

Fostering Sustainable, Integrated Medical and Behavioral Health Services in Medical Settings

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The integration of behavioral health (BH) and primary care services has been the subject of considerable attention for almost a decade. Such work has been motivated by the prevalence of chronic health problems in persons with BH conditions and correspondingly high rates of early death. Service integration efforts typically included cross-referral or bidirectional efforts to add some features of primary care to specialty BH settings or the reverse. This article proposes a third approach based on full service and financial integration and shows how it differs substantially from the other 2 models.

This new model has the potential to bring much-needed BH services to persons served in primary care settings who have these conditions, while fostering integrated services in specialty settings for those with the most severe mental or substance use conditions. The Patient Protection and Affordable Care Act could provide a valuable opportunity to implement this third model.

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An urgent need exists to improve the integration of care for mental and substance use disorders (or behavioral health [BH]) into primary and specialty medical services. Studies indicate that public sector patients receiving BH services in standalone BH settings have a shorter life expectancy (by 8 to 30 years) than Americans without BH conditions (1, 2), a phenomenon often attributed to lack of access to primary health care services. On the other hand, most patients with BH conditions are seen exclusively in either primary or specialty medical care settings, but most do not receive BH assessments and treatment (3, 4). For example, although nearly 50% of patients with chronic medical diseases have comorbid BH conditions (3, 5), more than 80% of the BH conditions remain untreated or ineffectively treated in primary and medical specialty settings. For the third of patients who receive BH care in the primary care sector, treatment for only 1 in 9 is evidence-based (4, 6). Only 50% of “treated” primary care patients with BH conditions see a BH specialist (3, 4). Untreated BH conditions in the primary care setting are associated with treatment nonresponse, illness persistence, higher medical illness complication rates, disability, increased health care service use, higher health care costs, and premature death (7–9). In 2012, the annual additional cost of medical care for the nearly 41 million Americans with BH conditions was an estimated \$290 billion (10, 11).

For almost a decade, national efforts have been under way to foster integration of BH services into primary care. In its simplest form, integration is present when actively communicating medical and BH providers are collocated, care is coordinated, and collaboration in assessing and treating patients for their total health needs is occurring. The U.S. Department of Health and Human Services; national managed health care organizations; and state, county, and local governments have undertaken efforts to encourage integration, but these efforts have had limited success in fostering the whole health of patients with medical and BH conditions. Three factors contribute to this apparent lack of success. First, there is the perception that a separate BH service delivery system is required for man-

aging difficulties with cognitions, emotions, and behaviors. Second, it is believed that independent payment systems are needed to maximize value and ensure adequate control of and support for delivery of BH services. Third, considerable stigma surrounds BH conditions and their treatment, making it difficult for representatives of BH and primary and specialty medical care to have the necessary dialogue that would facilitate service integration.

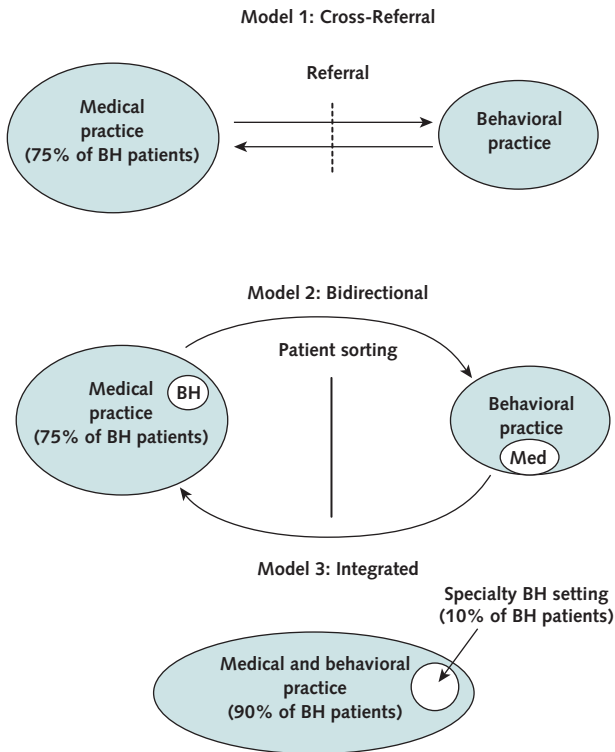
This article reviews the current status of primary medical and BH service delivery integration. It then outlines important strategies to consider for successful implementation of sustainable, integrated medical and BH services over the next 5 years. During this period, it is expected that provisions of the Patient Protection and Affordable Care Act will be initiated, offering key opportunities to achieve effective care integration.

CURRENT MODELS OF MEDICAL AND BH SERVICE DELIVERY INTEGRATION

In the current health care environment, because payment for general medical and BH conditions is segregated, these services are largely delivered in discrete settings. Unfortunately, care integration is proceeding along several distinct and often uneven trajectories. The traditional and most commonly used approach to patients with concurrent medical and behavioral conditions (**Figure, model 1**) is cross-referral between BH specialists and medical practitioners, both of whom typically work in 2 separate, noncommunicating service locations. This model, although simple, is also ineffective (12–16) because most patients referred for care never arrive at the referral site.

In the past several years, bidirectional, targeted integration (**Figure, model 2**) has been introduced in an effort to improve on the standard cross-referral model. In this second approach, the presumption is that patients fall into one of two largely nonoverlapping groups: patients with primary medical conditions but occasional BH conditions and those with primary BH conditions but occasional medical conditions. Patients in the former group would be

Figure. Three models of integrated care delivery.



BH = behavioral health; Med = medical.

treated in a primary care health home (PCHH), and those in the latter group would be treated in a BH home (BHH). Essentially, model 2 artificially inserts cross-disciplinary services into settings designed to deliver care only in their respective content areas. Financing for the services provided in model 2 is typically based on grants, which are not sustainable in the long run.

Model 2 emphasizes the need for on-site or easily accessible BH service in the PCHH and primary care services in the BHH. Although model 2 is currently being tested against model 1 (17), one of the challenges has been in identifying available and willing providers to deliver on-site or collaborative cross-disciplinary services in PCHHs or BHHs, even when payment resources have been identified.

Models 1 and 2 assume that effective health care for patients with medical and BH conditions can only be accomplished in care delivery settings that are separate, even when colocated. We disagree with this assumption. Undoubtedly, a subset of patients with chronic or severe BH conditions needs specialty BH services, similar to patients with diabetes, asthma, and renal failure for whom specialty settings and practitioners become de facto health home providers. We argue that patients with serious, primary BH conditions (for example, schizophrenia, bipolar disorder, or severe major depression) are legitimate candidates for specialty BH sector treatment. On the other hand, the 90% of

BH patients with mild to moderate BH conditions and many with more severe BH conditions would be better served if BH health care services were available as a standard health benefit in PCHHs.

PROPOSAL FOR AN ALTERNATIVE APPROACH (MODEL 3)

Given this rationale, we offer an alternative approach to integration (Figure, model 3), which should maximize health and function for patients with concurrent medical and behavioral conditions, regardless of service location. This represents a new opportunity that is not currently available for BH patients or BH providers. If most medical and BH practitioners can agree on unified clinical and financial principles for integrated service delivery and delivery support, then a coordinated transition can begin that will ultimately lead to better health outcomes and lower costs for the whole population. The Table compares how models 1, 2, and 3 handle the various integrated care delivery components.

When BH is viewed as a part of total health, then it (like obstetrics, surgery, and immunology) will become another area of health addressed in the PCHH. Unlike the bidirectional approach (Figure, model 2), the default approach in model 3 is for 90% of patients with BH conditions to be seen in primary and specialty medical settings in which BH is a core part of delivered services. The remaining 10% will be seen in an embedded specialty BH sector that, like other medical specialty settings, has ready access to collaborative general medical services for its patients when needed.

The introduction of BH personnel into PCHHs, however, requires forethought about how BH clinical services might best be set up and delivered. Research studies examining the collaborative care model (18, 19) during the past 20 years have shown that teams in which different BH providers play specific roles in PCHHs can lead to improved outcomes in patients with depression and anxiety, while reducing total health care costs (20, 21). The collaborative care approach could be used to address the acute BH care needs of outpatients seen in the medical setting.

The BH specialist has the greatest opportunity to bring value to the PCHH for patients with chronic but marginally controlled physical illnesses. This small percentage (22) of patients uses the most health resources and occupies inordinate amounts of provider time, which is often poorly compensated. Sixty percent to 80% of these patients have concurrent BH conditions (23, 24). Many (or perhaps most) of them require greater levels of BH intervention, but few receive it. They are usually those in whom first-line BH medications have failed or who have been in psychotherapy with limited improvement in symptoms or functional capacity. Improving access to case managers working with doctoral-level BH providers who can offer necessary evidence-based specialty services could facil-

itate better outcomes for this population. Integrated care coordinators (25) who have good relations with the patient's primary care physicians and clinical backup from a psychiatrist can help patients overcome clinical and non-clinical barriers to improvement.

Integration needs to occur not only in the PCHHs but also in specialty BH settings because these settings would assume the primary responsibility of caring for patients who have severe long-term BH conditions. Although the spectrum of BH conditions of patients seen in specialty BH settings will not be as broad as that found in PCHHs, more than 50% of them predictably have a chronic medical condition, such as diabetes, an obstructive lung disorder, or heart disease (26). Thus, every patient would have a lead BH provider and should also have a collaborating primary care physician. Together, these clinicians must function well as a team in providing preventive, acute, and long-term complex medical care along with BH care. The severity of these patients' BH conditions requires a close working relationship between BH and primary care providers. Further, in an integrated specialty BH setting, care coordination similar to that described earlier for medical settings would be needed for many (if not most) patients. In addition to addressing the BH needs of patients, integrated care coordinators would assume accountability for the patients' medical needs, social support (including housing, job support, and social network development), and health system logistics (for example, transportation or poor communication among providers). These factors are associated with poor outcomes independent of specific BH treatment.

FINANCING MODEL 3

Model 3 is not possible when separate systems exist for BH and medical payment. In fact, a recent Agency for Healthcare Research and Quality review of evidence-based integrated care studies (27) identified segregated medical and BH payment practices as the single most common

factor that prevented integrated program initiation, development, and sustainability. Thus, we recommend that medical and BH professionals demand that medical and BH benefits be combined in all provider contracts and that all health services be paid from a single budget by using common procedures. Unless this payment reform is a part of clinical health reform, 60% of BH patients who remain untreated in the medical setting will continue to add nearly \$300 billion annually to the total health care budget (11). Perhaps more important, entities that design special payment arrangements to meet fiscal requirements of integrated programs (for example, grant supplementation and profit center subsidies to create integrated care capabilities) will find that they are not sustainable in the long term, even if the integrated services bring value.

Transition to payment of BH benefits as a part of medical benefits can occur over a period of 3 to 5 years once the decision is made to do so. While integrated medical and BH services are being implemented, current independent medical and BH patient and provider contracts must sunset and be rewritten. New integrated contracts would include payment for all medical and BH services through 1 "medical" health plan funding pool. Primary players in this transition include purchasers (employers, government programs, and individuals), medical health plans, general hospital and clinic systems, health care providers, and patients. Payment reform needs to parallel clinical reform and allow for the development of integrated service delivery. Now is the perfect time for this transition because many hospital and clinic systems in the United States are building risk-bearing clinically integrated networks (that is, accountable care organizations). Because these delivery systems will be responsible for the quality of care and total health cost of populations, many hospitals, clinics, and their physicians that are developing integrated networks are now exploring how to recontract with medical health plans and government programs so that they can capitalize on more efficient and effective approaches to in-

Table. Integrated Care Components in Models 1, 2, and 3

Variable	Model 1	Model 2	Model 3
Access	Discreet and nonoverlapping medical and BH provider groups and treatment settings; frequent delays	Nonnetwork cross-disciplinary providers at primary service delivery site; selective access	Integrated medical and BH network providers uniformly present in service locations; ready access
Integrated care delivery	Clinician documentation information firewalls; crisis-dictated communication and care coordination; nonexistent continuity	Site-specific cross-disciplinary information access, communication, and care coordination; partial continuity	Full integrated medical and BH network provider information access, communication, care coordination, and continuity
Payment	Separate medical and BH benefits, claims adjudication procedures, and coding and billing rules	Separate medical and BH benefits, claims adjudication procedures, and coding and billing rules; subsidized cross-disciplinary services	Consolidated medical and BH benefit set, claims adjudication procedures, and coding and billing rules
Outcomes	Discipline-specific clinical and cost/saving accountability	Discipline-specific clinical and cross-disciplinary cost/saving accountability	Medical and BH clinical and cost/saving accountability

BH = behavioral health.

tegrated medical and BH care. Correctly configured, this area is considered to have much opportunity for growth.

NEXT STEPS

We would like to propose several necessary next steps for the development of model 3, whether in an integrated primary or specialty medical setting or an integrated specialty BH setting. First, BH and medical professionals must develop an improved understanding of each other's culture and practices. This can occur through integrated educational activities, such as combined residencies (28), cross-disciplinary internships, and joint meetings and symposia, and by discussing common issues and collaborating on solutions. Organizational arrangements will need to be developed to make these interactions possible because they do not currently exist.

Second, sustainable, integrated medical and BH financing must be implemented over the next 3 to 5 years. This will involve moving to contracts that consolidate payment for medical and BH benefits. To accomplish this goal, several distinct actions will be required. Purchasers, such as employers and government agencies, will need to build or buy health insurance products in which BH services are included as part of medical benefits. Health plans will need to embed BH services as part of medical benefits in all purchaser and provider contracts and then adjudicate claims by using common coding and billing rules and a single payment process. Providers (including professionals and facilities) will need to contract to deliver BH services as part of medical services with common payment procedures. Patients will need to demand BH service availability on par with other medical specialty services delivered in the medical setting.

Third, during finance reform, implementation of integrated care sites in primary, specialty medical, and specialty BH settings should be customized to the populations served based on the principles outlined above. We need to develop approaches for nontraditional BH and medical service delivery that provide prioritized outcome-changing interventions for targeted patient populations in the medical setting. The new integrated world will include on-site cross-disciplinary professionals with various levels of intervention expertise working in teams, using registry-based case-finding, employing treat-to-target delivery, and applying evidence-based interventions with escalation of care when real-time documentation shows less than expected improvement (29). As this occurs, proactive BH and medical leadership will need to collaborate to ensure the transition to support for persons with serious BH conditions in integrated specialty BH settings, which are part of the medical delivery and reimbursement system. In these settings, primary BH patients with concurrent medical conditions will also have access to outcome-changing and coordinated medical services.

We hope that this discussion will expand the dialogue between medical and BH practitioners and other health

care stakeholders about the steps that are needed to allow integrated care to mature. It is time that we initiate this important transition, but it will not occur unless basic changes are made in the way that care is delivered and reimbursed.

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References

1. Colton CW, Manderscheid RW. Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Prev Chronic Dis*. 2006;3:A42. [PMID: 16539783]
2. Druss BG, Zhao L, Von Esenwein S, Morrato EH, Marcus SC. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011;49:599-604. [PMID: 21577183]
3. Kessler RC, Demler O, Frank RG, Olfson M, Pincus HA, Walters EE, et al. Prevalence and treatment of mental disorders, 1990 to 2003. *N Engl J Med*. 2005;352:2515-23. [PMID: 15958807]
4. Wang PS, Aguilar-Gaxiola S, Alonso J, Angermeyer MC, Borges G, Bromet EJ, et al. Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. *Lancet*. 2007;370:841-50. [PMID: 17826169]
5. Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. *Lancet*. 2012;380:37-43. [PMID: 22579043]
6. Wang PS, Demler O, Kessler RC. Adequacy of treatment for serious mental illness in the United States. *Am J Public Health*. 2002;92:92-8. [PMID: 11772769]
7. Katon WJ, Seelig M. Population-based care of depression: team care approaches to improving outcomes. *J Occup Environ Med*. 2008;50:459-67. [PMID: 18404019]
8. Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips MR, et al. No health without mental health. *Lancet*. 2007;370:859-77. [PMID: 17804063]
9. Seelig MD, Katon W. Gaps in depression care: why primary care physicians should hone their depression screening, diagnosis, and management skills. *J Occup Environ Med*. 2008;50:451-8. [PMID: 18404018]
10. Melek S, Halford M, Perlman D. Depression treatment: the impact of treatment persistence on total health costs. Milliman Research Report. Denver, CO: Milliman; 2012. Accessed at <http://publications.milliman.com/publications/health-published/pdfs/depression-treatment.pdf> on 6 November 2013.
11. Melek S, Norris DT, Paulus J. Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry. Milliman American Psychiatric Association Report. Arlington, VA: American Psychiatric Association; 2013. Accessed at www.psychiatry.org/File%20Library/Practice/Professional%20Interests/Integrated%20Care/APA-Milliman-Report-Final-8-13-2013.pdf on 25 November 2013.
12. Cunningham PJ. Beyond parity: primary care physicians' perspectives on access to mental health care. *Health Aff (Millwood)*. 2009;28:w490-501. [PMID: 19366722]
13. Grembowski DE, Martin D, Patrick DL, Diehr P, Katon W, Williams B, et al. Managed care, access to mental health specialists, and outcomes among primary care patients with depressive symptoms. *J Gen Intern Med*. 2002;17:258-69. [PMID: 11972722]

14. **Simon GE, Ludman EJ.** Predictors of early dropout from psychotherapy for depression in community practice. *Psychiatr Serv.* 2010;61:684-9. [PMID: 20592003]
15. **Bradford DW, Kim MM, Braxton LE, Marx CE, Butterfield M, Elbogen EB.** Access to medical care among persons with psychotic and major affective disorders. *Psychiatr Serv.* 2008;59:847-52. [PMID: 18678680]
16. **Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, Kessler RC.** Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. *Arch Gen Psychiatry.* 2005;62:629-40. [PMID: 15939840]
17. **Patel V, Belkin GS, Chockalingam A, Cooper J, Saxena S, Unützer J.** Grand challenges: integrating mental health services into priority health care platforms. *PLoS Med.* 2013;10:e1001448. [PMID: 23737736]
18. **Archer J, Bower P, Gilbody S, Lovell K, Richards D, Gask L, et al.** Collaborative care for depression and anxiety problems. *Cochrane Database Syst Rev.* 2012;10:CD006525. [PMID: 23076925]
19. **Katon WJ, Lin EH, Von Korff M, Ciechanowski P, Ludman EJ, Young B, et al.** Collaborative care for patients with depression and chronic illnesses. *N Engl J Med.* 2010;363:2611-20. [PMID: 21190455]
20. **Unützer J, Chan YF, Hafer E, Knaster J, Shields A, Powers D, et al.** Quality improvement with pay-for-performance incentives in integrated behavioral health care. *Am J Public Health.* 2012;102:e41-5. [PMID: 22515849]
21. **Unutzer J, Katon WJ, Fan MY, Schoenbaum MC, Lin EH, Della Penna RD, et al.** Long-term cost effects of collaborative care for late-life depression. *Am J Manag Care.* 2008;14:95-100. [PMID: 18269305]
22. **Zuvekas SH, Cohen JW.** Prescription drugs and the changing concentration of health care expenditures. *Health Aff (Millwood).* 2007;26:249-57. [PMID: 17211035]
23. **Bradshaw LE, Goldberg SE, Lewis SA, Whittamore K, Gladman JR, Jones RG, et al.** Six-month outcomes following an emergency hospital admission for older adults with co-morbid mental health problems indicate complexity of care needs. *Age Ageing.* 2013;42:582-8. [PMID: 23800454]
24. **Goldberg SE, Whittamore KH, Harwood RH, Bradshaw LE, Gladman JR, Jones RG; Medical Crises in Older People Study Group.** The prevalence of mental health problems among older adults admitted as an emergency to a general hospital. *Age Ageing.* 2012;41:80-6. [PMID: 21890483]
25. **Kathol R, Perez R, Cohen J.** *The Integrated Case Management Manual: Assisting Complex Patients Regain Physical and Mental Health.* 1st ed. New York: Springer Publishing; 2010.
26. **Druss BG, Walker ER.** Mental disorders and medical comorbidity. *Synth Proj Res Synth Rep.* 2011:1-26. [PMID: 21675009]
27. **Kathol RG, Butler M, McAlpine DD, Kane RL.** Barriers to physical and mental condition integrated service delivery. *Psychosom Med.* 2010;72:511-8. [PMID: 20498293]
28. **Summergrad P, Silberman E, Price LL.** Practice and career outcomes of double-boarded psychiatrists. *Psychosomatics.* 2011;52:537-43. [PMID: 22054623]
29. **Kathol RG, deGruy F, Rollman BL.** Value-based, financially sustainable behavioral health components in patient-centered medical homes. *Ann Fam Med.* Forthcoming.

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