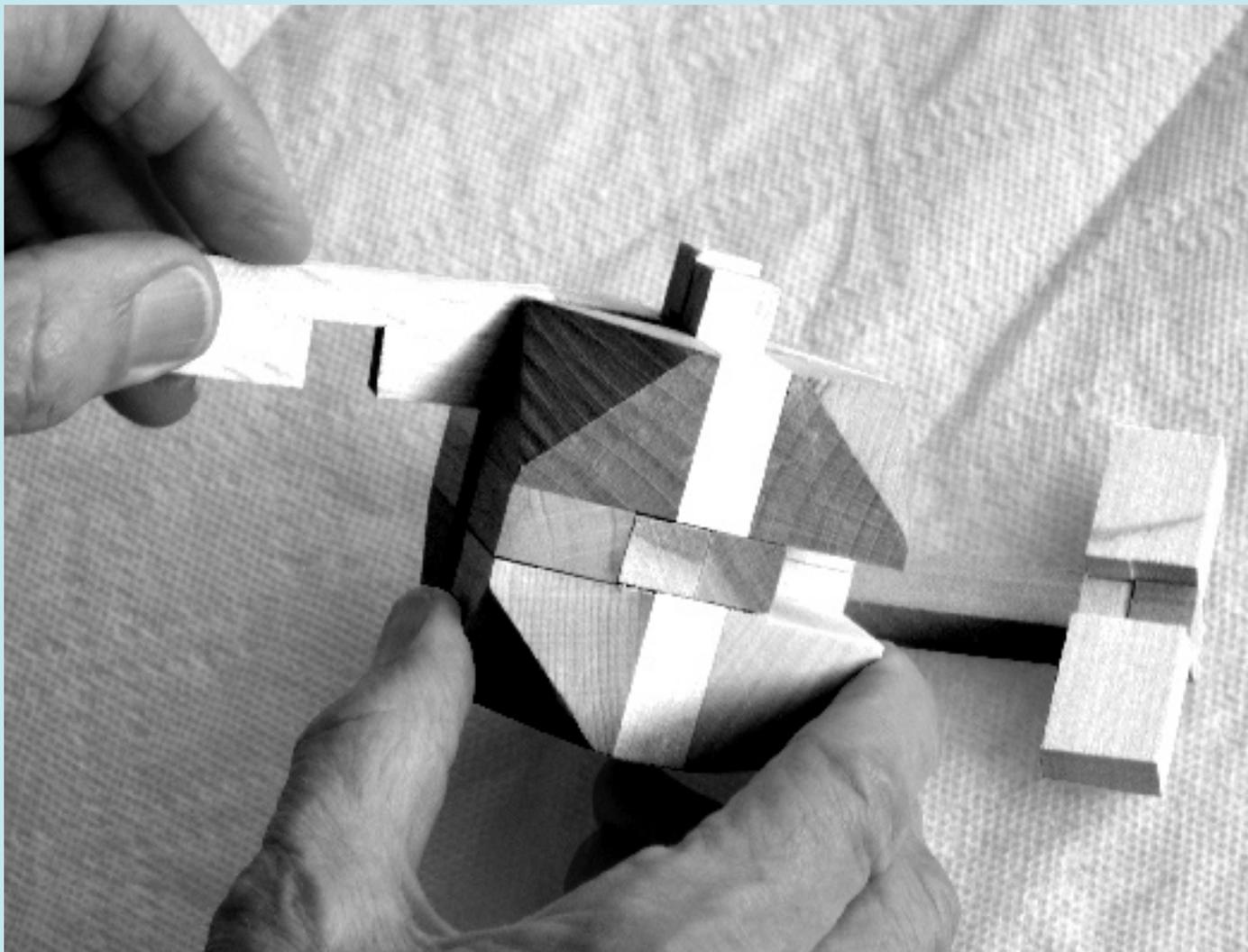


# GET IT TOGETHER



## How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders

EXECUTIVE SUMMARY OF  
A REPORT BY THE BAZELON CENTER FOR MENTAL HEALTH LAW  
JUNE 2004

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## How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders

### EXECUTIVE SUMMARY

This report examines model programs for improving integration and coordination of behavioral health and primary health services for adults and children with serious mental disorders who rely on the public mental health system for their care. It summarizes findings of a series of studies and offers recommendations for policymakers.

There is an extensive body of literature and demonstration projects to improve integration of mental health in primary care for individuals with mild to moderate mental disorders. The Bazelon Center's study fills a gap by focusing primarily on integration of care for people with serious mental illnesses.

The problems stemming from a fragmented health care system are particularly acute for this population. In a recovery-oriented mental health system, physical health care is as central to an individual's service plan as housing, job training or education.

Recently, the President's New Freedom Commission on Mental Health stressed the importance of a recovery-oriented public mental health system with services based on a single, comprehensive plan that focuses on all of a consumer's service needs. The Institute of Medicine has also called for the "coordination of care across patient conditions, services and settings over time," while recognizing this as a major challenge. However, creating the necessary structures and incentives for integrated care is not simple.

We examined several models, from unified physical and behavioral health programs to improved collaborations across separately located providers. To differentiate between the models, we use the term "integration" when

physical and mental health care services are delivered to the individual in a unified and holistic manner and "coordination" when information is shared and separate providers are linked through special initiatives or policies.

#### **People with serious mental disorders often have serious physical health care problems.**

Numerous studies over the last 30 years have found high rates of physical health-related problems and death among individuals with serious mental illnesses. In one study, nearly half had at least one chronic illness severe enough to limit daily functioning. People with mental

illnesses are also more likely to have multiple physical disorders. A study in Massachusetts found that adults with a mental illness were roughly twice as likely to have multiple medical disorders as adults without a mental illness and that those with both a mental illnesses and a substance abuse disorder were the likeliest of all to have medical problems.

Many of these physical health problems are very serious. A recent study of adults discharged from psychiatric hospitals found 20% with chronic and serious conditions such as HIV infection, brain trauma, cerebral palsy and heart disease. As many as 75% of individuals with

schizophrenia have been found to have high rates of serious physical illnesses, such as diabetes, respiratory, heart and/or bowel problems and high blood pressure. High rates were also seen for vision (93%), hearing (78%), and dental (60%) problems.

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In part due to a predisposition to diabetes but also from the effects of atypical antipsychotic medications, which exacerbate this predisposition, individuals with schizophrenia have especially high rates of diabetes.

Cardiovascular diseases are also very prevalent among people with mental illnesses. Again, psychiatric medications exacerbate the problem because they are associated with obesity and high triglyceride levels, known risk factors for cardiovascular disease. Adults with serious mental illnesses are known to have poor nutrition, high rates of smoking and a sedentary lifestyle—all factors that place them at greater risk for serious physical disorders, including diabetes, cardiovascular disease, stroke, arthritis and certain types of cancers.

While children with serious mental disorders do not appear to have parallel high rates of physical disorders, many adolescents engage in risky behavior, such as alcohol or drug use, smoking or unprotected sex. Further, the increased use of psychiatric medications with this population may contribute to obesity and the risk of diabetes and cardiovascular disease.

Despite such extensive medical needs, adults with serious mental illnesses often do not receive treatment. A review of 18 studies estimated that, on average, 35% of individuals with serious mental disorders have at least one undiagnosed medical disorder. Among people with schizophrenia, fewer than 70% of those with co-occurring physical problems were currently receiving treatment for 10 of 12 physical health conditions studied. Preventive services are also lacking: a study of veterans with mental illnesses found lower rates of vaccinations and cancer screenings.

The consequences are dire. Individuals with serious mental illnesses living in the community have age-related mortality rates 2.4 times the rate for the general population. The lifespan for men with schizophrenia is about 10 years shorter than average—among women, nine years.

Clearly, regular primary care services are needed to protect the health of people with serious mental illnesses. Integration of that care with behavioral health services is particularly important because it produces better outcomes. For example, a study involving 120 veterans with serious mental illnesses found that those who received

care at an integrated site were more likely to make primary care visits and less than half as likely to have emergency visits.

## **PRINCIPAL BARRIERS TO INTEGRATED CARE**

Historically, people with serious mental illnesses have been treated as if mental illness were the sole defining factor of their health and their lives. Separate health, mental health and substance abuse service delivery systems and funding sources, differences among providers in practice orientation and training, and various consumer concerns are just some of the barriers that must be overcome to deliver effective integrated care. Despite widespread understanding that fragmentation negatively affects quality of care and outcomes, a number of stumbling blocks remain.

### ***Patterns of financing create problems.***

In the public sector, health, mental health and substance abuse services are funded separately, reinforcing the segregation of services and delivery systems. This segregation is perpetuated in managed care arrangements in which physical health and behavioral health care services are provided under separate contracts.

The payment system constrains efforts to improve integration since providers generally are not reimbursed for time spent communicating with colleagues and are discouraged by inadequate reimbursement for the longer office visits that would uncover issues beyond the primary presenting disorder. In recent years, resource pressures have led to primary care office visits typically no longer than 13 to 16 minutes.

### ***Cultural differences lead to isolation.***

A long history of separation has left providers unfamiliar with issues in the other's field. While psychiatrists may discount primary care physicians' knowledge of mental health issues, primary care physicians often see psychiatrists as inaccessible, non-medical and uncommunicative. Medical school and residency programs contribute to these views by emphasizing the biomedical, technical aspects of care and not giving adequate weight



to psychosocial factors. Already somewhat skeptical about whether mental health diagnosis and treatment is evidence-based, primary care physicians are likely to consider substance abuse treatment as outside the mainstream, more the province of social services than of medicine.

Primary care providers generally communicate more easily with other specialists than with behavioral health providers. Since behavioral health practitioners often do not provide care in hospitals, they may be isolated from both primary care and specialty physicians. Studies suggest that personal knowledge is the most important factor in identifying a specialist, so the lack of regular contact is a barrier to referrals and collegial interaction.

Differences in professional style impede close working relationships. Primary care physicians often experience frustration in attempts to work with mental health providers, particularly with public mental health programs, because they are unaccustomed to working with agencies and interdisciplinary teams. They may become discouraged if they cannot reach a psychiatrist and are expected to discuss a case with another mental health professional or case manager.

Cultural barriers are an even greater problem between primary care and substance abuse providers. Some substance abuse treatment programs preclude the use of medications, while physicians generally have a much more positive view of pharmacological treatment. Substance abuse providers are often dismissive of physicians who they believe ignore substance abuse issues. Even the integration of mental health and substance abuse care is problematic due to cultural differences among providers.

### **Training is key.**

Most primary care physicians do not receive significant training in psychiatry or practice guidelines that emphasize integration of mental health and primary care services. We found more than a dozen studies that examine the poor rate of recognition of mental disorders in

primary care settings, showing that half to two thirds of diagnosable mental disorders go unrecognized.

Other barriers that make primary care providers hesitant to serve people with mental illnesses are concerns about their own skill in identifying mental disorders, worries about time constraints and limited access to professional backup when serious problems are uncovered. A study of more than 700 pediatricians found that most lack confidence in their own diagnostic skills and knowledge of mental health issues.

Similarly, mental health providers tend to overlook signs of physical disorders, with consumers reporting that their health concerns are often dismissed as psychosomatic or the result of their mental illnesses. This problem is exemplified in a study indicating that nearly half of women's health problems were over-

looked by psychiatrists.

Generally, neither group receives training related to collaborative practice arrangements, interagency systems or interdisciplinary teams.

### **Needed services are often unavailable.**

According to the President's New Freedom Commission on Mental Health, the public mental health system is "in shambles," with the capacity to provide only a minimal level of care. As a result, most public systems only accept individuals with the most serious mental disorders. Substance abuse systems likewise limit eligibility to particular priority populations.

Primary care providers are reluctant to refer patients if there are long waiting lists for services and if they have been unable in the past to secure mental health speciality services for their patients. When primary care providers cannot make needed referrals and are not told why, they presume that effective collaboration is not feasible.

Access to primary care is also an issue. Studies consistently show that people with mental disorders are less likely to be treated for physical conditions and less likely

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to receive preventive care. Even when individuals have health insurance, this lower level of service is seen, suggesting that multiple factors influence the disparity.

### **Information-sharing is essential but difficult.**

While behavioral health service plans are long and focused on the broad array of issues that must be addressed, primary care records are short summaries. When sent a typical mental health record, primary care providers may be frustrated by the difference in orientation and the time it takes them to find needed information.

Information systems, too, are often different in mental health and primary care offices. With electronic records, the software may be incompatible or, when records are kept on paper, reporting forms, if they exist, may not include the information needed.

Confidentiality laws and practices for mental health and substance abuse are more stringent than for physical health care. A study of three Medicaid behavioral health plans found that information-sharing between providers in different systems is hindered by differing confidentiality rules. Before records can be shared, individuals must sign a separate release authorizing their mental health or substance abuse providers to furnish information to their primary care physician. Some behavioral health providers simply do not ask for authorization nor do they discuss the advantages of sharing information with others who are involved in the consumer's care.

### **Consumers have concerns.**

Studies have consistently documented that adults with serious mental illnesses face barriers in obtaining health care and seek it less frequently than others. Over half of individuals with mental illnesses reported at least one perceived barrier to care (such as transportation problems), while only 19% of the general population reported facing one or more of these barriers.

Consumers may have difficulty understanding how to get services and how to follow treatment instructions, or they may avoid medical care due to fear. Isolation, cog-

nitive impairment, attentional difficulties or other behavioral factors may play a role and make interactions with primary care providers problematic. Some individuals may forego needed medical care because of prior negative experiences with providers.

Many mental health consumers are also concerned about disclosing information about their mental illness or substance abuse problem due to the potential for discrimination and social isolation. Older adults often have an even greater fear of stigma.

## **SERVICE DELIVERY MODELS FOR INTEGRATED CARE**

Although the barriers to effective integrated care for individuals with serious mental disorders are many, it is encouraging that a number of piloted programs have achieved some measure of success. This report examines four approaches: 1) the embedding of primary care providers within public mental health programs; 2) unified programs that offer mental health and physical health care through one administrative entity; 3) initiatives to improve collaboration between independent, office-based primary care and public mental health; and 4) co-location of behavioral health providers in primary care offices.

The following sections discuss the ability of the first three models to overcome the above-cited barriers to integrated care for people with serious behavioral disorders. The fourth, co-location, examined briefly in the full report, is best used for integration of services to consumers with mild to moderate mental illnesses, who are seen mostly in primary care settings.

### **Primary care embedded in a mental health program**

The embedding of primary care in a mental health program ensures strong working linkages between primary care and mental health providers and is particularly appropriate for adults with serious mental illnesses, whose

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primary contact with the health system is through their mental health provider. We studied four examples.

These programs allow extra time in primary care visits for providers to deal with the more complex medical issues presented by these individuals. Many of the programs are staffed with physician assistants and nurses, who typically have more flexible schedules than physicians. Routine appointments may be 30 to 45 minutes. To address the lack of resources for integrated care, these programs rely on both third-party reimbursements and specific funding to cover the cost of the longer appointments and the time providers spend in collaboration.

Cultural barriers often evaporate in an embedded program. When providers are co-located, daily interactions lead to more collegial work, higher quality care and greater consumer satisfaction. Practitioners learn from each other informally and their more formal training needs are met in planned professional-development activities. In an embedded model, primary care providers develop a better understanding of why patients fail to follow through on health care advice and develop more effective strategies. One of the most striking findings from these case studies is that many of the barriers to integration (particularly those that stem from cultural differences or lack of provider training) are overcome without special initiatives.

Information-sharing is greatly improved in embedded programs, where the importance of an integrated medical record is recognized. Many of the programs are also developing electronic record systems. Consumers report greater comfort with information-sharing among providers when the providers operate out of the same program.

Improved access to health prevention and treatment occurs in these programs. In addition to clinical services, support groups, health education classes and other activities are offered. Consumers are helped to develop the skills and motivation to take an active role in managing their own health, such as by diet and exercise, and by following treatment regimens. Embedded programs have

also developed initiatives to address the high prevalence of certain disorders, such as diabetes, hypertension, tobacco abuse, asthma, obesity, foot problems, HIV and dental problems.

To ensure consumers of access to primary care services as part of their service plan, the mental health team must be responsible for ensuring that consumers access the primary care services on a regular basis.

Providers in embedded programs report greater satisfaction and feel that integration has improved access and quality. They note improved diagnosis and treatment of previously unreported but significant illnesses and an increased number of consumers who receive regular screening, health education and preventive services. As a result, individuals in embedded programs are less likely to use emergency rooms and crisis-oriented health services.

Consumers report more comfort with primary care providers who work in a program for people with serious mental disorders. They were enthusiastic about embedded programs and about a “one-stop shopping” approach.

Embedded programs visited were operating in either rehabilitation or day treatment programs. There are significant advantages to incorporating primary care within a rehabilitation program because of the program’s emphasis on recovery and focus on self-management skills. In some areas, accessible primary care services could be made available within an outpatient mental health clinic program. One option is for mental health agencies is to ask a local community health center to establish a satellite primary care clinic within the mental health agency.

### **Unified primary care and mental health programs**

Combining publicly funded primary care and behavioral health into a unified program is the most seamless approach of the models studied, integrating not only delivery of care but also administration and financing. We studied three sites, each providing a full range of

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behavioral health and primary care services, using multiple providers who work as an integrated team. One is a combined community health center and community mental health center. Others are not single entities but collaborations across a number of agencies. Participating agencies may include mental health, substance abuse, health, Medicaid, maternal/child health, child welfare and juvenile justice.

One of the strengths of this approach is that it overcomes barriers regarding time and resources for collaboration. Providers are paid through the agency for time that is required for collaboration, including reimbursement for in-person attendance at case-planning team meetings.

Unified arrangements are economically efficient, offering opportunities for administrative savings and physical plant efficiencies. Data from the Mental Health Services Program for Youth in Massachusetts, for example, showed that in the first year it reduced per member/per month costs by 18% over the estimated capitation rate.

Overcoming financing barriers has been effective at Cherokee Health Systems, a community mental health center and federally qualified community health center providing integrated services at 21 sites in Tennessee. Cherokee obtains reimbursement from payers to cover its costs. It also can access special financing for rural areas or underserved populations.

The other programs have special funding arrangements and receive support from other sources, such as a medical school, the state or the county.

Cultural barriers are overcome in the unified programs, as in the embedded programs, and for similar reasons. In addition, in a unified model, integration is an agency-wide effort involving both clinical and administrative staff. As a result, all staff become sensitive to consumer issues, and programs have fewer worries about inexperienced personnel who lack the understanding and patience to work with this population.

Information-sharing is addressed in unified programs, which generally work with an integrated medical record

containing physical health records, mental health records and prescription drug information. With single records, paper or electronic, providers do not have to duplicate health histories or depend on patient recall to learn about treatment plans. Individuals with serious mental illnesses also are less concerned about the sharing of information with their primary care provider in a unified program where staff clearly work together.

Access, continuity and quality of care improve in these models and the advantages are similar to those described for the embedded primary care model. For consumers, these programs provide a single point of access whether they present with a physical or a mental health problem. Consumers find the “no wrong door” approach to all of health care more friendly, less stigmatizing and easier to access. Unified programs ease concerns about stigma because the facility is not singled out as a mental health site.

### **Policy for an integrated approach**

Making health care more accessible to adults in the public mental health system should be a high priority

for policymakers. Whether primary care is embedded in a mental health program or services are provided in a unified mental health and primary care program, these models have produced excellent results and reduced health disparities among people with serious mental illnesses. Outcome and consumer-satisfaction data, as well as anecdotal reports, support the finding that these programs are very effective in meeting the needs of individuals with serious mental illnesses.

For each model, there are policy issues to be resolved regarding service delivery, financing, monitoring and quality assurance. Integration policy must focus first

on ensuring that clinical integration occurs, and then the structures must be designed and financing mechanisms put in place to support it.

In developing policy to encourage either embedded or unified programs, policy approaches might include:

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- ◆ ***Providing start-up funds for establishment of embedded or unified programs*** to cover clinical and administrative needs. These monies may be provided by the public mental health authority or sought from foundations, businesses, government and other health care agencies. Funded agencies must ensure that individuals have a consistent and regular source of primary care.
- ◆ ***Stipulating the requirements that mental health agencies furnishing on-site primary care must meet***, related to delivery of care (health assessments, prevention and treatment), development of a unified plan of care, information-sharing and case management services.
- ◆ ***Ensuring that reimbursement rates reflect the cost of providing services and the time spent on care coordination*** for individuals with serious mental illnesses and co-occurring physical disorders. In a fee-for-service arrangement, payers should develop billing codes that allow providers to be compensated for longer office visits and for collaboration. In managed care, payers should provide higher capitation rates for individuals with serious mental disorders and co-occurring health conditions. Increased costs associated with this risk adjustment will be offset by reduced use of hospital or other costly crisis services.
- ◆ ***Placing the responsibility for primary care services to individuals with serious mental illnesses clearly on one entity.*** Medicaid managed care payments for primary care should be made to unified or embedded programs. To accomplish this, managed health care plans should be required to credential and include in their network providers working in a unified or embedded program. Alternatively, individuals with serious mental disorders could be allowed to opt out of their managed health plan for primary care and their capitation payment could follow them to either a mental health carve-out plan or (in a fee-for-service system) to a mental health provider agency.

Creation of a unified program requires planning and collaboration between leaders of previously separate entities. Merging of a community health center and a community mental health center is a model that states may

want to explore, particularly for underserved rural areas. If the resulting unified agency is led by mental health professionals, it will be stronger on mental health care delivery. However, if it is led by a primary care agency, there may be a need for requirements to assure effective behavioral health care and provision of a full range of mental health services, including psychiatric rehabilitation.

### **Improving collaboration between separate providers**

We studied four state Medicaid systems addressing coordination of primary care and behavioral health for people with serious mental disorders, in Massachusetts, Michigan, Oregon and Oklahoma. Strategies used to improve collaboration include special targeted programs, financial incentives, managed care contract requirements, and provider education and training.

Integration of care is difficult when providers practice separately and have separate administrative structures, information systems and funding sources. This model requires numerous adjustments and special efforts to overcome each of the barriers to collaboration. On the other hand, this approach causes the least disruption to traditional practice.

Lack of time for collaboration is an issue in the four systems reviewed. Although each provides a higher capitation rate for people who are eligible for Medicaid as a result of disability, few systems increase capitation for individuals with the most severe mental illnesses or with co-occurring physical disorders. While adjustments to capitation and reimbursement rates have helped, they have not fully addressed the time and funding constraints that deter meaningful collaboration.

Compensating for lack of financial compensation, some of these projects provide mental health backup to primary care providers, such as mental health consult lines or mobile mental health assessment teams to screen primary care patients in a psychiatric emergency.

To overcome cultural differences, some mental health agencies reach out to offer opportunities for interaction between their mental health practitioners and primary care practitioners. These can be formal or informal opportunities to forge better working relationships.



Information flow is more difficult between separate providers. A common complaint in the site visits, from both behavioral health and primary care providers, was lack of feedback after making a referral. Strategies to address this include significant use of case managers or having a case manager or psychiatric nurse accompany the consumer on a primary care appointment so that key information can be shared with clinical staff at the mental health program.

In fact, the most common strategy to overcome barriers to coordination between separately located providers is to give case managers this responsibility. In the four states studied, managed care contracts require health plans to offer case management for complex and high-cost cases. Case managers for physical health care may be registered nurses and often work closely with mental health system case managers. In one state, both work out of the same office, conduct home visits together and coordinate closely on individuals' needs. Some states have varying levels of case management to meet the varying needs of consumers who need intensive services, short-term support or targeted, one-time outreach.

Information-sharing could be improved if health plans used quality assurance mechanisms to address coordination. However, where this occurs the results show that information-sharing still does not always occur, suggesting that incentives may be needed. The accuracy of pharmacy information can be improved if providers develop a system to update each other regularly on new prescriptions rather than relying on patients' self-report.

Privacy laws and practices are also a greater barrier between separately located offices, as separate consent is required for the sharing of information. Some consumers appear reluctant to agree due to concerns about how their independent primary care provider might then view them.

Access to mental health or primary care services can be improved when programs provide transportation. Some mental health programs have staff who accompany members to primary care appointments to cut down on

the number of missed appointments. Some states require their Medicaid health plans to do outreach to those who miss scheduled follow-up.

To overcome training deficits, several systems had developed information materials and training sessions for primary care providers to improve their management of individuals with mental health care needs.

Despite these efforts, consumers in systems where behavioral and physical health care is furnished separately report little collaboration. They also continue to have concerns about providers' sharing information about them, particularly if they have not had a chance to review it first.

Although efforts to improve collaboration and bridge the cultural divide among separate providers have been somewhat successful, it is apparent that many problems remain. Moreover, these initiatives had to engage in several layers of effort to overcome barriers that would fall by them-

selves if the providers were working together as a team out of one location.

### **Policy for a collaborative approach**

Various policy strategies can encourage greater coordination between different sites, including mandates for mental health provider agencies to more comprehensively address their consumers' physical health care needs and to demonstrate strong linkages with local primary care providers. A mix of incentives and mandates laid out in this report could bring more attention to collaborative care.

- ◆ ***Initiatives to improve communication and understanding between the two fields*** can be built into contracts for public care. Case managers will play a critical role in linking consumers to all providers of their care. Information-system problems could be addressed by facilitating the adoption of electronic records and developing standard, simplified forms for sharing information with primary care providers.
- ◆ ***Consumers can be encouraged to consent to information-sharing***, helped to appreciate its importance

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and allowed to participate in decisions about what will be shared.

- ◆ ***Access will be improved if primary care providers receive information on local mental health resources*** and how to access care from the public mental health system. Consumers might be provided transportation passes or accompanied on visits to make it easier for them to see their primary care provider.
- ◆ ***Consultations should be readily available*** to ensure that primary care providers have sufficient behavioral health support. Psychiatric phone consult lines and mobile mental health teams are two ways to provide backup when prompt responses are needed.
- ◆ ***Funding strategies include the use of performance measures, coupled with incentives***, for health plans to ensure greater collaboration with behavioral health providers or carve-out plans. In both fee-for-service and managed care plans, resources should be provided for extra time to meet the primary care needs of individuals with serious mental disorders and for the time to engage in collaboration across systems.
- ◆ ***Agencies can provide educational materials and organize continuing education programs*** to help primary care providers acquire the skills to work with individuals with serious behavioral health disorders. Also, mental health provider agencies should be encouraged to meet with local primary care providers who serve significant numbers of consumers with mental illnesses to discuss problems of collaboration and work out solutions and new approaches.

## **OTHER POLICY RECOMMENDATIONS**

In addition to adopting policies that foster a particular model of integrated or coordinated care, states may need to adopt broader policies, affecting the public mental health and primary care systems more widely.

### **Monitoring, quality assurance, evaluation**

Current Medicaid contracting language to improve integration of care is ineffective, since states generally have only broad contract provisions with no details on how this is to be achieved. States should make more use

of incentives to improve performance.

Since effective monitoring depends on good data, health and behavioral health plans and fee-for-service providers should be required to collect and report data, such as:

- ◆ health-status indicators for mental health consumers, including blood glucose levels for diabetics and blood pressure levels for hypertensives, number who receive appropriate preventive health care screenings and health education, and number who adopt changes related to exercise, smoking, weight and nutrition;
- ◆ use of emergency rooms for physical health care issues (pre- and post-integration);
- ◆ admissions to psychiatric facilities and average lengths of stay (pre- and post-integration);
- ◆ other quality assurance measures, e.g., chart reviews;
- ◆ number of charts with signed consent forms and indications that communication between the mental health and the primary care provider has occurred;
- ◆ indications in charts that various prescribers have exchanged pertinent information on medications; and
- ◆ consumer and provider satisfaction surveys.

After three years of operation, states may also wish to evaluate their new initiatives, contracting for an independent cost-benefit analysis of data over a five-year period.

### **Training**

Various strategies can help practitioners improve care integration, such as:

- ◆ feedback to practitioners about how their care management measures up to their peers' and to practice guidelines through the use of provider profiles;
- ◆ training programs and behavioral health support for providers who care for individuals with significant behavioral health and medical care needs; and
- ◆ conferences and educational programs with incentives to participate, such as continuing education credits.

### **Software development**

Software development has been costly and time-consuming for the programs we studied. States may wish to consider either developing model software to handle inte-

grated records for local agencies to use or providing grants for agencies to develop their own software.

### **Privacy**

States should ensure that all providers engaged in integrated care understand the privacy requirements of the federal Health Insurance Portability and Accountability Act (HIPAA) and state privacy laws. Among other provisions, HIPAA requires that mental health provider notes not be shared without a specific and separate consent from the consumer, that individuals have access to their own medical record if they wish and that record-sharing is documented in the individual's record.

### **Consumer issues**

States should support initiatives to help consumers take an active role in managing their chronic medical and behavioral health conditions. Educational efforts should include information on wellness. Mental health programs serving meals should emphasize good nutrition. Health education classes and support groups can help consumers learn to take an active role in managing their health.

### **State agency communications**

Communication and collaboration between state Medicaid agencies, health and mental health authorities and substance abuse agencies is essential. These agencies should engage consumers, families and other stakeholders in discussions of how to improve integration of care.

### **FEDERAL GOVERNMENT POLICIES**

The report makes several recommendations on how the federal government can also play a role in promoting integration of care. For example, changes are needed to current federal Medicaid policy that does not allow payment for more than one office visit on the same day.

Other federal agencies could develop quality of care and performance measures related to integration, fund demonstration projects of embedded and unified programs and provide technical assistance to the field. Federal resources for improving provider and system infrastructure would be valuable, including grants for work-

force development initiatives to ease provider shortages and for development of information systems capable of integrating physical and behavioral health information.

### **CONCLUSION**

Integration of physical health care with behavioral health care for adults and children who have serious mental disorders is extremely important to consumers and a priority policy of the Bazelon Center. Until now, discussions of integration have tended to focus on the need for behavioral health support within primary care practices, principally to address mild or moderate mental disorders such as depression. Little has been written about how to integrate care for people with serious mental disorders.

Any recovery-oriented public mental health system must develop a consumer-driven vision of integrated care. Therefore, regardless of the specific approach considered, it is extremely important to engage consumers, families and other advocates in the development of new policies.

The site visits conducted for this report are encouraging. They indicate that embedding primary care within a mental health program or unifying mental health and health care delivery agencies yields by far the best integration of care for individuals using public mental health services. Once primary care and behavioral health providers are working in close proximity, thorny problems of communication and cultural differences dissolve and extensive policy micro-management is unnecessary. However, some consumers may still prefer to continue seeing a separately located primary care provider, and for them greater collaboration across separate providers is needed.

It is time for policymakers to ensure that people with serious mental disorders fit into a unified health care system that offers parity between health and mental health care. Integration of primary care and mental health services holds the promise of moving behavioral health care delivery closer to the mainstream. This study confirms that where there is a will, there are many ways to approach this problem, with a good potential for success.

Models exist. Needed now is the political will to get it together and action to make the necessary changes.

