changes the focus from traditional mental health services to behavioral health being a key component of a medical appointment.

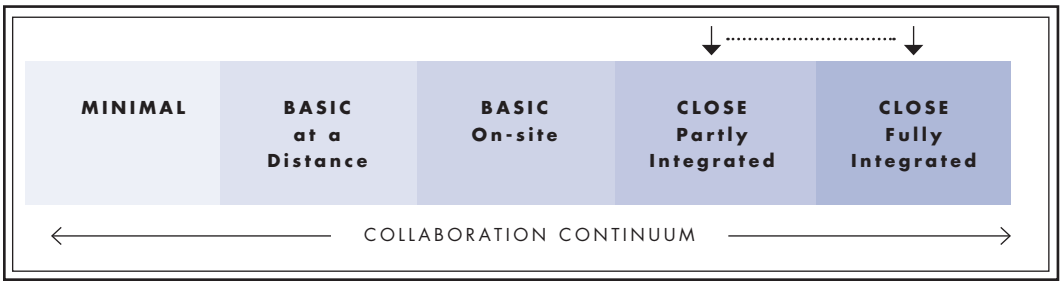
If a practice wants to use its behavioral health staff to provide secondary prevention, population health intervention, and chronic care assessment to treat conditions falling in the health psychology domain, the practice must have access to the new health and behavior assessment/intervention codes (AMA 2009 CPT codes 96150–96155). These codes have been created specifically for this purpose and are billed under the medical diagnosis. However, access is not sufficient. If these codes are to be viable at the practice level, the following considerations need to be taken into account when creating billable services:

- which disciplines will be authorized to use the codes in light of workforce demands
- how reimbursement policies will support patients being seen by more than one provider on the same day
- how many brief intervention visits are needed when and if annual limits are set based on codes/visits

TABLE 10: EXAMPLES OF PRACTICE MODEL 7—PRIMARY CARE BEHAVIORAL HEALTH

PROGRAM	STATE	DESCRIPTION
The U.S. Air Force Behavioral Health Optimization Project	Nationwide	This project began by training several behavioral health clinicians in the primary care behavioral health model. Using a train-the-trainer approach, the project has trained dozens of behavioral health providers at Air Force health facilities around the country. The U.S. Navy and Army have now begun a similar training initiative. (The U.S. Air Force curriculum is listed in the resources section.)
Buncombe County Health Center	North Carolina	This practice provides 85 percent of the safety-net care for low-income county residents. It is staffed by twelve physicians, physician assistants, and nurse practitioners, with three full-time co-located behavioral health clinicians. Clinicians work side by side with physicians. While a typical physician may see fifteen patients a day, a typical behavioral health clinician will see about ten patients. Behavioral health clinicians work out of medical examination rooms. One "behaviorist" is always on-call and available to immediately triage patients. The physicians and clinicians use the same waiting room and the same medical record. The behavioral health clinician makes specific, evidence-based recommendations to the physician. Prompt feedback is given to the physician either verbally or in a chart note. The behavioral health clinician is a member of the primary care team and is viewed more as a primary care provider than as a specialty mental health therapist.

PRACTICE MODEL 8: COLLABORATIVE SYSTEM OF CARE



The eighth and final model is referred to as a *collaborative system of care* and may be partly or fully integrated depending on degree of collaboration. It is a hybrid model but is recognized by its use of an integrated model with a collaborative system of services wrapped around the core model—a system of care. The concept of a system of care has been widely used in the child mental health arena (Stroul and Blau 2008).

The collaborative system of care model has particular promise for serving the Quadrant II and Quadrant IV population—those patients with high mental health needs and those who require more specialized mental health services than primary care can realistically offer. If the separate specialty mental health services are seamlessly woven together with the primary care services, a highly integrated model can be achieved. The examples in table 11 illustrate how this model can be accomplished to serve two high-need (and high-risk) populations, adolescents and the homeless.

EVIDENCE BASE

The distinctive nature of this model means evaluations are highly variable, and it is difficult to draw definitive conclusions. For example, in the Rebuilding Lives program (see table 11), outcomes were impressive. Large numbers of clients obtained entitlements, accessed sustained housing, improved their community functioning, and experienced a two-thirds reduction in arrests (Edwards, Garcia, and Smith 2007). Other programs did not consistently demonstrate positive results.

IMPLEMENTATION CONSIDERATIONS

This model seeks to develop individualized plans of care for high-risk patients across multiple service agencies. The range of medical, mental health, substance abuse, and social agencies providing services to high-risk patients can be extensive. Therefore, in order to sustain this type of model, it will be important to engage additional partners, such as housing, education, employment, justice, and welfare organizations. This effort will need to include securing the buy-in and implementing the policy changes required to distribute financing across an array of funders.

FINANCIAL CONSIDERATIONS

As outlined in prior models, all of the funding considerations regarding service coordination, agency integration, policy, and confidentiality will play into this model, but the degree of difficulty will incrementally increase with each new partnership. Accomplishing the vision of a single plan of care will require significant financial flexibility from federal, state, and local funders.

Both the Technical Assistance Partnership for Child and Family Mental Health and the Judge David L. Bazelon Center for Mental Health Law have developed tools to assist jurisdictions in building sustainable systems of care. Links to these tools are provided in the resources section of this report.

TABLE 11: EXAMPLES OF PRACTICE MODEL 8—COLLABORATIVE SYSTEM OF CARE

PROGRAM	STATE	DESCRIPTION
Center for Adolescent Health	New Hampshire	The Center for Adolescent Health—Belknap County Adolescent Treatment Initiative provides a continuum of health services for adolescents with emphasis on substance abuse treatment, primarily using screening and brief intervention (SBI). The program works with primary care practices in the region to screen adolescents for behavioral health problems and to provide brief interventions. An interdisciplinary diagnostic clinic, the Center for Adolescent Health provides consultation and coordinates care but does not serve as a primary care provider. Partner agencies collaborate to provide a seamless continuum of outpatient and residential adolescent substance abuse treatment services.
Rebuilding Lives PACT Team Initiative	Ohio	Rebuilding Lives is a collaborative of behavioral health, primary care, housing, and other supports to serve the homeless population in Columbus. The core model is care coordination provided by an FQHC, which delivers comprehensive medical services. Partner agencies provide supportive housing (using the "housing first" philosophy) and an array of mental health and substance dependence services. An Assertive Community Treatment Team, using Integrated Dual Disorder Treatment, is a key service. The integrated service system functions in a highly coordinated fashion.

CONSIDERATIONS FOR CHOOSING A MODEL

There are many considerations for policymakers, planners, and providers of physical and behavioral health care in determining the best model of practice. Peek (2005) has identified some initial reasons for and goals in choosing an integration model:

- lessen the stigma of accessing mental health care
- improve use of physician time and appointment availability
- implement in-house alternatives to outside mental health referrals
- increase successful mental health referrals to clinicians whom primary care providers actually know
- gain quick access to mental health emergency and crisis help during the clinic day
- integrate a liaison for timely referral for and coordination of specialty mental illness treatment for serious cases
- help with psychosocially complex and chronic cases
- implement on-site "curbside" consultation to help physicians treat ordinary mental health conditions in the practice
- help patients with chronic illness manage their disease (for example, diabetes, asthma)
- identify patients with depression who are elderly and/or have other chronic medical conditions
- help front-desk and other clinic staff regarding patients with challenging behaviors
- help getting patients ready for chemical dependency care

Similarly, integrated care initiatives must be designed around particular community-level and statewide considerations. There will not be one single type of approach for all communities. That's because each community differs in its needs, resources, and practice patterns, and these variables will influence the model that is the best fit.

Mauer and Druss (2007) have outlined several key issues to be considered by policymakers and other planners. Those considerations are as follows:

- *Array of and capacity of services in the community*. What services are available, and is there access to sufficient amounts of the services that are needed?
- *Trained workforce*. Do current behavioral health providers and primary care staff have the right skills to deliver planned services on-site? Pre-service and/or in-service training of primary care workers on mental health issues and of behavioral health providers on physical health issues are essential prerequisites for mental health integration. Collaborative or shared care models in which joint consultation and intervention are held between primary care workers and mental health specialists are an especially promising way of providing ongoing training and support.
- *Organizational support in providing services*. Do managers provide encouragement and support for collaborative activities, and what is the impact on operations, documentation, billing, and risk management?
- *Reimbursement factors*. Do payers support collaborative care and make it easy or difficult for the behavioral health care providers and primary care providers to work together?

- *The population that is targeted for services.* Is the focus on older adults, adults, children, ethnic populations, the privately insured, the publicly insured, the uninsured?
- *Consumer preferences.* Are patients more likely to accept care in primary care or specialty behavioral health settings?

Table 12 provides a summary of the collaborative approaches and practice models discussed in this report. Because the boundaries among models are diffuse, this summary is useful only to comprehend broad concepts and will not apply with exactness to many idiosyncratic implementations of collaborative care. For those interested in more program/model descriptions, an excellent source is the winter 2009 issue of the *National Council Magazine* by the National Council for Community Behavioral Healthcare.

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

	COORDINATED		CO-LOCATED	
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**
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
Type of Setting/ Provider of Behavioral Health Care	• Private practices; settings with active referral linkages • Care managers and behavioral health specialty providers	• Private practices; settings with active referral linkages • Physician or other medical professional with consultative support from a psychiatrist or other behavioral health professional	• HMO settings; medical clinics that employ therapists or care managers • Therapists and specialty mental health clinicians	• HMO settings; medical clinics that employ therapists or care managers • Care managers

		INTEGRATED	
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**
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
• HMO settings; medical clinics that employ therapists or care managers • Traditional mental health team members and a medical professional (nurse, nurse practitioner, or physician)	• Large practices and medical systems • Psychiatrists and therapist	• Large practices and medical systems • Mental health professional	• HMO settings; medical clinics that employ therapists or care managers • Care managers (though this may vary) with close collaboration among partner agencies

(continued)

TABLE 12 *(CONTINUED)*

	COORDINATED		CO-LOCATED	
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**
Populations Best Served	• Quadrants I and III (Low behavioral health needs) • Applicable to all ages	• Quadrants I and III (Low behavioral health needs) • Applicable to all ages	• Quadrants I–III (Low and high behavioral health needs) • Applicable to all ages with adaptations	• Quadrants I–III (Low and high behavioral health needs) • Applicable to all ages with adaptations
Barriers to Implementation	• 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	• 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	• 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	• 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

		INTEGRATED	
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**
• Quadrants II and IV (High behavioral health needs) • Applicable to all ages with adaptations	• 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	• 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	• Quadrants II and IV (High behavioral health needs) • Applicable to all ages with adaptations
• 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	• 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	• 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	• 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

(continued)

TABLE 12 *(CONTINUED)*

	COORDINATED		CO-LOCATED	
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**
Economic Outcomes*	• May generate savings because of more cost-effective treatment • Cost-offset savings possible	• May generate savings because of more cost-effective treatment • Cost-offset savings possible	• Generates savings because of leveraging • Generates savings because of cost-effectiveness • May generate cost-offset savings	• Generates savings because of leveraging • Generates savings because of cost-effectiveness • May generate cost-offset savings
Health Outcomes	• No evidence-based studies	• 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	• 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	• 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)
Why Choose This Model?	• When reimbursement structure does not support behavioral health in primary care or primary care in specialty mental health	• When reimbursement structure does not support behavioral health in primary care or primary care in specialty mental health	• When provider, either through billing or partnership, is able to sustain a more integrated model between primary care and specialty mental health	• 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.

		INTEGRATED	
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**
• Generates savings because of leveraging • Generates savings because of cost-effectiveness • May generate cost-offset savings	• Generates savings because of cost-effectiveness • Generates savings because of leveraging • Greatest potential for substantial cost-offset savings	• Generates savings because of cost-effectiveness • Generates savings because of leveraging • Greatest potential for substantial cost-offset savings	• Generates savings because of leveraging • Generates savings because of cost-effectiveness • May generate cost-offset savings
• 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)	• Patients less likely to have ER visits • Patients less likely to report a problem with continuity of care	• 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	• Evaluations are highly variable in this model • Potential for improved outcomes demonstrated in some studies
• When provider, either through billing or partnership, is able to sustain a more integrated model between primary care and specialty mental health	• 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	• 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	• When provider, either through billing or partnership, is able to sustain a more integrated model between primary care and specialty mental health

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.

INCREMENTAL STEPS IN A CHALLENGING FISCAL ENVIRONMENT

In the current fiscal environment, local and state governments are facing unprecedented budgetary pressures and fiscal constraints. It is more likely that jurisdictions may stage their pathway toward a close and fully integrated system. A tiered approach, albeit longer, may provide policymakers and other planners with an opportunity to obtain (and ensure) forward momentum. Table 13 provides an outline as to how a jurisdiction may take incremental steps in a challenging fiscal environment. Understandably, it would be beneficial to consider addressing the first tier before moving forward as these activities seek to reveal and maximize existing resources.

TABLE 13: INCREMENTAL STEPS FOR INTEGRATING CARE

TIER	ACTIVITIES	DESIRED OUTCOME(S)/ACTION(S)
Maximizing Existing Resources	Identify and empower a senior-level health leader with authority and accountability for developing a strategic integration plan.	Implementation of a shared strategic plan within state departments of health and human services, or the equivalent.
	Perform a comprehensive statewide environmental assessment that goes beyond departments. Include many perspectives such as provider and payer types.	The Federal Partners Primary Care/ Mental Health Integration Workgroup undertook a comprehensive review of federal agencies that included cataloging funding initiatives (Weaver 2008). An example: Medicaid EPSDT requirements (Title XIX) mandate comprehensive and preventive child health programs for individuals under the age of twenty-one. Preventive care services to identify physical and mental conditions must be provided during the beneficiaries' well-child visits. States also must provide other necessary health care, diagnoses services, treatment, and other

(continued)

TABLE 13 *(CONTINUED)*

TIER	ACTIVITIES	DESIRED OUTCOME(S)/ACTION(S)
		measures to correct or ameliorate defects as well as treat physical and mental illnesses and conditions discovered by the screening services (U.S. Department of Health and Human Services 2008).
	Integrate financial data for the purpose of analysis. Payment for services is often siloed within different systems, making total costs elusive. One example is when behavioral health is carved out.	Understanding of the total cost of care for an individual. Knowing the clinical profile of the highest-cost patients.
	Conduct a comprehensive review of laws that prevent communication and exchange of pertinent health information and seek to remove those barriers.	An example: the State of Wisconsin Act 108 removed state-imposed barriers to the exchange of information (State of Wisconsin Department of Health and Family Services 2007).
	Create standard protocols for laws outside of jurisdiction that support and promote the exchange of information between service providers. The protocols should clarify confidentiality provisions of HIPAA, state, and federal laws as they impact the exchange of information. Ensure that integrated care is part of the discussion regarding new HIT standards and meaningful use definitions.	A standard consent form that is state endorsed and can be used across the continuum of care.

(continued)

TABLE 13 *(CONTINUED)*

TIER	ACTIVITIES	DESIRED OUTCOME(S)/ACTION(S)
	Realign current workforce infrastructure to support evidence-based integrated care. Existing resources can be leveraged across systems.	Expansion of mental health case managers' roles to improve patient access to preventive primary care services. Expansion of disease management programs to incorporate behavioral health screenings and clinical pathways.
	Identify what information derived from administrative claims data is meaningful to providers and care managers caring for patients with behavioral and/or chronic conditions.	Reports of adverse events, medication compliance, or the absence of appropriate follow-up to identify gaps in care. If developed around the patients' needs versus the specific discipline of the provider, more collaborative and integrated processes will be encouraged.
Initial Investment of Resources	Develop medical home initiatives. Increasing health care reform discussions appear to support a medical home or primary care case management (PCCM) model. Generally, these models must demonstrate budget neutrality. For example, in the Community Care of North Carolina program, hundreds of millions of dollars have been saved by managing the highest-cost and highest-risk recipients through a population management strategy (North Carolina Foundation for Advanced Health Programs 2008).	Primary care provider taking a heightened responsibility for patient-centered care, of which integrating behavioral health could be a key component. Expanded definitions of care coordination, disease management, and care management to incorporate both physical and behavioral health.

(continued)

TABLE 13 *(CONTINUED)*

TIER	ACTIVITIES	DESIRED OUTCOME(S)/ACTION(S)
	Ensure that payment for services by more than one provider on the same day can occur, so that both a physical and behavioral health care provider can bill for services on the same patient.	Provider teams working to ensure that the right services are provided in a coordinated fashion.
	Work with academic and other training centers and national associations to create opportunities to increase knowledge and skill sets across disciplines.	Expansion of the number of providers that can support their patients' physical and behavioral health needs with evidence-based services. Training of residents and new behavioral health providers in using tools designed for implementation in an integrated setting.
Significant Redesign with Financial Incentives and Reim-bursement Structures	Recognize the shortage of primary care and realize that patients presenting at the primary care office with a variety of needs could be addressed by a behavioral health provider if so empowered. In addition, therapy codes for mental health, maternal health, and substance abuse exist that could be expanded to include behaviors related to tobacco, nutrition, exercise, sleep, pain, chronic medical conditions, and the development of self-management plans.	Integration of services results in additional brief codes being funded. The primary care provider is able to leverage the most appropriate team member for the patient and increase the efficiencies of the practice. The benefit is correctly structured into the health plan. For example, a brief smoking cessation session would not be applied to an individual's limited mental health benefit.

(continued)

TABLE 13 *(CONTINUED)*

TIER	ACTIVITIES	DESIRED OUTCOME(S)/ACTION(S)
	Ensure that primary care providers have access to timely, quality specialty mental health and substance abuse services so that patients can be moved up on the continuum of care as appropriate.	Primary care providers having timely access to psychiatric consultations via phone consultation, tele-medicine, or referral (on- or off-site).
	Ensure that psychiatrists have access to E/M codes if their responsibilities are to be expanded to include monitoring for physical conditions. For the patient with severe and persistent mental illness, they may be the only medical provider who has routine contact.	Psychiatrists being reimbursed in a manner that is consistent with their professional physician colleagues. Careful review of the health plan benefits to ensure that resources are reallocated to the E/M codes with parity.

RECOMMENDATIONS FOR HEALTH CARE DELIVERY SYSTEM REDESIGN TO SUPPORT INTEGRATED CARE

As policymakers, planners, and providers of physical and behavioral health care proceed with the steps to integrating primary care and behavioral health care, it is important to secure the buy-in of other key stakeholders in the community in order to truly redesign the health care delivery system. Policymakers can have the best vision; however, gaining traction throughout the medical community requires a multipayer and multistakeholder approach. Listed below are recommendations to consider whether *planning*, *designing*, or *implementing* a health care delivery system redesign that supports integrated care.

PLANNING

- Increase public-private partnerships by involving major players in the development of a shared vision. These include key governmental leadership, professional societies, major public and private payers, educational institutions, consumers, and provider representatives and individuals who understand complex reimbursement structures. Members of the business community and philanthropic organizations are often overlooked as important participants in this effort; their input and support should be obtained.
- Realize that jurisdictions will vary greatly in how their public programs are administered. In the event that public sector programs have contracted with commercial HMOs/MCOs, the state will need to drive contract negotiations to ensure quality standards. The National Committee for Quality Assurance (NCQA) has developed MCO accreditation standards for quality management and improvement with regards to behavioral health. The NCQA accreditation process for Medicaid health plans, though minimal, has components related to behavioral health (National Committee for Quality Assurance 2007).
- Consider a neutral entity to create a strategic plan for how primary and behavioral health care systems are integrated. For example, the Institute for Clinical Systems Improvement worked in Minnesota with medical groups, major health plans, the Department of Human Services, employer groups, and patients to create a process to fund care management and psychiatric consultation services via a bundled case rate (2008a, 2008b).

DESIGNING

- Investigate the National Council for Community Behavioral Healthcare (NCCBH), which has several tools that have been developed to assist jurisdictions in the planning and implementation stage. Its State Assessment of BH/PCP Integration Environment contains a comprehensive checklist for states (Mauer 2004).
- Encourage payers to run integrated financial data for the purpose of analysis with regards to clinical and financial outcomes. This review may identify common areas of concern and potential opportunity that can be the basis for shared objectives and can look at the issue of cost

shifting, which often occurs when one side reduces costs at the expense of the other side. For example, after running such an analysis, if multiple payers confirm that untreated substance use results in significantly higher cost in the medical benefit plan, they may opt to develop a joint plan of action.

- Utilize professional associations that are promoting the adoption of evidence-based standards of care for mental health and substance abuse in primary care for both adult and pediatric patients. For example, the American Academy of Pediatrics' *Bright Futures* publication (Hagan, Shaw, and Duncan 2008) contains many recommendations with regards to behavioral health, such as conducting a psychosocial/behavioral assessment for all ages and alcohol/drug use assessment for ages eleven through twenty-one. The work of the associations can assist the partners in keeping quality at the center of the discussion and create buy-in among providers. Consumer participation should also be secured in the development of the measures. However, adopt only the most meaningful measures so providers can move forward with clear objectives that are attainable in a timely fashion.
- Develop a shared implementation plan that is driven by data, evidence-based guidelines, and consumer input. It is likely that the financial and clinical data will drive the first phase of implementation and its ongoing monitoring.
    - Assess how current systems will perform when new services are provided by primary care and specialty mental health providers. Plan well and when possible develop consistent policy so that confusion at the provider level is reduced during implementation.
    - Walk through the model from multiple perspectives, taking into consideration state and federal policies, place of service, number of providers, authorization policies, and impact on medical visits and mental health visits. Run proactive diagnostic tests to confirm that the claim will be paid as expected. Administrators and providers become highly frustrated by denied claims. Discover and fix unanticipated financial edits contained within payment systems before going live.
- Ensure that implementation tools are designed with input from primary care providers, specialty providers, and consumers. Technical assistance and training during implementation will need to include clinical services, practice redesign, cultural competency, reimbursement, and policy. Plan for and fund the workforce necessary to train and support the primary and behavioral health providers with this substantial change in practice. Secure professional societies' endorsements and assistance in marketing, training, and communicating the clinical content.

IMPLEMENTING

- Reassure providers that integrated care is clinically beneficial and financially viable.
- Conduct technical assistance and training programs. Training needs are going to be substantial for both primary and behavioral health providers. Some will occur naturally with consultation

and integration. In addition to the training needs mentioned above, it will be crucial to adopt evidenced-based behavioral health tools designed for primary care as some primary care and specialty behavioral health providers may not be well versed in these clinical pathways. Specialty mental health providers will also need support and training to adopt evidenced-based physical health screenings.

- Identify opportunities for primary care providers to achieve the NCQA standards for a patient-centered medical home (National Committee for Quality Assurance 2008). Key components include patient tracking and registry functions, case management, adoption and implementation of evidence-based guidelines, patient self-management support, and referral tracking. Identify opportunities to ensure that these new tools incorporate and address patients' physical and behavioral health care needs.
- Set realistic timelines for project and practice implementation. A good plan may take several years to implement and should be accomplished in a thoughtful process.
- Share information with providers and other interested stakeholders when claims data and quality outcomes are measured.

CONCLUSION

It is widely anticipated that the integration of primary care and behavioral health services will be a key part of health care reform in the coming decade. And redundancies in health care administrative and service delivery structures will continue to fuel the call for integrated care.

While the drive to integrate services has emanated primarily from primary care, the mental health system has an obvious stake in it. The mental health system must actively work with primary care to support and enhance the role of primary care providers in delivering mental health care.

It is important to recognize that the current health care environment is embracing quality improvement and the concept of the patient-centered medical home. At the same time, all stakeholders understand the need to contain costs and to streamline care, thus providing the health care industry with an extraordinary opportunity to reshape the way behavioral health care is provided. The current fiscal climate, though daunting, can be the needed stimulus (or catalyst) for jurisdictions to redesign their delivery system in a holistic and patient-centered manner, using an integrated approach that is able to meet the full spectrum of a patient's physical and behavioral health care needs. Commitment from jurisdictions to integrate mental health care is fundamental to success. Integration can be facilitated not only by mental health policy but also by strong health policy that emphasizes mental health services within primary care. It is hoped that our collective efforts will, as Strosahl said in 1997, create an integrated system where "the mind-body schism [will be] forever sealed."

RESOURCES

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Aetna Depression in Primary Care: www.aetna.com/aetnadepressionmanagement/teamMembers/carePlanners.html.

American Academy of Family Physicians: www.aafp.org.

American College of Lifestyle Medicine: www.lifestylemedicine.org.

Canadian Collaborative Mental Health Initiative: www.ccmhi.ca.

CareIntegra: www.careintegra.com.

Cherokee Health Systems: www.cherokeehealth.com.

Collaborative Family Healthcare Association: www.cfha.net.

Commonwealth of Pennsylvania Screening, Brief Intervention, Referral and Treatment: www.ireta.org/sbirt/.

Health Buddy System: www.healthbuddy.com.

Hogg Foundation for Mental Health: www.hogg.utexas.edu/programs_ihc.html.

ICARE Partnership: www.icarenc.org.

Integrated Behavioral Health Project (IBHP): www.ibhp.org.

Integrated Primary Care, Inc.: www.integratedprimarycare.com.

Intermountain Behavioral Health Program: www.intermountainhealthcare.org.

iPSYC: www.ipsyc.com.

John A. Hartford Foundation—Improving Mood: Promoting Access to Collaborative Treatment (IMPACT): www.jhartfound.org/program/impact.htm.

Judge David L. Bazelon Center for Mental Health Law: www.bazelon.org.

MacArthur Initiative on Depression and Primary Care: www.depression-primarycare.org.

Mountainview Consulting Group: www.behavioral-health-integration.com.

National Council for Community Behavioral Healthcare: www.nccbh.org.

National Institute on Alcohol Abuse and Alcoholism: www.niaaa.nih.gov.

Substance Abuse and Mental Health Services Administration's Guide to Evidence-Based Practices (EBP) on the Web: http://samhsa.gov/ebpWebGuide/index.asp.

Substance Abuse and Mental Health Services Administration's Screening, Brief Intervention, and Referral to Treatment Initiative: http://sbirt.samhsa.gov/about.htm.

Substance Abuse and Mental Health Services Administration's State Planning and Systems Development Branch: http://mentalhealth.samhsa.gov/publications/allpubs/KEN95-0021/default.asp.

Technical Assistance Partnership for Child and Family Mental Health—Sustaining Systems of Care: http://tapartnership.org/SOC/SOCsustaining.php.

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AMERICAN MEDICAL ASSOCIATION—CURRENT PROCEDURAL TERMINOLOGY CODES*

- Alcohol and/or substance (other than tobacco) abuse structured screening (for example, AUDIT, DAST) and brief intervention (SBI) services (99408/99409)
- Smoking and tobacco use cessation counseling visit (99406/99407)
- Administration and interpretation of health-risk assessment instrument (for example, health hazard appraisal) (99420)
- Health and behavior assessment and intervention codes (for example, health-focused clinical interview, behavioral health observations, psychophysiological monitoring, health-orientated questionnaires), each fifteen minutes face to face with the patient, utilized with medical diagnostic codes (96150–96155)
- Telephone evaluation and management services to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days or leading to an E/M service or procedure within the next twenty-four hours or soonest available appointment. Provided by physician (99441–99443) and provided by a qualified nonphysician health care professional (98966–98968)
- Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (for example, nurses, therapists, social workers, nutritionists, physicians, pharmacists) to report on tests and/or laboratory results, to clarify or alter previous instructions, to integrate new information from other health professionals into the medical treatment plan, or to adjust therapy (99371–99373)
- Therapy codes allowing for brief and traditional mental health services (90801–90857)
- E/M—Office consultation for a new or established patient, which requires varying levels of key components: history; examination; medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs (99241–99245)
- E/M—Office or other outpatient visit for the evaluation and management of a new patient, which requires varying levels of key components: history; examination; medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs (99201–99205)
- E/M—Office or other outpatient visit for the evaluation and management of an established patient, which requires varying levels of key components: history; examination; medical decision making.

* http://www.ama-assn.org/ama/pub/category/3113.html

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs (99211–99215)

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