GRANTMAKERS IN HEALTH

Filling a Gap in Care:

The Need for Behavioral Health Integration

In the United States, mental disorders are the leading cause of disability for ages 15-44, affecting about a quarter of the population over age 18 (Kessler 2005; U.S. Census Bureau 2005). This group is at higher risk for chronic physical health conditions, but primary care is often provided in isolation of behavioral health care, and vice versa. An integrated approach addresses this challenge by systematically coordinating physical and behavioral health services to more fully meet individual needs.

The separation between primary and behavioral health care is not a new problem. Previous efforts to bridge the gap have focused on provider education and an increased use of referrals, neither of which have led to large improvements in, or access to, care. Referrals have been especially problematic, as patients often do not follow through due to lack of insurance, high copays, distance to provider, and stigma (Hogg Foundation for Mental Health 2008).

MODELS OF CARE

Over time numerous models of integrated care have been developed, with varying success. Because integrated care is an emerging field, there is debate as to which models provide the best form of integrated care, and which are the most realistic.

- **Colocation**, where primary care and behavioral health specialists are located in the same setting, can be problematic, as it does not require primary care doctors and behavioral health clinicians to communicate with each other. The convenience of having the two providers in close proximity, however, may increase mental health treatment initiation and adherence (Ginsberg and Foster 2009).
- **Consultation**, where behavioral health specialists provide support to primary care doctors, frequently occurs via telephone or videoconferencing. This model can increase access to care, particularly around medication management, but cannot easily provide more intense support.
- **Collaboration**, or the collaborative care approach, borrows from the chronic care model developed to manage conditions, such as diabetes, and is viewed by many to be the most effective model of integrated care.

The collaborative care approach incorporates behavioral health clinicians into the primary care setting. This is practical, as many people seek behavioral health care from their primary care physician, in part due to the surrounding stigma. In this model, a care manager, supervised by a psychiatrist, monitors patient response to treatment and provides support and education.

Primary care has also been incorporated into behavioral health care settings, creating another form of collaboration. This model can be particularly helpful for individuals with serious mental illnesses who may be more comfortable in the behavioral health setting.

BARRIERS

Clinical, organizational, legal, and financial barriers stand in the way of integrated care. Among the most challenging are the hurdles around billing and reimbursement. Public and private health insurance companies often keep physical and behavioral health care separate, leading to a maze of financial complexities. For example, insurers may not pay for two encounters with the same organization on the same day (such as when behavioral health and primary care appointments are scheduled together) and they may not pay providers for the time spent coordinating care.

OPPORTUNITIES FOR FUNDERS

Making the switch to an integrated system of care is difficult, but foundations can help provide much of the support, as illustrated by the following examples.

➤ ***Planning for Evaluation*** – Awareness of the need for integrated care has grown considerably, but models, financing structures, and related policies are still evolving, and further examination is necessary to document results and, consequently, solidify support. In 2008, to incorporate behavioral health services into primary care settings across southeast Michigan, The Ethel and James Flinn Foundation funded the implementation and evaluation of integrated care at eight diverse sites, including health clinics, school-based health centers, and hospitals. As the evaluation plan was developed, the foundation and grantees agreed upon eight outcomes to be measured across all sites, including mental and physical health diagnoses and patient and provider satisfaction. At the end of the three-year grant, results will be reported in a field guide on lessons learned.

Around the same time grantees were being identified, the state provided funding with a very similar purpose to 11 community mental health centers. To strengthen each

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others' work, the foundation invited the 11 state-funded sites to join their evaluation, and the state-funded sites opened up their established learning community to the foundation's grantees (Cole 2009).

Also focusing on assessment, the Endowment for Health in New Hampshire supported an evaluation of four primary care clinics with an established history of integration. Each of the sites provides integrated care in a slightly different way, but all serve low-income populations. Earlier this year, an individual evaluation plan was created for each clinic, as well as a broader cross-site plan. Both aim to provide information on the impact of integration on patient outcomes and cost of care. Differences between the clinics are seen as a strength of the study and reflective of the real world, as integrated care models typically vary from site to site. Results will be used to inform state policymakers, since integrated care is unlikely to gain widespread traction without rigorous evaluation results. In general, funding research can be risky because the results are unknown, but the endowment has had success in the past; a previous evaluation study led to a new Medicaid benefit in the state (Kaplan and Ryder 2009).

➤ ***Focusing on Children's Care*** – Because of the importance of prevention and early intervention, work on integrated care has also focused on children. In 2007 the Child Health and Development Institute of Connecticut (CHDI), a subsidiary of the Children's Fund of Connecticut, awarded integrated care funding to four pediatric primary care practices, each of which partnered with a behavioral health organization. All grantee sites have experienced success with the project, and results include expanded primary-care based behavioral health intervention services and an established model of collaboration between the partnering primary care and behavioral health providers.

As part of the grant, providers at each of the sites were trained to administer a screening tool used to identify developmental and behavioral problems in children. Training varied from site to site and was provided through CHDI's Educating Practices in their Communities program, which utilizes a variety of training modules to inform clinic staff about critical children's health issues. Current modules include *Connecting Children to Behavioral Health Services* and *Children's Behavior Problems: Brief Office Interventions (*Honigfeld 2009).

To develop and enhance integrated care models across the state, the Illinois Children's Healthcare Foundation (ICHF) has funded 19 implementation grants over the past two years. ICHF has also provided an additional seven planning grants to collaborative groups across the state to analyze existing service capacity, identify gaps in service, develop an evaluation plan, and produce a strategic and financial sustainability plan. As these programs develop, ICHF has identified several key lessons learned:

- Both effective leadership and the development of trust among partners are fundamental to program success.
- The language used by mental health providers and primary care providers can have different meanings and contexts. This should be taken into consideration as screening tools are developed and medical records are shared.
- Financial and policy barriers must be overcome early in the process (Lemke 2009).

While the integrated care knowledge base grows, so do the momentum for change and the opportunities for effective funder involvement.

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