Primer on Integrating Primary Care and Behavioral Health Care

A new report from the Milbank Memorial Fund provides a primer on integrating primary care and behavioral health care. It describes eight models along a continuum—from minimal collaboration to full integration—and provides an implementation planning guide. Integration will be a critical component of health care reform in the coming decade, the report concludes. It will be driven by redundancies in administrative and service delivery structures and the current embrace by health care systems of quality improvement and the concept of the patient-centered "medical home." These factors, along with the need to contain costs, are "providing the health care industry with an extraordinary opportunity to reshape the way behavioral health care is provided."

The 88-page report, *Evolving Models of Behavioral Health Integration in Primary Care,* ends with a 16-page list of references and selected readings that attests to the authors' introductory statement: there is a vast amount of information in the field of collaborative and integrated care, more than any single document can synthesize. A robust and burgeoning literature includes seminal work by more than a dozen prominent leaders, a monograph-length literature review, dozens of technical reviews covering topics such as financing and program assessment, several influential books documenting basic concepts, numerous toolkits and how-to manuals, Web sites offering an array of resources, two journals covering the field, and a national membership organization. Rather than synthesize this mass of information, the report examines salient themes to identify practical implications for policy makers, planners, and providers of general medical and behavioral health care.

Four concepts are common to all models of integrated care: the medical home, the health care team, stepped care, and the four quadrants of clinical integration. The medical home has become a mainstream theory in primary care, in particular for patients with chronic illnesses. Although it is not specifically an integrated care model, the concept encompasses the philosophy of integration. The health care team is deeply seated in the field, the report notes. In integrated care, the team-patient relationship replaces the doctor-patient relationship, and a patient's visit is "choreographed" with various members of the team. Stepped care is widely used in integrated models and refers to provision of care that is the least disruptive to a person's life; the least intensive, extensive, and expensive to achieve positive patient outcomes; and the least expensive in terms of staff needed to provide effective services.

The four-quadrant framework identifies the setting in which patients should receive care on the basis of their needs—from low to high physical health risk and complexity and low to high behavioral health risk and complexity. For example, quadrant IV is for patients who have high needs in both areas, such as individuals with schizophrenia who have hepatitis C; these patients are typically served in both primary and specialty care settings, with a strong need for collaboration between the two.

Models of integrated care can be organized along a continuum that begins with minimal collaboration followed by basic collaboration at a distance, basic collaboration on site, close collaboration in a partly integrated system, and close collaboration in a fully integrated system. The report describes eight distinct models while acknowledging that most initiatives in real-world settings are hybrids that blend elements of these models. The eight models are improved collaboration, medically provided behavioral health care, colocation, disease management, reverse colocation, unified primary care and behavioral health, primary care behavioral health, and a collaborative system of care. Eight separate sections provide definitions of each model and describe strategies used for integration of care. A summary of evidence from randomized controlled trials is followed by considerations for implementing and financing the model. Existing programs that use the model are briefly described.

For example, practice model 5—reverse colocation—is situated on the continuum at the point of close collaboration in a partly integrated system. It reverses the usual approach in which behavioral health care is integrated into primary care and instead seeks to improve general medical care for persons with serious and persistent mental illness. A primary care physician, physician's assistant, nurse practitioner, or nurse may be stationed part- or full-time in a specialty setting, such as a rehabilitation program or an outpatient psychiatric clinic. Studies of this model are in their infancy, the report notes, but early findings indicate the model's potential to reduce lifestyle risk factors—for example, through screening for hypertension and diabetes. Implementation considerations for reverse colocation include how to address issues such as treatment consents, maintenance of medical records, and referral processes. Mental health case managers in this model will need to develop skills to promote wellness and help patients manage medical conditions. Financial considerations include the potential difficulty of hiring primary care providers, particularly for uninsured and Medicaid patients with multiple comorbid conditions. In addition, mental health agencies may be unable to access codes to bill for medical visits. As an example of this model, the report cites the Community Support Services Center in Akron, Ohio, which serves adults with severe mental illness and which established an integrated primary care clinic and pharmacy in 2008.

How can policy makers, planners, and providers of care determine which model is the best for their agency or community? A brief section lists issues for consideration, such as the primary goals of the initiative, available resources, and consumer

preferences. Because current fiscal realities in many locales will dictate incremental progress, the report outlines a tiered approach designed to maintain forward momentum toward integration, starting with maximizing existing resources, then investment of new resources, and then significant system redesign.

The report is available on the Milbank Web site at www.milbank.org.

New National Strategy to Reduce Drug Use

On May 11 President Obama released the Administration's 2010 National Drug Control Strategy, which establishes five-year goals for reducing drug use and its consequences. The strategy, which was developed by the Office of National Drug Control Policy (ONDCP) with input from federal, state, and local partners, shifts national policy away from the "war on drugs," declared by President Nixon in 1971.

The strategy emphasizes prevention of drug use before it starts, integration of evidence-based treatments into the mainstream health care system to reduce consumption and demand, innovations in the criminal justice system to break the cycle of drug use and crime, and international partnerships to disrupt transnational drug-trafficking organizations. In a statement accompanying the policy's release, National Drug Policy Director Gil Kerlikowske noted that the Obama Administration views drug use more as a public safety and public health problem than a criminal matter that emphasizes punishment and incarceration.

The strategy establishes five-year goals to reduce the rate of drug use among youths by 15%, decrease use among young adults by 10%, reduce the number of chronic users by 15%, lower the incidence of drug-induced deaths by 15%, and decrease the prevalence of "drugged driving" by 10%. In addition, the strategy identifies three challenges on which the Administration will focus this year: prescription drug abuse, which is the fastest-growing drug problem in the country; drugged driving, which recent weekend roadside surveys have found involves one in six drivers; and prevention of drug use. The strategy document notes that persons who reach the age of 21 without developing an addiction are unlikely to develop one later.

Critics have pointed out aspects of the policy that do not reflect the balanced approach emphasized by Administration officials and that maintain the status quo, particularly in regard to federal drug control spending. In the fiscal year 2011 budget, 64% of total spending is for domestic law enforcement, interdiction, and international support, whereas 36% is targeted at prevention and treatment—levels nearly identical to those of previous Administrations. Others point out that although federal officials have acknowledged that interdiction and eradication in countries such as Colombia and Afghanistan have no impact on the availability of drugs in the United States, the new strategy nevertheless embraces these approaches.

The 2010 National Drug Control Strategy along with related documents and resources are available on the ONDCP Web site at http://www.whitehousedrugpolicy.gov/strategy.

NEWS BRIEFS

APA surveys public on stigma: A survey conducted for the American Psychiatric Association (APA) in April found that although stigma associated with mental illness still exists, more than a third of Americans believe that it has declined. When asked about factors that are influential in reducing stigma, 79% cited openness among friends, family, and public figures about their personal experiences with mental illnesses as at least moderately influential. Other factors cited as at least moderately influential are the increased amount of mental health information available online (75%), accurate portrayals of mental illnesses on television and in movies (72%), public figures or celebrities who talk about their experiences with mental illnesses (71%), and social networking sites related to the topic of mental illnesses (61%). When asked how concerned they are about the possibility that they would ever be given a diagnosis of a mental disorder, 38% were at least somewhat concerned and 48% said they were at least somewhat concerned for a family member. Two-thirds agreed that people with mental illnesses can get better. A total of 2,285 adults responded to the Harris Interactive online survey, which was conducted as part of the APA's Healthy Minds. Healthy Lives campaign (www.healthyminds.org).

Kaiser briefs address issues in of health reform: The Kaiser Family Foundation has posted several new issue briefs on its Health Reform gateway page (healthreform.kff.org). The reform law designates Medicaid as the coverage pathway for low-income Americans. *Optimizing Medicaid Enrollment: Perspectives on Strengthening Medicaid's Reach Under Health Care Reform* draws on interviews with Medicaid program directors and other experts, who describe the expansion of Medicaid as a strategic moment to recast Medicaid as an affordable health coverage program for working people and families and to improve its enrollment and renewal operations. *Financing New Medicaid Coverage Under Health Reform: The Role of the Federal Government and States* examines how the federal government and the states are expected to split responsibility for financing Medicaid coverage, which will be expanded to millions of low-income adults in 2014. *Explaining Health Reform: Medicare and the New Independent Payment Advisory Board* describes how the board created under health reform is expected to limit growth in Medicare spending over time.

Index to Advertisers June 2009