The Role of Primary Care Providers in Mental Health Care: Models and Evidence

A Literature Review Submitted to the Myers-JDC-Brookdale/Brandeis Collaboration on Mental Health

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EXECUTIVE SUMMARY

The provision of quality, evidence-based behavioral health care is a significant challenge in the US and elsewhere. Findings from the National Comorbidity Survey, suggest that among US adults with a mental health disorder, only forty percent receive any type of behavioral health care (Kessler, Ciu, Deler, & Walters, 2005). Given that upwards of 26.2% of the US adult population has a behavioral health disorder in any given year (Kessler et al., 2005), the challenges of adequate service provision are noteworthy.

The recent spate of healthcare reform in the US and mental health care reform in Israel, afford numerous opportunities to assess, evaluate and learn from these reform efforts. This brief article is intended to orient the Israeli reader to ongoing efforts in US – particularly in the past decade – to develop and implement system delivery reforms in primary care settings that better integrate primary care and behavioral health. The models of primary and behavioral health integration examined in this essay exist along a continuum of options from separate settings, to co-location, to full integration of care. Evidence suggests that integration of primary care and behavioral health has the potential to enhance patient outcomes via earlier identification of psychiatric symptoms and increased access to evidence-based behavioral health services (Collins, Hewson, Munger, & Wade, 2010).

The models of collaborative or integrated care noted in this report have received a great deal of attention in the US from researchers and policymakers alike. However, important questions remain with respect to the implementation of multiple models, and which forms of integration function best, particularly within the context of managed care. The roles of primary care physicians are numerous and varied. Models of integration must pay attention to organizational and structural factors that allow for primary care physicians to draw on the strengths of their discipline while being mindful of the clinical setting, physician time constraints, skills and training.

This article examines the challenges of integrated care in the US. The multiple roles of primary care providers, the value of integrated care models, and a brief explanation of various integration models are discussed with emphasis placed on the strengths and weaknesses of each model, and the challenges of implementation within a managed care setting. A brief discussion of the relevance of the integration models for Israel's mental health reform follows. Implementation of an integrated model of care may be helpful in addressing Israel's desire to improve access to and quality of mental health care.

Introduction

The provision of quality, evidence-based behavioral health care remains a significant challenge both in the US and in many other countries. Findings from the national comorbidity survey, (Kessler, Ciu, Deler, & Walters, 2005), suggest that only forty percent of US adults with a mental health disorder receive care. Given that upwards of 26.2% of adult population has a behavioral health disorder (Kessler et al., 2005), the challenges of service provision are significant. Indeed, a large percentage of both mental health and substance use disorders go undetected or are improperly diagnosed (Frank & Glied, 2006; Kessler et al., 2005). Unmet need for behavioral health care is high, particularly among vulnerable populations including ethnic and racial minorities, the elderly, youth and individuals with low income (Unützer, Schoenbaum, Druss, & Katon, 2014; Wang et al., 2005).

Better integration of behavioral health care and primary care could offer an efficient means of detecting behavioral health disorders and increasing access to appropriate care (Collins, Hewson, Munger, & Wade, 2010). In the US, models of collaborative or integrated care have received a great deal of attention from researchers and policymakers alike, particularly since the President's New Freedom Commission on Mental Health report (2003). The report, which placed emphasis on "recovery" for individuals with behavioral health disorders through the provision of community-based, consumer-driven services and active partnerships between the client, health care providers and families, set the stage for large scale reform of publicly funded behavioral health services in the US (Hogan, 2003; Hyde, 2014; Jacobson, 2004; Willging, Lamphere, & Rylko-Bauer, 2015).

Although significant barriers to integration exist in the US, there are a number of compelling reasons why such efforts have gained traction. First, evidence suggests that patients prefer this approach (Chen et al., 2006). Nearly one quarter of individuals with a behavioral health disorder present first to their primary care provider (PCP) (Collins et al., 2010; Fortney, 2014). Certainly progress has been made in improving how behavioral health is provided in primary care (Frank & Glied, 2006), however, mental health and substance use disorders are too often misdiagnosed as physical conditions in primary care settings, particularly in elderly individuals (Karlin & Fuller, 2007). Many primary care physicians practice in a work environment characterized by competing demands and limited time. These constraints, in concert with insufficient training in behavioral health and a limited pool of mental health providers to whom referrals can be made, makes addressing the behavioral health care needs of patients a challenge (Fortney, 2014, p. 1).

Second, behavioral health disorders and serious, chronic physical illness are often co-morbid (Kessler et al., 2005). A majority of individuals who present to primary care with a comorbid behavioral and physical health condition never receive treatment for their behavioral health disorder; evidence suggests that left untreated, behavioral health conditions may make recovery from physical health conditions more complicated(Klein & Hostetter, 2014). We know for example, that primary care is essential for individuals with severe mental illness (SMI). Because individuals with SMI are often engaged in specialty mental health care, but not primary healthcare, they may not receive quality medical health care resulting in higher rates of morbidity and lower life expectancies than individuals in the general population (Fortney, 2014). While issues concerning the care and treatment of individuals with SMI are vitally important, this discussion is beyond the scope of this paper.

Third, the integration of behavioral health and primary care has the potential to increase treatment initiation and retention. Speer & Schneider report that upwards of 75% of patients referred to specialty care are "lost" to follow-up, particularly given long waiting times for an appointment (Speer & Schneider, 2003). When behavioral health treatment is provided in a primary care setting, 90% of patients present for an appointment (Speer & Schneider, 2003). At the same time, integrated care may be less stigmatizing to the patient as mental health and substance use disorders are treated within the confines of primary care and can be seen as a normative part of health (Zeiss & Karlin, 2008).

A recent policy brief by the Kennedy Forum entitled "Fixing Mental Health Care in America, A National Call for Integrating and Coordinating Specialty Behavioral Health Care into the Medical System", stresses the importance of pursuing a stronger behavioral health service delivery system in a primary care setting. The brief posits that a fully integrated behavioral health care model in primary care will be beneficial in reaching more of the population in need of behavioral health services, providing quality mental health care and in supporting primary care physicians while reducing costs to the health care system via early and effective treatment (Fortney, 2014).

The promise of integrated care, as outlined in the Kennedy Forum brief is similar to the goals of Israel's mental health reform efforts (Nirel & Samuel, 2014). According to Nirel and Samuel, the primary objectives of reform in Israel are to realize:

1) "Improvements in the quality of care;
2) Expand availability and accessibility of services and;
3) Increase efficiency" (Nirel & Samuel, 2014, p. 2)

Israel looks to achieve these objectives through the use of managed care elements, integration between mental health and medical health service delivery systems and

additional funding resources (Nirel & Samuel, 2014). Given ongoing efforts to reform mental health care in Israel, this article is intended to orient the Israeli reader to ongoing efforts in US – particularly in the past decade – to develop and implement system delivery reforms in primary care settings that better integrate primary care and behavioral health. Numerous opportunities to assess, evaluate and learn from these reform efforts exist.

This brief review explores the roles that primary care physicians in the US play in behavioral health. First we explore why behavioral health care is so integral to high quality primary care; an exploration of the changing nature of primary care follows. A brief clarification of terminology is followed by a discussion of different models of integration. The report continues with discussion of the models, challenges within managed care and evidence of their effectiveness. We conclude with a brief discussion of the models being used in Israel based on information presented in the Samuel & Rosen manuscript 2012 (Samuel & Rosen, 2012).

Changing nature of Primary Care in the US and the role of the Primary Care provider

Both the nature of primary care and the role of the primary care provider have changed markedly since the 1960s (Abrams, Schor, & Schoenbaum, 2010). Today's primary care providers are tasked with providing an array of services, both for purposes of prevention and patient wellbeing. Care for individuals with chronic health conditions, including diabetes and obesity is commonplace, as are visits relating to mental health disorders and/or substance abuse (Regier et al., 1993). It's estimated that nearly half of all care for behavioral health conditions occurs in primary care settings (Unützer et al., 2014). Efforts to coordinate and/or integrate care are based, in part at least, on the recognition that the discipline of primary care, in and of itself, cannot possibly provide the type of population-based, comprehensive care required (Abrams et al., 2010).

Integrated care will require changes in the way that primary care providers work and understand the nature of their roles (Abrams et al., 2010). Active, collaborative teams with care managers and other supports for behavioral health services are required (Unützer et al., 2014). Integrated care may necessitate the use of telemedicine, specialty consultations, health information technologies and reimbursement strategies that allow health information to be shared across practice settings (Abrams et al., 2010).

Key behavioral health tasks in primary care

Most evidence in support of effective strategies that address the intersection between primary care and behavioral health relates to the identification and treatment of

depression, a mood disorder commonly seen in primary care settings (Unützer et al., 2014). Primary care physicians may perform any number of tasks along a continuum of care. Strategies for effective behavioral health care in primary care include the following: screening, assessment and diagnosis, referral or treatment, monitoring and follow-up care. Each of these strategies will be briefly described.

Screening and Diagnosis

A variety of well-validated screening tools have been developed for common mental health disorders in primary care settings. Screening is the most widely adopted and most prevalent mental health activity conducted by primary care physicians (Pignone et al., 2002). Evidence suggests that screening plays an important role in enhancing detection rates of mental health disorders, particularly depression (Unützer et al., 2014). However, even in concert with provider feedback, screening has not been shown to positively effect clinical outcomes (W. Katon & Gonzales, 1994).

Challenges to conducting behavioral health screening in primary care settings include:

- Multiple competing demands and brief appointment visits
- Provider familiarity with and knowledge of the screening tool
- Lack of active referral to care and/or comprehensive systems for following individuals who screen positive
- Lack of insurance coverage for the service

Referrals

Referrals most often involve varying forms of 'hand offs' to a specialty mental health care provider. Logic suggests that increasing rates of referral to specialty care ought to be helpful in addressing the treatment needs of primary care patients, but research suggests that perhaps one-half of all patients who receive a referral to specialty mental health care fail to follow through with the referral (AHRQ, 2008). Moreover, primary care physicians often report having poorer access to behavioral health providers than do other physical health specialists (Unützer et al., 2014). Unützer and colleagues maintain that reliance on specialty care is unlikely to address the high rate of unmet need observed in primary care settings. Even when patients access specialty care, evidence-based treatment guidelines are not necessarily observed.

Challenges to conducting referral to mental health treatment by a primary care provider include:

- Lack of access to suitable mental health providers and/or evidenced based behavioral health resources
- A lack in relationship between PCP and local mental health providers

Treatment

With advent of multiple new and effective pharmaceuticals, primary care physicians are have taken up an increasing share of the work of treating mental health and substance abuse disorders. Practice guidelines are readily available, but the mere availability of clinical guideline has not necessarily made treatment decisions any easier; evidence suggests that primary care providers often require additional guidance. Provider guidelines even in concert with provider training/education programs may not be sufficient to enhance the mental health care in primary care settings (Hodges, Inch, & Silver, 2001). Increasingly however, managed care organizations are encouraging primary care providers to prescribe psychiatric medications. This could be because medication use can substitute for some specialty psychiatry services, and because it allows the primary care provider to monitor psychiatric medications jointly with medications for other chronic conditions (Mauch, 2011).

Challenges to primary care physicians in treating mental health disorders commonly seen in primary care, such as depression and anxiety, include:

- Lack of familiarity with psychotropics, particularly if the client's depression does not readily respond to commonly used medication
- Inability to combine medication assisted treatment with other evidence based guidelines/treatment modalities
- Limited time and/or frequency of patient visits to sufficiently monitor medication adherence, uptake and impact

Follow-up and Monitoring

The evidence examining the follow-up and monitoring of depressed patients in primary care settings points to a significant gap between routine screening and systematic follow-through with patients (Solberg, Trangle, & Wineman, 2005). Ideally, follow-up should occur after each visit with the primary care physician, in accordance with the patient's needs and preferences. The patient should be monitored regularly for changes in symptom severity, as well as their treatment plan and referrals. We know a great deal about what works in terms of follow-up and monitoring of depressed patients in primary care, but implementation has proven more challenging (FFMPLC & Kahn, 2004).

Challenges to conducting follow up and monitoring by a primary care provider include:

- A traditional "episodic" approach to the provision of primary care may impede structured plans for follow-up
- Lack of team-based approach in many traditional and/or smaller primary care practices
- Lack of resources necessary to provide necessary practice-based support.

How managed care may affect the roles that primary care physicians adopt

The role of the US primary care provider in behavioral health has been strongly influenced by external factors imposed by managed care organizations. Restrictions and limitations on which, if any, components of mental health care primary care providers are able to perform may be imposed by managed care organizations (Woltmann et al., 2012). It should be noted that deficiencies in implementation of coordinated care do not result from lack of professional commitment to effective and appropriate care (Frank, Huskamp & Pincus, 2003). Rather, significant challenges exist in the organizational structure of the health care system and the financial disincentives - primarily related to reimbursement - that do not promote collaborative models of care (Frank et al., 2003).

The gap between fiscal incentives and best practice models is the fundamental reason why collaborative care models have not been widely adopted in the US (Frank et al., 2003). If reimbursement incentives were redesigned to support quality improvement efforts and best practice models, including payment for screening and assessment of behavioral health conditions, care coordination and collaboration, best practice models could be more readily implemented (Frank et al., 2003). For example, a primary care physician cannot file and/or receive reimbursement, from either Medicare or private insurers, for both a physical and a mental health screening on the same individual in a given day. Without the opportunity to receive compensation for work conducted, the physician is less likely to perform a behavioral health screening (Collins et al., 2010).

Alternative models for integrating behavioral health and primary care

The delivery of healthcare in the US is undergoing substantive changes. The 2010 Patient Protection and Affordable Care Act has the potential to redesign the way that primary care is administered (Ader et al., 2015; Druss & Mauer, 2010) The next section briefly describes three modes of collaborative care.

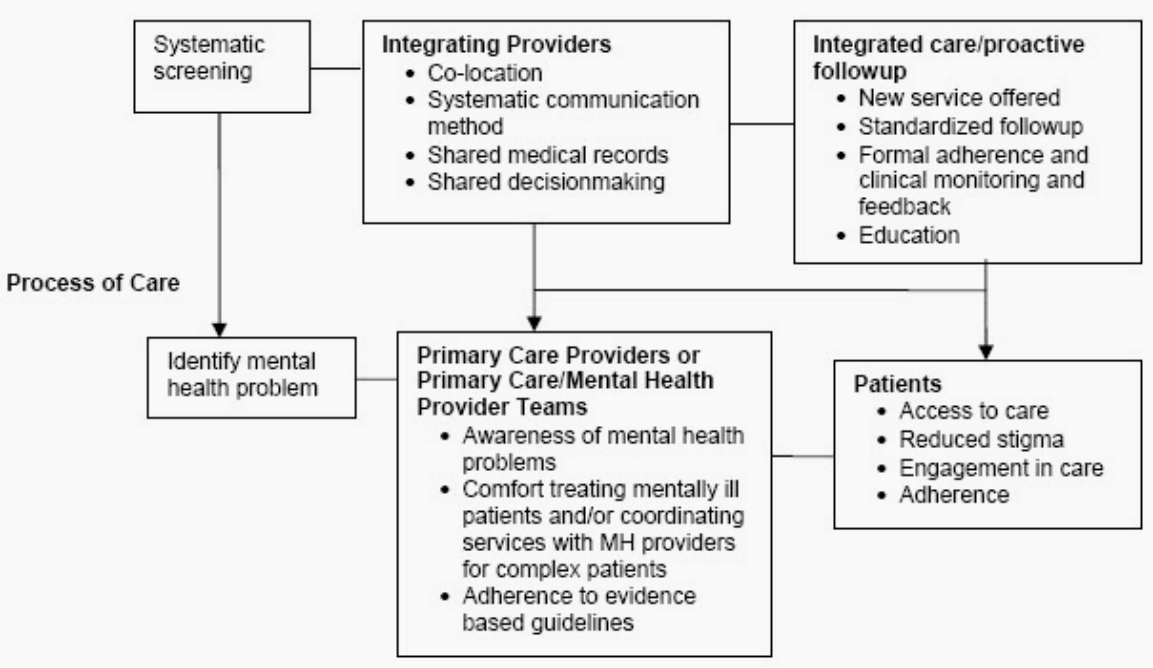
Coordination, co-location and integration

Models of collaborative care can be classified according to the extent of integration: coordinated, co-located and fully integrated. In coordinated settings, primary care physicians and behavioral health practitioners practice in separate facilities. Communication is mostly conducted at a distance, by telephone, on-line or via email (Ader et al., 2015; Collins et al., 2010). Primary care physicians routinely screen for mental health issues and they will provide brief intervention treatments when appropriate, while strong relationships and communication across providers allows for successful referrals if necessary. Coordinated approaches are widely practiced in the U.S. A recent report suggests that more than 30 states have implemented coordinated care programs (Ader et al., 2015; Kuehn, 2011).

Co-location of behavioral health and primary care, where both teams practice within the same facility, is generally regarded as a more integrated model. Referrals are made in-house, though outside specialists may be utilized as well. In theory, co-location approaches foster enhanced patient care and outcomes. Primary care physicians continue to conduct screenings, may engage in a consult, but more often refer patients to specialty care since the likelihood of follow through is better in co-located care models. Research demonstrates the positive benefits of co-location – particularly with respect to minimizing patient stigma and enhancing treatment initiation (Kolko et al., 2014; National Quality Forum, 2010; Patterson, Roth, Woods, Chow, & Gomes, 2004). Important limitations to the co-location approach remain as both systems of care may continue to utilize discrete medical records, reimbursement procedures and appointment scheduling policies. Nonetheless, some researchers maintain that co-location may offer the best approach in terms of patient outcomes and cost containment for practices unprepared or not inclined to transition to a fully integrated approach (Collins et al., 2010).

In fully integrated approaches (see figure 1 below), behavioral health providers practice within the primary care system and work actively with primary care providers offering consultation, advice and education. They serve as both direct care providers and advisors to the team of primary care providers (Collins et al., 2010). In general, integrated approaches offer the advantage to the practice of increasing services and augmenting the ability of practitioners to address a wide variety of behavioral and physical health needs in a timely manner (Bartels et al., 2004; Cunningham, 2009; Mitchell & Selmes, 2007; Unützer et al., 2002). Multiple providers perform various functions. However the team decides upon the right course of action and treatment planning is based on a team consultation. Patient outcomes associated with fully integrated models have received less attention, but evidence suggests that both coordinated and co-located settings are associated with increased access to behavioral health access and treatment (Bartels et al., 2004; Hedrick et al., 2003), enhanced treatment adherence, better functional outcomes and cost-effectiveness (Liu et al., 2003).

Figure 1.



(AHRQ, 2008)

It should be noted that the terms "integrated care" and "collaborative care" are often used interchangeably, however, basic distinctions remain (AHRQ, 2008; Blount et al., 2007; World Health Organization, World Organization of National Colleges Academies, & Academic Associations of General Practitioners/Family Physicians, 2008). Integrated care describes a system in which mental health care is provided *within* a primary care setting (Collins et al, 2010). Collaborative care is characterized by discrete settings and functions (Collins et al, 2010). These distinctions will be more evident as the various models are explored.

Collins et al. (2010) describe the distinction between collaborative and integrated care in detail. What follows is a brief synopsis of their conceptualization of eight practice models that lie along a continuum of care. Particular attention is paid to the roles of the primary care physician. In addition, we examine structural and fiscal barriers salient to managed care incentives and restrictions. Evidence in support of these models as well as potential applications to reform efforts in Israel is also noted.

Models of Coordination & Integration

The Milbank Foundation report "*Evolving Models of Behavioral Health Integration in Primary Care*", highlights eight models of care along a continuum of integration. These models possess differing features of integrated and coordinated care characteristics

including various roles and activities for primary care physicians and other team members. Brief descriptions of each model, and the roles played by the primary care physician, are presented below.

1. Minimal Collaboration models are categorized by little if any regular communication between primary care physicians and mental health specialists (Collins et al., 2010). The two disciplines work in separate facilities with separate systems and financing structures. Primary care physicians do not conduct mental health screenings and/or have a limited referral process for specialty mental health care (Collins et al., 2010). Often, neither the primary care practice nor the mental health provider has the resources or the capacity to coordinate care (Collins et al., 2010).

2. Medically-Provided Behavioral Health Care. In this model, primary care physicians deliver mental health care, although they may consult with a psychiatrist or psychologist (Collins et al., 2010). As the primary care physician conducts all of the activities of mental health treatment, including screening, assessment, diagnosis, treatment and follow-up care, s/he is well trained in behavioral health and relatively well versed in the use of psychotropic medications (Hunter, Goodie, Oordt, & Dobmeyer, 2009)

3. Co-Located Care. This model is based on the premise that the likelihood of collaboration increases with proximity and ease of communication (Collins et al., 2010). Still, with co-location, primary care and behavioral health maintain two discrete delivery systems (Collins et al., 2010). The primary care physician conducts screenings, though assessments and treatments are directed to the mental health provider (Collins et al., 2010).

4. The Chronic Care Model strives for early identification, access to care, use of evidence based treatment practices and increased rates of treatment compliance and self care management (Collins et al., 2010). A key provider in this model is the care manager who not only supports the patient in treatment compliance but also manages the communication and coordination of care (Collins et al., 2010). This model operates through co-location of both disciplines but adds interventions that are designed for use in the primary care setting (Collins et al., 2010). In this model, all aspects of the treatment protocol are conducted within the primary care practice. The PCP conducts the screening, diagnostic and prescribes treatment but other members of the primary care team such as nurse practitioners and care manager and/or social workers may engage in other roles as well (Collins et al., 2010). Close monitoring and follow up with chronic care patients is a key element of this model, as is patient education and development of self-management skills (Collins et al., 2010). Members of the primary care team -other than the primary care physician -

administer all activities, while psychiatrists and psychologists are available for consultation (Collins et al., 2010).

5. Reverse Co-Location, requires primary care physicians to serve patients medical needs within the behavioral health delivery systems (Collins et al., 2010). In this model both primary care physicians and mental health clinicians receive training in the other discipline with the goal of better recognition of symptoms of mental and/or physical health disorders (Collins et al., 2010). Primary care physicians do not conduct mental health aspects of care, but retain their role as a physical health provider.

6. Unified Primary Care and Behavioral Health. This model folds psychiatric care into the primary care practice. These models are full service delivery care centers that have been implemented in unique settings such as federally qualified health centers and in the Veterans Health Association (Collins et al., 2010). While primary care physicians continue to conduct screenings, they are not called to perform other mental health services (Collins et al., 2010).

7. Primary Care Behavioral Health is a fully integrated care setting where behavioral health care is a regular part of general medical care (Collins et al., 2010). A behavioral health practitioner is a member of the primary practice team. The primary care physician is the primary provider, although the behavioral health provider may co-manage some patients (Collins et al., 2010). The primary care physician conducts the initial screening and makes a referral as needed. The behavioral health provider generally conducts all other mental health care protocols. This model emphasizes a population-based approach with the goal of providing education, brief interventions and self-management techniques for individuals with a behavioral health disorder and those deemed at increased risk (Collins et al., 2010). This approach serves a large number of patients and reaches those who may not otherwise receive care or follow-up with a referral (Collins et al., 2010).

8. Collaborative System of Care. This model may be partially or fully integrated. It best serves a population whose mental health needs tend to be more severe or persistent (Collins et al., 2010). This model integrates primary care and specialty behavioral health care systems and is most often designed for high-risk populations such as the homeless or elderly (Collins et al., 2010).

Barriers to Integration:
Payment Structure

The barriers and challenges to integrated care in the US are numerous. Most barriers are related to financing. Although there is some evidence that integration leads to potential savings in overall medical expenses (AHRQ, 2008), the financing problem is exacerbated by the structure of contemporary primary care, where practices often contract with various insurance plans and inconsistencies across plans' payment approaches are frequent. Indeed, the Agency for Healthcare Research and Quality recognizes that financial barriers to integrated care models exist "primarily because many activities associated with integrated care, such as many care management functions, consultations and other communication activities between providers, and telephone consultation with patients, are not traditionally reimbursed under typical fee-for-service care" (AHRQ, 2008).

In the US, integrated care programs and insurance plans are attempting to address many of these barriers. These efforts include establishing reimbursements for screenings and strategies to cover case managers (AHRQ, 2008). Fundamental to redesign is a restructuring of reimbursement that pays for performance or replaces replace fee-for-service payments with bundled payments (AHRQ, 2008; Frank et al, 2003). Organizational issues and infrastructure also act as barriers to implementing integrated care models. Most models revolve around strategies for structural and procedural change and the acquisition of new knowledge and training in the mental health field (AHRQ, 2008). Adoption of a comprehensive and shared electronic medical records system that respects current privacy laws is essential (AHRQ, 2008; World Health Organization et al., 2008) Lastly the Agency for Healthcare Research and Quality report raises concern about sustainability of integrated care models. According to the report, "translating integrated programs into real-world clinical settings using models from trials with positive results is a challenge. Implementation has taken place at the cost of model fidelity since financial barriers impede program solvency" (AHRQ, 2008).

Managed Care

Managed care can be very effective at containing costs for patients with behavioral health disorders and is most successful in doing so through primary care patient management (Blount et al., 2007; Chiles, Lambert, & Hatch, 1999; Fraser, 1996; Harvey et al., 1998; W. J. Katon, Roy-Byrne, Russo, & Cowley, 2002; Pincus, Pechura, Keyser, Bachman, & Houtsinger, 2006). Medically-Provided Behavioral Health, Co-located and Reverse Co-located Care, (Models 2, 3 and 5) function easily within managed care systems. In these models there is no need to seek reimbursement for collaborative contact and pre-approvals for primary care treatment plans are faced with minimal resistance, since treatment in primary care settings will be less expensive than specialty

care (Blount et al., 2007). In fact managed care often encourages the use of models that retain patients in primary care rather than specialty care settings, such as the Medically-Provided Behavioral Health model (Blount et al., 2007; Pincus et al., 2006).

Yet even greater support for integration could be achieved if the managed care organizations offered reimbursements for trainings for primary care physicians and their staff in behavioral health (Collins et al., 2010). As noted previously, Fee-For-Service codes separate billing services between physicians and mental health specialists and do not allow billing of two separate services, physical visit and mental health screen for instance, that occurred in the same day (AHRQ, 2008; Mauch, 2011). This payment structure does not incentivize primary care providers to screen during their visits (Blount et al., 2007).

The Disease Management Model, Unified Primary Care and Behavioral Health, Primary Care Behavioral Health and Collaborative System of Care (models 6, 7 and 8) fall to the far right of the spectrum in the highly integrated section, with varying degrees of full integration and collaboration. In many of these models their coordination component hinges on a care manager or case coordinator position, however the activities of this position are often non-reimbursable (Collins et al., 2008). Other issues arise for these models when working through managed care. Most revolve around non-reimbursement issues for other key components of the model. In particular, collaboration, communication and information sharing, team time, referral follow up and consultations from the mental health provider are not billable (AHRQ, 2008).

Finally, it should be noted that delayed approval may impede treatment (Blount et al., 2007). For instance, mental health patients may be resistant to some care components, and the ability to begin a course of treatment when the patient is willing to engage is important (Blount et al., 2007). However if the insurer delays approval beyond this timeframe it may reduce the benefits of treatment (Blount et al., 2007). Additionally, treatment plan approvals are made by distant managed care organizations rather than on site patient centered treatment teams. Finally, some insurers reject recommendations made by physicians, preferring to try less costly treatments first (Blount et al., 2007; Frank et al., 2003).

Models of Coordination & Integration: Evidence

Research studies assessing the benefits of integrated or collaborative care are numerous. A brief description of the benefits of integration across a variety of health care settings is noted with particular attention paid to evidence in the area of integrated behavioral health and primary care.

Overall, the service and patient oriented benefits of integration are numerous and well documented, including improved access and treatment initiation (Watts, Shiner, Pomerantz, Stender, & Weeks, 2007; Unützer et al., 2002), better functional outcomes (Bartels et al., 2004; Hedrick et al., 2003) enhanced clinical outcomes, adherence to medication and cost containment (W. Katon et al., 2002; Rollman et al., 2005; Unützer et al., 2002). Randomized controlled trials (RCTs) have shown the use of care managers to be clinically effective in reducing hospitalizations (Blount et al., 2007; Collins et al., 2008). Meta-analyses reports also concluded that these models are cost effective, upwards of a 40 percent savings in acute care costs for primary care patients who receive behavioral health services (Blount et al., 2007).

Many early trials of integration models used the Wagner Chronic Care Model (CCM) as the basis of design. All of the reported studies for integrated Chronic Care Models showed positive results for "symptom severity, treatment response, and remission when compared to usual care" (AHRQ, 2008). One primary study based on the Chronic Care Model was The Robert Wood Johnson Foundation Initiative- Depression in Primary Care: Linking Clinical and System Strategies (Collins et al., 2010). The study uniquely attempted to address financial and structural barriers as well as patient outcomes. Another notable study on CCM is the randomized control trial conducted by the John A Hart Foundation Initiative titled Improving Mood: Promoting Access to Collaborative Treatment (IMPACT). The results of this large clinical trial are encouraging: intervention subjects reported lower rates of depressive symptoms compared at follow-up compared to baseline and higher rates of treatment engagement than control subjects (Unützer et al., 2002).

A 2012 Cochrane meta-analysis examining clinical outcomes and cost effectiveness across 76 sites demonstrates the effectiveness of integrated care (Archer et al., 2012; Fortney, 2014). The analysis found that an integrated model improved patient functioning and clinical outcomes more successfully than traditional care for common mental health disorders such as depression and anxiety (Archer et al., 2012; Fortney, 2014). However, such improvements were not nearly as robust for other mental health disorders and substance abuse disorders (Archer et al., 2012; Fortney, 2014). Significant costs benefits as well as enhanced patient satisfaction and improved clinical outcomes were also observed in the IMPACT study of collaborative care for co-occuring disorders including depression, in older adults (Unützer et al., 2002). In fact, the IMPACT study data point to evidence of significant cost savings in the long run with a 6:1 return on investment for every dollar spent (Unützer et al., 2002).

While evidence supports the chronic care model, resources and changes to payment structures are required to successfully implement this model. Nevertheless, the CCM is

currently at the forefront of US health care system reforms for patients with chronic illnesses (Collins et al., 2010; Rittenhouse & Shortell, 2009). It has become the preferred model for adoption in the nation's health care reform legislation and has taken the form of Patient Centered Medical home models in the private insurance market and health home models of care for the public insurance, Medicaid. Druss et al (2001) found positive outcomes for the Unified Primary Care and Behavioral Health model in a randomized control trial (Collins et al., 2010; Druss, Rohrbaugh, Levinson & Rosensheck, 2001). Results included reduced emergency room visits, enhanced health status and retention in treatment (Collins et al., 2010; Druss et al., 2001). To date, the Primary Care Behavioral Health model has not yet been rigorously evaluated (Collins et al., 2010). It should be noted that for the most part, these models are being adopted through voluntary efforts or CMS (The Centers for Medicaid & Medicare Services) demonstration projects, not a nationwide rollout.

Implications for reform efforts in Israel

According to the Samuel and Rosen study (2012) individuals in need of behavioral health services in Israel present most often in primary care. In response to this reality and in light of the expected mental health reforms, Israeli health plans have been developing ways to support primary care physicians in serving mental health patients (Samuel & Rosen, 2012). Briefly, will examine current efforts of each health plan as described in the report and align these activities with the models discussed.

Given its formal psychiatric consultation linkage and referral source for psychiatric care, Clalit's model is similar to the Medically-Provided Behavioral Health and some form of collaborative care model. The Leumit Health Plan also has formal psychiatric consultation linkages and referral sources for psychiatric care for their patient population (Samuel & Rosen, 2012). It appears that they are interested in designing a care management/care coordination component with a nursing staff to support patient compliance. Leumit therefore is instituting aspects of the both the Medically-Provided Behavioral Health and a form of collaborative care, as well as key components (case management) of the Chronic Care and other more integrated models.

Maccabi has formalized support to primary physicians with consultation services from local psychiatrists and psychologists as in the Collaborative care models. The report suggests that Maccabi plans to develop Chronic Care Models (CCM) within the behavioral health care system. The establishment of multi-professional clinics assumes a multi-disciplinary team, which may include primary care physicians, as in reverse co-location models. As noted, Meuhedet is developing the most integrated form of care(Samuel & Rosen, 2012). Their design mirrors the Unified Primary Care and Behavioral Health Model, as mental-health care is provided at the primary health sites,

while clinics are portrayed as "psychological-medical service" delivery centers (Samuel & Rosen, 2012). In addition mental health staff are an integrated part of the primary practice team and viewed as partners, educators, and advisors.

It appears that all four health plans are moving toward a Medically-Provided Behavioral Health model for soft psychiatry, such that primary care physicians will be the primary mental health care provider with assistance from psychiatric consultation services (Samuel & Rosen, 2012). The Milbank Fund report highlights resources necessary for the development of each model as well as considerations for each.

Summary

Evidence is clear that integration of primary care and mental health are essential to enhanced patient wellbeing, improved clinical outcomes and cost containment. Still important questions remain regarding implementation of multiple models, which models work best where and which can successfully function within a managed care environment. As noted the roles of primary care physicians are numerous and varied, attention must be paid to organizational and structural factors that allow for primary care physicians to draw on the strengths of their discipline while being mindful of the clinical setting, their time constraints, skill sets and training.

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Bibliography

Abrams, M., Schor, E. L., & Schoenbaum, S. (2010). How physician practices could share personnel and resources to support medical homes. *Health Affairs, 29*(6), 1194-1199.

Ader, J., Stille, C. J., Keller, D., Miller, B. F., Barr, M. S., & Perrin, J. M. (2015). The medical home and integrated behavioral health: advancing the policy agenda. *Pediatrics, 135*(5), 909-917.

AHRQ, Butler, Mary, Kane, Robert, McAlpine, Donna, Kathol,Robert, Fu, Steven, Hagedorn, Hildi, Wilt, Timothy. (2008). Intergration of Mental Health/Substance Abuse adn Primary Care *Evidence Reports AHRQ* (Vol. Evidence Reports/Technology Assessments, No 173).

Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., . . . Coventry, P. (2012). Collaborative care for depression and anxiety problems. *Cochrane Database Syst Rev, 10*(10).

Bartels, S. J., Coakley, E. H., Zubritsky, C., Ware, J. H., Miles, K. M., Areán, P. A., . . . Costantino, G. (2004). Improving access to geriatric mental health services: a randomized trial comparing treatment engagement with integrated versus enhanced referral care for depression, anxiety, and at-risk alcohol use. *American Journal of Psychiatry*.

Blount, A., Schoenbaum, M., Kathol, R., Rollman, B. L., Thomas, M., O'Donohue, W., & Peek, C. (2007). The economics of behavioral health services in medical settings: A summary of the evidence. *Professional Psychology: Research and Practice, 38*(3), 290.

Chen, H., Coakley, E. H., Cheal, K., Maxwell, J., Costantino, G., Krahn, D. D., . . . Zaman, S. (2006). Satisfaction with mental health services in older primary care patients. *The American journal of geriatric psychiatry, 14*(4), 371-379.

Chiles, J. A., Lambert, M. J., & Hatch, A. L. (1999). The Impact of Psychological Interventions on Medical Cost Offset: A Meta‐analytic Review. *Clinical Psychology: Science and Practice, 6*(2), 204-220.

Collins, Hewson, D., Munger, R., & Wade, T. (2010). Evolving Models of Behavioral Health Integration in Primary Care (New York: Milbank Memorial Fund, 2010). New York, NY: Milbank Memorial Fund.

Cunningham, P. J. (2009). Beyond parity: primary care physicians' perspectives on access to mental health care. *Health Affairs, 28*(3), w490-w501.

Druss, B. G., & Mauer, B. J. (2010). Health care reform and care at the behavioral health—primary care interface. *Psychiatric Services, 61*(11), 1087-1092.

Druss, B. G., Rohrbaugh, R. M., Levinson, C. M., & Rosenheck, R. A. (2001). Integrated medical care for patients with serious psychiatric illness: a randomized trial. *Archives of General Psychiatry, 58*(9), 861-868.

FFMPLC, F. o. F. M. P. L. C., & Kahn, N. B. K., Jr, MD. (2004). The future of family medicine: a collaborative project of the family medicine community. *The Annals of Family Medicine, 2*(suppl 1), S3-S32.

Fortney, J., Sladek, R, Unutzer, J. . (2014). Fixing Mental Health Care in America: A National Call for Integertaing and Coordinating Specialty Behavioral Health Care into the Medical System. In T. K. Forum (Ed.), *An Issue Brief Released by the Kennedy Forum*: The Kennedy Forum and Advancing Integrated Mental Health Solutions Center.

Frank, R. G., & Glied, S. A. (2006). *Better but not well: Mental health policy in the United States since 1950*: JHU Press.

Frank, R. G., Huskamp, H. A., & Pincus, H. A. (2003). Aligning incentives in the treatment of depression in primary care with evidence-based practice. *Psychiatric Services, 54*(5), 682-687.

Fraser, J. S. (1996). All that glitters is not always gold: Medical offset effects and managed behavioral health care. *Professional Psychology: Research and Practice, 27*(4), 335.

Harvey, I., Nelson, S. J., Lyons, R. A., Unwin, C., Monaghan, S., & Peters, T. J. (1998). A randomized controlled trial and economic evaluation of counselling in primary care. *British Journal of General Practice, 48*(428), 1043-1048.

Hedrick, S. C., Chaney, E. F., Felker, B., Liu, C. F., Hasenberg, N., Heagerty, P., . . . Paden, G. (2003). Effectiveness of collaborative care depression treatment in Veterans' Affairs primary care. *Journal of general internal medicine, 18*(1), 9-16.

Hodges, B., Inch, C., & Silver, I. (2001). Improving the psychiatric knowledge, skills, and attitudes of primary care physicians, 1950-2000: a review. *American Journal of Psychiatry, 158*(10), 1579-1586.

Hogan, M. F. (2003). New Freedom Commission report: the President's New Freedom Commission: recommendations to transform mental health care in America. *Psychiatric Services, 54*(11), 1467-1474.

Hunter, C. L., Goodie, J. L., Oordt, M. S., & Dobmeyer, A. C. (2009). *Integrated behavioral health in primary care: Step-by-step guidance for assessment and intervention*: American Psychological Association.

Hyde, P. S. (2014). State mental health policy: A unique approach to designing a comprehensive behavioral health system in New Mexico. *Psychiatric Services*.

Jacobson, N. (2004). *In recovery: The making of mental health policy*: VU University Press.

Karlin, B., & Fuller, J. (2007). Geriatric mental health service use and treatment outcomes: Implications for primary care practice. *Geriatrics, 62*, 26-35.

Katon, W., & Gonzales, J. (1994). A review of randomized trials of psychiatric consultation-liaison studies in primary care. *Psychosomatics, 35*(3), 268-278.

Katon, W., Russo, J., Von Korff, M., Lin, E., Simon, G., Bush, T., . . . Walker, E. (2002). Long‐term Effects of a Collaborative Care Intervention in Persistently Depressed Primary Care Patients. *Journal of general internal medicine, 17*(10), 741-748.

Katon, W. J., Roy-Byrne, P., Russo, J., & Cowley, D. (2002). Cost-effectiveness and cost offset of a collaborative care intervention for primary care patients with panic disorder. *Archives of General Psychiatry, 59*(12), 1098-1104.

Kessler, R., Ciu, W., Deler, O., & Walters, E. (2005). Prevalence, Severity, and Comorbidity of Twelve-month DSM-IV Disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry, 62*(6), 617-627.

Klein, S., & Hostetter, M. (2014). In Focus: Integrating Behavioral Health and Primary Care [Press release]. Retrieved from http://www.commonwealthfund.org/publications/newsletters/quality-matters/2014/august-september/in-focus

Kolko, D. J., Campo, J., Kilbourne, A. M., Hart, J., Sakolsky, D., & Wisniewski, S. (2014). Collaborative care outcomes for pediatric behavioral health problems: a cluster randomized trial. *Pediatrics*, peds. 2013-2516.

Kuehn, B. M. (2011). Pediatrician-psychiatrist partnerships expand access to mental health care. *Jama, 306*(14), 1531-1533.

Liu, C.-F., Hedrick, S. C., Chaney, E. F., Heagerty, P., Felker, B., Hasenberg, N., . . . Katon, W. (2003). Cost-effectiveness of collaborative care for depression in a primary care veteran population. *Psychiatric Services*.

Mauch, D. (2011). *Reimbursement of mental health services in primary care settings*: DIANE Publishing.

Mitchell, A. J., & Selmes, T. (2007). Why don't patients attend their appointments? Maintaining engagement with psychiatric services. *Advances in Psychiatric Treatment, 13*(6), 423-434.

National Quality Forum, N. (2010). Preferred practices and performance measures for measuring and reporting care coordination: a consensus report. *Preferred practices and performance measures for measuring and reporting care coordination: a consensus report*: National Quality Forum, NQF.

Nirel, N., & Samuel, H. (2014). Work practices and the provision of mental-health care on the verge of reform: a national survey of Israeli psychiatrists and psychologists. *Isr J Health Policy Res, 3*(1), 25.

Odom, C. H., & Milbank, S. L. (2010). Evolving Models of Behavioral Health Integration in Primary Care By Chris Collins, Denise Levis Hewson, Richard Munger, and Torlen Wade May 2010.

Patterson, E. S., Roth, E. M., Woods, D. D., Chow, R., & Gomes, J. O. (2004). Handoff strategies in settings with high consequences for failure: lessons for health care operations. *International Journal for Quality in Health Care, 16*(2), 125-132.

Pignone, M. P., Gaynes, B. N., Rushton, J. L., Burchell, C. M., Orleans, C. T., Mulrow, C. D., & Lohr, K. N. (2002). Screening for depression in adults: a summary of the evidence for the US Preventive Services Task Force. *Annals of internal medicine, 136*(10), 765-776.

Pincus, H. A., Pechura, C., Keyser, D., Bachman, J., & Houtsinger, J. K. (2006). Depression in primary care: learning lessons in a national quality improvement program. *Administration and Policy in Mental Health and Mental Health Services Research, 33*(1), 2-15.

Regier, D. A., Narrow, W. E., Rae, D. S., Manderscheid, R. W., Locke, B. Z., & Goodwin, F. K. (1993). The de facto US mental and addictive disorders service system: Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry, 50*(2), 85-94.

Rittenhouse, D. R., & Shortell, S. M. (2009). The patient-centered medical home: will it stand the test of health reform? *Jama, 301*(19), 2038-2040.

Rollman, B. L., Belnap, B. H., Mazumdar, S., Houck, P. R., Zhu, F., Gardner, W., . . . Shear, M. K. (2005). A randomized trial to improve the quality of treatment for panic and generalized anxiety disorders in primary care. *Archives of General Psychiatry, 62*(12), 1332-1341.

Samuel, H., & Rosen, B. (2012). How are the Health Plans Mobilizing to Provide Mental-Health Services? Jerusalem Israel: Myers-JDC-Brookdale Institute.

Solberg, L. I., Trangle, M. A., & Wineman, A. P. (2005). Follow-up and follow-through of depressed patients in primary care: the critical missing components of quality care. *The Journal of the American Board of Family Practice, 18*(6), 520-527.

Speer, D. C., & Schneider, M. G. (2003). Mental health needs of older adults and primary care: Opportunity for interdisciplinary geriatric team practice. *Clinical Psychology: Science and Practice, 10*(1), 85-101.

Unützer, J., Katon, W., Callahan, C. M., Williams Jr, J. W., Hunkeler, E., Harpole, L., . . . Lin, E. H. (2002). Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *Jama, 288*(22), 2836-2845.

Unützer, J., Schoenbaum, M., Druss, B. G., & Katon, W. J. (2014). Transforming mental health care at the interface with general medicine: report for the presidents commission. *Psychiatric Services*.

Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 629-640.

Watts, B. V., Shiner, B., Pomerantz, A., Stender, P., & Weeks, W. B. (2007). Outcomes of a quality improvement project integrating mental health into primary care. *Quality and Safety in Health Care, 16*(5), 378-381.

Willging, C. E., Lamphere, L., & Rylko-Bauer, B. (2015). The Transformation of Behavioral Healthcare in New Mexico. *Administration and Policy in Mental Health and Mental Health Services Research, 42*(3), 343-355.

Woltmann, E., Grogan-Kaylor, A., Perron, B., Georges, H., Kilbourne, A. M., & Bauer, M. S. (2012). Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: systematic review and meta-analysis. *Perspectives, 169*(8).

World Health Organization, W., World Organization of National Colleges Academies, & Academic Associations of General Practitioners/Family Physicians, A. F. (2008). *Integrating mental health into primary care: a global perspective* (G. a. I. Funk, M Ed.): World Health Organization.

Zeiss, A. M., & Karlin, B. E. (2008). Integrating mental health and primary care services in the Department of Veterans Affairs health care system. *Journal of Clinical Psychology in Medical Settings, 15*(1), 73-78.