



New Models for Integrating Behavioral Health and Primary Care

Lessons from Six Colorado Health Care Providers

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Health Coach Gabriela Pena meets with a patient at Union Square Health Home in Lakewood. BRIAN CLARK/CHI

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Introduction

Colorado is forging ahead with new models of care delivery that integrate the treatment of behavioral health and physical health.

These evolving models combine physical health care with behavioral health care, often in one setting and with one team of providers, instead of the traditional method of providing these services separately.

By consolidating physical and behavioral care, practices across the state are aiming to make their patients healthier while lowering long-term costs in the process. And as the Affordable Care Act leads to more Coloradans with insurance that covers mental health and substance use needs, health care organizations are hoping to better meet increased demand.

Colorado is placing a big bet on the expected benefits of blending physical and behavioral health care. Care integration is a focus of Colorado's \$65 million State Innovation Model (SIM) award from the Centers for Medicare & Medicaid Services (CMS). The state's goal is to have fully integrated primary and behavioral health care available to 80 percent of Coloradans by 2019.

This bet, however, builds on a solid foundation of work underway in Colorado. Many practices already are innovating around integration in both the private and public sectors.

The Colorado Health Institute (CHI) studied six practices that are testing an array of approaches to integration, tailoring models to their locations, their client populations, their workplace cultures and their available resources, among other considerations.

These groundbreaking clinics are spread across Colorado in both urban and rural areas. Some are privately funded while others are supported by



The hub of New West Physicians behavioral health initiative is its clinic in Golden. BRIAN CLARK/CHI

public money. But they have at least two things in common. Each demonstrates how communities are developing local health care solutions to meet local needs. And each has lessons for Colorado's policymakers, health care leaders and practices just beginning the integration journey.

Based on our analysis of these practices, CHI has identified **five critical success factors** for implementing an integrated approach to care delivery.

While integration is a complex undertaking, practices both inside and outside of Colorado can consider these factors as part of a strategic approach to the hard work of combining primary care and behavioral health.

The Five Critical Success Factors

1. Align the Level of Integration With Patient Needs and Practice Capacity.

Focusing on patient needs drives the most effective integration models. Patient needs exist along a continuum for both behavioral health care and medical care, from prevention and wellness services to complex and ongoing care for chronic conditions. The complexity of patient needs drove the integration models we observed, ranging from primary care providers consulting with mental health professionals located in the same building to hiring mental health clinicians to join the practice.

2. Innovate and Adapt Both the Workforce and the Workplace.

Many of today's clinicians have not been trained to work on integrated primary care and behavioral health teams. We observed that new kinds of providers, or providers practicing in new ways, are the linchpin to effective integration. The best workplace cultures for integration are flexible, able to adapt quickly but thoughtfully to a changing environment.

3. Create New Funding Models That Support Integration.

The scale at which behavioral health care can be combined with primary care services

will largely depend on how quickly payment models that can sustain integration are implemented. Demonstrating a return on investment, both financially and in improved health outcomes, will help persuade insurers to pay for more services that are critical to providing integrated care.

4. Recognize that Patient Numbers Impact Integration Potential.

Patient volume drives decisions regarding the level of integration and the specialization of the integrated team, according to our observations. A practice must care for enough patients to support the infrastructure and staff needed to provide the range of needed behavioral health and medical services.

5. Lead Creatively and Learn Constantly.

Integration is new. It presents many challenges. And practice leaders must be creative and flexible to address them. The leaders we observed are committed to the model, attentive to providing the resources and training to make it work and willing to make midcourse corrections. Ongoing evaluation will be essential to better understand the clinical and business reasons for integration. While necessary, it will be costly.

CHI's analysis highlights critical questions that practices should ask as they decide on a care delivery model, identifies useful strategies for advancing integration and provides lessons from the field for providers and policymakers in a rapidly changing environment.

This is a first look at a quickly evolving field. Many of these models are new, and evaluation is, in many cases, just beginning. CHI will continue to track progress, following up with the clinics profiled here to learn more about what is working well and what challenges remain.

Colorado's Definition of Behavioral Health Integration

"The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms and ineffective patterns of health care utilization."

Integrated Care

Putting Health Together Again

1. Good behavioral health is key to good overall health.

Behavioral Health Includes:



About **1 of 10**
Coloradans (10.6%)

Report poor mental health, defined as eight or more days in the past month when their mental health was not good.²



About **866,000**
Coloradans (17.1%)

Needed behavioral health services at some point during the year, according to the most recent estimates available (2009).⁴

The Connection

Of Coloradans reporting **Good Mental Health 90.0%** also report **Good Physical Health**.³

Of Coloradans reporting **Poor Mental Health 55.3%** also report **Good Physical Health**.³

2. But the traditional health care system treats behavioral health and physical health separately.



Primary Care

Often the first place that behavioral health needs are identified. But when patients are referred to a behavioral health provider, many don't go.⁵



Lost in the Middle

Most mental health conditions aren't treated at all or are inadequately treated.⁶

Nearly eight percent of Coloradans – more than 337,000 people – report not getting needed mental health services.⁷



Behavioral Health Care

Patients in the mental health system often don't get physical health care, which can lead to premature death from treatable medical conditions.^{8,9}

3. Integrating behavioral health care and primary care treats the whole person.



A Picture of Integrated Care

- One team of providers, both primary care and behavioral health
- A systematic and cost-effective approach
- Sharing information on a timely basis
- A defined group of patients and their families.



The Goals

- Improved Health Outcomes
- Lower Cost
- Better Experience of Care



What is Behavioral Health Integration?

The patient has a care team consisting of both primary care and behavioral health clinicians. They collaborate to address physical health, mental health, substance use, stress and behaviors that contribute to chronic illness. The care team also helps the patient to more effectively use the health system.

An integrated model uses standard procedures such as screenings and consultations to identify needs and to provide access to appropriate care. But it also has flexibility to serve varied populations. For example, people with severe and persistent mental illness often require a different care team than those who are generally healthy.

There are a variety of ways to deliver care in a more integrated way:

- **Providers** might work in separate locations with established systems to refer patients and communicate about their needs.
- **Co-locating** the physical health and behavioral health providers in the same building, or even in the same office space, could be the next step. This makes communication easier and allows patients to consult with both providers at the same time.
- **A care team** that shares exam rooms, medical records, scheduling and visits with patients, represents an even more fully integrated approach.

The *Standard Framework for Levels of Integrated Healthcare*, published by the SAMSHA-HRSA Center for Integrated Health Solutions, provides detailed descriptions of how key elements of integration — communication, physical proximity and practice change integration — define six levels of integration. These levels of integration range from minimal collaboration to a fully merged, integrated practice.¹⁰



Colorado's SIM Project

The State Innovation Models (SIM) initiative — a Centers for Medicare & Medicaid Services Innovation Center program — supports state-level testing of innovative approaches to health care delivery and payment.

Colorado won a \$65 million SIM award in December 2014, one of 17 states to receive this kind of funding.

Each awardee has detailed a “big idea” that will accelerate movement toward the Triple Aim goals of better health care, improved health outcomes and lower costs.

Colorado's big idea is to improve the health of Coloradans by providing access to integrated primary care and behavioral health services for 80 percent of the state's residents by 2019. The integrated care will be delivered in coordinated community systems and be supported by value-based payment structures.

The vision includes practice transformation, population health and consumer engagement, payment reform, robust IT infrastructures and quality measurement.

Colorado's Timeline

2015: Ramp up with practice assessment tools, IT infrastructure and regional planning

2016: 100 practices on board; launch regional population health transformation collaboratives; ongoing evaluation

2017: 150 practices on board

2018: 150 practices on board



Integrating Behavioral Health and Primary Care in Colorado

The six practices studied by CHI illustrate an array of approaches to integrating behavioral health and primary care. Three are safety net providers that focus on serving low-income and vulnerable populations. The other three are commercial market practices, which rely primarily on payments from commercial insurers. (See Map 1.) They were selected for the diversity of settings and models they represent.

SAFETY NET

Cortez Integrated Healthcare

This clinic on Colorado's Western Slope is part of Axis Health System, which also operates a community health center in Durango as well as community mental health centers and school-based health centers across southwest Colorado. The Cortez clinic, designed specifically for integrated care, opened in January 2012. Primary care and behavioral health providers work in tandem in shared exam rooms, supported by new tools for screening and sharing health information with both providers and patients.

Salud Family Health Centers

A community health center with 10 clinics across north central Colorado, Salud Family Health Centers has provided integrated care for nearly 20 years. Each primary care clinic has at least one behavioral health provider sharing exam rooms and electronic medical records with the primary care providers. The behavioral health providers screen new and high-risk patients, provide consultation with medical providers and other members of the care team, as well as provide ongoing behavioral health care and therapy services.

Union Square Health Home

Serving adults with serious mental illness, Union Square Health Home launched in early 2013 in a new Lakewood building. Enrollees receive both behavioral health and medical care at the same clinic. Care coordination is the central component of this health home approach, facilitating collaborative, team-based care. It is a partnership between Jefferson Center for Mental Health, a community mental health center, Metro Community Provider Network,

a community health center, and Arapahoe House, a substance use disorder treatment provider.

COMMERCIAL PRACTICES

New West Physicians

This is a primary care group practice with 18 locations across metro Denver. New West refers patients to therapists and a child psychiatrist who rent office space from New West and accept private insurance, but are not employees. These behavioral health providers communicate closely with primary care providers to better coordinate care. New West recently hired an adult psychiatrist who primarily manages medication and collaborates closely with primary care providers via a shared electronic health record. New West accepts insurance for this employed psychiatrist.

Primary Care Partners

A private practice with three locations in the Grand Junction area, Primary Care Partners participates in a variety of payment reform pilot projects that support integration of behavioral health and primary care. Behavioral health providers rotate through the primary care clinic, so there is always a behavioral health provider available for consultations, diagnoses and referrals. The behavioral health providers are employed by a behavioral health practice that shares a building with Primary Care Partners.

Kaiser Permanente Colorado

A health care system with 32 medical offices along the Front Range, Kaiser is both an insurer and a provider. Because of this, medical records are shared by primary care, behavioral health and specialist providers, making Kaiser well situated to provide integrated services. Kaiser has placed behavioral health providers in primary care clinics to improve communication and to promote patient acceptance. Behavioral health providers are part of care teams designed for patients with specific diagnoses, such as those who have both depression and poorly controlled diabetes.

► [Read our case studies beginning on page 19.](#)

Taking the First Step

Lessons from the practices CHI observed will be useful as a guide for the initial strategic thinking and the subsequent on-the-ground implementation necessary to increase the integration of behavioral health and primary care.

Each of these six practices began by answering basic questions such as as the number of patients they serve, the level of their physical and behavioral health needs, the services that would be reimbursed and available funding streams to cover unreimbursed services.

They then delved into workforce decisions, training options, data sharing and IT requirements, as well as funding.

All of these considerations led to the most important strategic decision: selecting the level and look of integration appropriate for their practice.

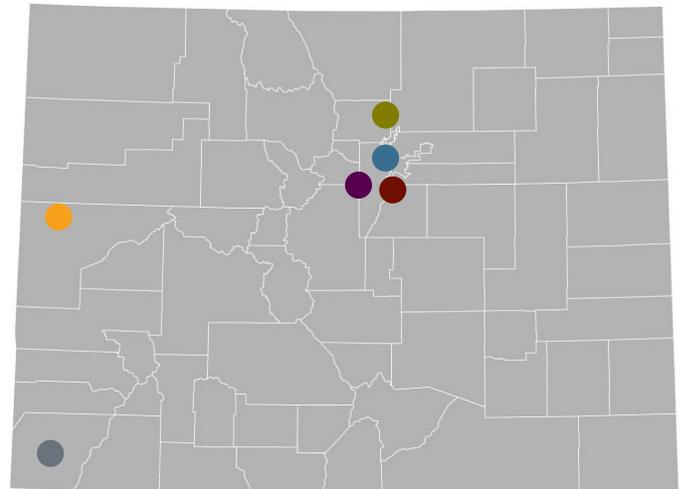
Important thinking on this process has been done by the federally funded SAMSHA-HRSA Center for Integrated Health Solutions. Its *Standard Framework for Levels of Integrated Healthcare* describes six levels of integrated care, ranging from minimal collaboration between a medical provider and a behavioral health provider to a fully integrated practice where care is merged and the approach to providing care has been transformed. (Please see Figure 1.)¹¹

Several practices observed for this paper are operating at high levels of collaboration, approaching full integration.

The safety net organizations most closely meet the criteria for full integration. They tend to be high-volume clinics serving populations with more acute behavioral health needs and they often have access to grant funding to support integrated models of care. Behavioral health and primary care providers share clinic space, patients and clinical data. Behavioral health is an integral part of the primary care visit for all new patients as well as those who need further behavioral health services.

Several clinics, both private and public, have behavioral health and primary care providers in the

Map 1. The six practices studied by CHI



● **New West Physicians (Denver Metro Area)**

● **Primary Care Partners (Grand Junction)**

● **Kaiser Permanente Colorado (Front Range)**

● **Salud Family Health Centers (Northern/Central Colorado)**

● **Cortez Integrated Healthcare (Cortez)**

● **Union Square Health Home (Lakewood)**

same location, sharing at least some clinical systems and meeting regularly to discuss patient needs.

For some clinics, co-location with close collaboration is the best model for now and may be sufficient to meet the needs of most of their patients, particularly if their patient population is relatively healthy. For others, it may be a step toward further integration.

This paper analyzes these important decisions through the framework of the success factors we observed at the six Colorado clinics.

Success Factor One:
Align the Level of Integration
With Patient Needs and Practice Capacity.

Focusing on patient needs drives the most effective integration models that we observed. These needs,

Figure 1. Six Levels of Integrated Care*

Coordinated		Co-Located		Integrated	
Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Beginning Collaboration	Basic Collaboration at a Distance	Basic Collaboration On-Site	Close Collaboration On-Site, Some Systems Integration	Close Collaboration, Approaching Integrated Practice	Full Collaboration, Transformed/ Merged/ Integrated Practice
Key Element: Communication		Key Element: Proximity		Key Element: Practice Transformation	

Based on the SAMHSA-HRSA Standard Framework for Integrated Healthcare

both for behavioral health care and medical care, exist along a continuum from prevention and wellness services on one end to complex and ongoing care for chronic conditions on the other.

Poor physical health contributes to poor behavioral health, and vice versa, so people with high physical health needs often have significant behavioral health needs as well.

Still, it is challenging for practices to assess which services are most frequently needed by their patients. They must first define the client population and then identify which services are needed and how often they are needed.

Some services, such as screenings and preventive care, are frequently provided because many people can benefit from them. More complex and specialized services are needed less often — unless the practice serves a specific population. For example, a clinic that specializes in treating people with severe mental illness will see greater need for long-term therapy.

All six clinics conduct screening for common

behavioral health conditions, such as depression and anxiety. Based on the results, they may provide access to short-term therapy, substance use disorder treatment or longer-term therapy. The therapy is either provided in the practice's integrated setting or through referral if the patient's needs are better met in a different setting.

Cortez Integrated Healthcare and Union Square Health Home, two safety net providers where many patients have high levels of behavioral health needs, provide the most specialized services in an integrated setting, including long-term therapy and psychiatric medication management by a psychiatrist. Salud sees patients with a range of behavioral health needs.

On the commercial side, New West provides more limited integrated services — mostly screening and referral — because its patients tend to have fewer needs and it is not reimbursed for counseling services. New West, however, recently hired a psychiatrist to provide psychiatric medication management and it has established a close working relationship with therapists. Primary Care Partners

Figure 2. The Six Practices: Behavioral Health Services Integrated with Primary Care

Practices	Behavioral Health Services					
	Screening	Behavior Change Education	Short-Term Therapy	Substance Use Treatment	Long-Term Therapy	Psychiatric Medication Management
New West	Yes	For patients with diabetes, pre-diabetes	Referred	Referred	Referred	Psychiatrist or primary care provider w/ consultation
Primary Care Partners	Yes	Yes	Yes	Some services	Referred	Primary care provider w/ consultation, referred as needed
Kaiser Permanente	For higher risk patients	Some in primary care clinic; some referred to prevention department	Yes	Some services; referred as needed	Referred to behavioral health department	Some in primary care clinic; some referred to behavioral health department
Salud Family Health Centers	Yes	Yes	Yes	Some services; referred as needed	Referred	Primary care provider w/ consultation, referred as needed
Cortez Integrated Healthcare	Yes	Yes	Yes	Yes	As needed	As needed
Union Square Health Home	Yes	Yes	No*	Yes	All clients	Yes

* All patients need long-term therapy

offers more integrated services because it receives funding from pilot projects.

The Kaiser Permanente Colorado system offers all services, with screening and short-term therapy provided in the primary care clinic and all other services referred to other Kaiser departments. The prevention and wellness department provides behavior change education and coaching. The behavioral health department provides more intensive and longer-term behavioral health services.

Many of the practices started integration work with a focus on mental health but are exploring ways to

expand into more behavior change coaching.

Success Factor Two:
 Innovate and Adapt Both the Workforce and the Workplace.

After identifying patient volumes and needs, practices can begin to focus on assembling the appropriate workforce, from care coordinators or health coaches who have less specialized training, to doctoral-level providers, such as psychologists or psychiatrists. (See Figure 2.)

Figure 3. The Six Practices: Providers on Integrated Care Teams

Practice	Types of Care Providers					
	Primary Care	Care Coordinator	Counselor/ Clinical Social Worker	Substance Use Disorder Specialist	Psychologist	Psychiatrist
New West	Yes	For diabetic, pre-diabetic patients	Referred	Referred	No	As needed
Primary Care Partners	Yes	As needed	Yes	As needed	As needed	Referred
Kaiser Permanente Colorado	Yes	For patients with certain diagnoses	Referred to behavioral health department	Referred to behavioral health department	Yes	Referred to behavioral health department
Salud Family Health Centers	Yes	For many Medicaid patients	Yes	As needed	Yes	Consultation and referral as needed
Cortez Integrated Healthcare	Yes	As needed	Yes	As needed	As needed	As needed
Union Square Health Home	Yes	Yes	Yes	As needed	Yes	Yes

Many of the practices we observed have contracts with other organizations or providers instead of hiring all members of the care team. Some of the practices have hired staff to help navigate social support resources such as housing or applications for public benefits. (See Figure 3.)

Patient care teams vary based on need. Union Square Health Home, for instance, has highly specialized providers because it has many patients with acute needs. But New West Physicians relies more on referral relationships with counselors, while a New West psychiatrist maintains communication with primary care doctors through a shared electronic health record.

Generally, a primary care provider and a master's degree-level counselor make up the core care team. Many practices have a psychologist on staff, but fewer have staff psychiatrists. Many of the practices we studied provide some substance use treatment from mental health counselors with special training.

The practices often assign care coordinators to patients with specific needs, such as diabetes, or

people with depression who also have diabetes or heart disease. Some clinics have added peer specialists, health coaches or transitional case managers.

Although many of the practices do not have specialists on staff, they all have referral relationships with organizations that can provide those services. For example, Salud Family Health Centers has ties with community mental health centers where it can refer patients.

Existing relationships often guide how care teams are developed. When Primary Care Partners decided to bring behavioral health providers into its clinic, it turned to providers already working in its building. Union Square Health Home grew out of many years of collaboration between organizations specializing in medical care, mental health and substance abuse treatment.

Even after these staffing decisions are made, implementing team-based care is challenging. Many providers do not have training or experience in these new models of care. Each team member must learn to work with the rest of the team, coming to

consensus regarding clinical decisions. The team must continually evaluate what is working and what is not and make changes to support the integrated model.

Creating an adaptive clinic culture is crucial to ensuring that teams work well.

Enhanced communication is also a crucial component of successful integration. Both the sharing of clinical data and direct communication, in person, over the phone or by other means, is necessary.

Where an organization stands on communication — from sharing some information between providers via a printed care plan to a fully shared electronic medical record to regular team meetings — depends on the structure of the organization, available resources and how long the integration project has been in place. (Please see Figure 4.)

Implementing new technologies to improve data sharing can be expensive, and larger practices are often better able to cover the up-front costs. Kaiser and Salud are large organizations with fully integrated electronic medical record systems that include behavioral health information. Providers have access to patient records — with the exception of therapy notes that are protected by law — at any time.

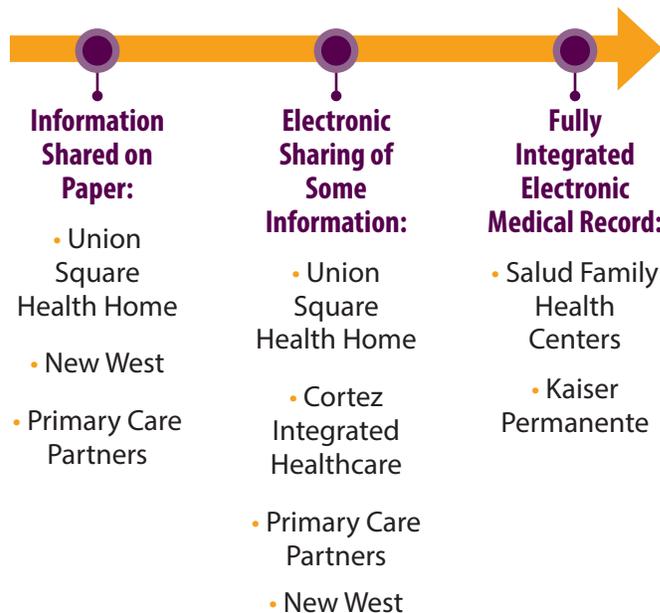
Union Square Health Home is much smaller and newer. It is working to create a system of electronic medical records between behavioral health providers and medical providers and is now sharing some information electronically, but this work is complicated and only possible at this smaller scale due to a grant.

Cortez Integrated Healthcare also used grants to develop a way to share information between the electronic medical record systems used for behavioral health services and the systems used for medical services.

Success Factor Three:
 Create New Funding Models that Support Integration.

Historically, behavioral health care and medical care have been paid for separately, with different

Figure 4. The Progression of Data Sharing



billing requirements. Because of this, most of today's insurance payment models are not designed to support integrated care.^{12,13,14} And some aspects of integrated care, such as brief consultations between providers, aren't reimbursed at all.

Any viable business needs to be paid for its work. Identifying a sustainable source of funding is key to implementing behavioral health integration. It's also a significant obstacle to large-scale integration in Colorado.^{15,16,17}

The safety net practices we observed have been successful in obtaining grant funding to help support the higher costs of integration. (See Figure 5.)

For example, workforce training grants support about a third of the behavioral health staff at Salud Family Health Centers. Cortez Integrated Healthcare received grants to build its clinic and launch the new approach to care.

Pilot programs may be funded without a long-term commitment. For example, Primary Care Partners is participating in a pilot program funded by the Center for Medicare & Medicaid Innovation and another by the Colorado Health Foundation. Both are testing the cost effectiveness of new payment models.

But private practices generally fund the integrated services internally. They will need to demonstrate a return on investment to private insurers in order to scale up a sustainable integration model in the private market.

New West Physicians, for example, has no additional funding for integrated care. Most private insurers have separate contracts for behavioral health and physical health services. New West plans to hire therapists within the next year who are credentialed with their insurers, which would allow New West to bill for behavioral health care on a fee-for-service basis.

This will strengthen integration at New West because the staff therapist will share the practice's electronic health record system with medical providers. Still, New West doesn't expect fee-for-service payments to cover the cost of providing behavioral health services. To address this gap, New West hopes to negotiate a contract that includes capitated payment for both medical and behavioral health services.

Kaiser Permanente Colorado, as both the insurer and provider of care, has a capitated model based on a per member per month payment for all care, including physical and behavioral health. While this avoids the need to bill separately for services, it is still challenging to design a budget that funds different departments and supports integrated care.

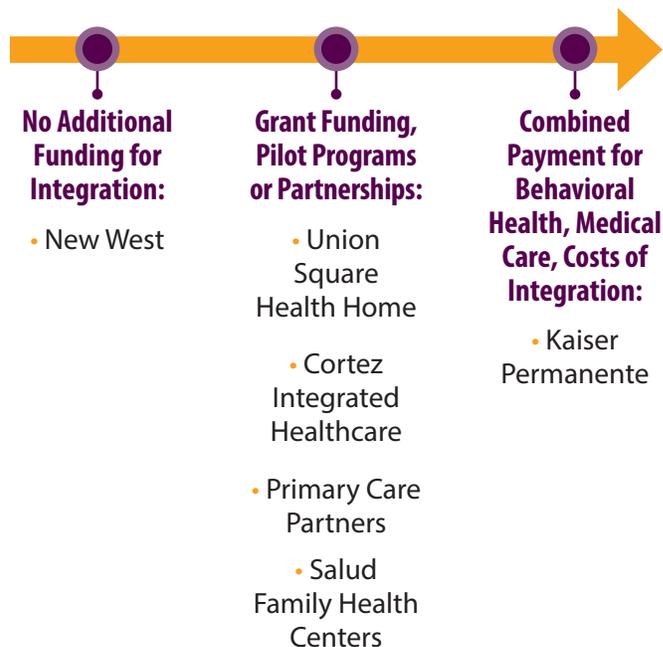
Kaiser's providers are paid out of their departmental budgets. But the costs of integration and savings from more effective care are often seen across departments. For example, better integrated care may result in fewer visits to the emergency department, but that integration requires more services from the behavioral health department.

Success Factor Four: Recognize that Patient Numbers Impact Integration Potential.

Serving a critical mass of patients is an important starting point for integrating care. While practices of any size can move toward increased integration, the question of how many patients are served must be considered as the integrated model is developed.

Hiring new providers will be more cost effective if

Figure 5. The Spectrum of Funding Models



there are enough patients to keep their schedules full. So having teams that always include at least one medical provider and one behavioral health provider is only feasible if the practice is seeing enough patients with these needs.

Primary Care Partners, for example, generally sees the same group of patients on an ongoing basis. It found that over the course of a year, most patients had been in for an appointment, and many of their behavioral health needs had been addressed. Primary Care Partners still believes that having a behavioral health provider working in the primary care clinic is beneficial for both patients and providers, but pent-up demand has largely been met.

The number of patients served also affects the financial viability of some approaches of behavioral health integration. If a per capita payment is available for integrated care, that funding will only cover the costs of the additional time, workforce and infrastructure to support integration if there are enough patients. Smaller practices may not see enough patients for a per capita payment for integrated care to cover the costs.

Figure 6. Evaluation Approaches

	Provider feedback	Qualitative data on patient and provider experience of care	Quantitative process measures (e.g. screening, follow-up treatment)	Health outcomes
New West Physicians	x			
Primary Care Partners	x	x	x	x
Kaiser Permanente Colorado	x	x	x	x
Salud Family Health Centers	x	x	x	x
Cortez Integrated Healthcare	x	x	x	x
Union Square	x	x	x	x

Success Factor Five:
Lead Creatively and Learn Constantly.

All of the leaders of the practices described in this paper believe in the promise of integration and are nationally recognized in this field. And each is a creative and supportive manager, which is critical in leading a team toward a new model of care.

They repeatedly emphasize the importance of having partners at all levels of the organization who understand, value and promote integration. This new model of care needs to be woven into the fabric of the practice.

Ruth Benton, CEO of New West Physicians, says that New West began working toward a more integrated model of care because primary care providers saw that their patients needed these services. New West continues to move forward with a more integrated approach even though the organization isn't making a profit on this model. She is committed to a more integrated approach, and hopes that in the future payment reforms will make it financially sustainable.

Tillman Farley, medical director of Salud Family Health Centers, has championed integration of behavioral and physical health care. Having the medical director focusing on the need for behavioral health helped establish it as a priority among the staff.

Bern Heath and Pam Wise Romero have led the development of Cortez Integrated Healthcare,

transforming a community mental health center into an integrated health care system. Acknowledging that their integrated model of care is new and different, they developed a series of trainings for clinic workers to make sure the model is fully understood and implemented.

Each practice we studied also values ongoing learning and evaluation. But some have more resources than others to take this on. (See Figure 6.)

The larger organizations and those with grant funding are more likely to have robust evaluation plans. But even then, evaluations tend to focus on current needs of the organization or a funder's research interest.

Some evaluations are anecdotal. Others explore how integrated care is being implemented. Some are also looking at the patient and provider experience, gathering qualitative data about integrated care from those perspectives. And several are looking at health outcomes, measuring whether patients become healthier after receiving integrated care.

For example, Salud is assessing how integrated care affects pregnant women and new mothers. Union Square Health Home is including all patients enrolled in the health home in its evaluation in order to understand the effect of integrated care on the health of those with serious and persistent mental illness.

As payers seek evidence that integrated care improves quality and helps contain costs, large-scale evaluations will be essential.

Conclusion

Examining specific examples of behavioral health integration takes the leap from theory to practice, illustrating both the challenges and the rewards for patients, care providers and health care organizations.

Practices are trying different approaches to integrate behavioral health and primary care based on the number of patients served, the needs of those patients and reimbursement. They are reporting benefits to increased integration. Providers appreciate the ability to consult with their behavioral health or medical counterparts and they believe it is helping patients get the care they need. Early

findings indicate that patients appreciate integrated services as well and show improvements in health.

While each situation is unique, an overview of the six Colorado practices provides themes and lessons that can be useful as health leaders seek to strengthen behavioral health integration.

Integration is happening quickly. Part of the challenge is identify the balance of services that are both helpful to patients and financially sustainable, and to identify the most efficient and effective team to deliver those services.



Dr. James Bachman, MD, left, and Dr. Deborah Casuto, PsyD, right, discuss a patient's health at Kaiser Permanente's Skyline Medical Offices in Denver. BRIAN CLARK/CHI

Colorado Behavioral Health Integration Projects

Colorado's State Innovation Model (SIM):

Colorado has been awarded a federal innovation grant to implement a transformation of the state's health system. Integration of behavioral health and primary care is one of the major goals. More information is available at <https://sites.google.com/a/state.co.us/sim-colorado>

Advancing Care Together (ACT):

This five-year program provided funding to 11 demonstration projects in Colorado to identify and test promising models of integrating behavioral health and primary care, to evaluate processes and outcomes of these models, and to actively disseminate results and best practices. Funded by the Colorado Health Foundation and led by the University of Colorado Department of Family Medicine, ACT began in 2011. Funding to demonstration sites ended in August 2014. Evaluation results will be available in the fall of 2015. For more information, please visit www.advancingcaretogether.org

Sustaining Healthcare Across Integrated Primary Care Efforts (SHAPE):

This project is a collaboration between Rocky Mountain Health Plans, the University of Colorado Department of Family Medicine, the Colorado Health Foundation and the Collaborative Family Healthcare Association. The objectives are to determine if a global payment method will support and sustain the integration of behavioral health in primary care, understand how different payment models affect clinical models of care and related costs and test the real world application of a global payment model to inform future policy. SHAPE is working with six family practices on Colorado's Western Slope to accomplish these objectives.

This is a three-year project, which began in spring of 2013. More information is available at www.sustainingintegratedcare.net

Colorado Medicaid's Accountable Care Collaborative Payment Reform Pilot Initiative:

In July 2013, the Colorado Department of Health Care Policy and Financing selected a payment reform pilot program, as required by legislation passed in 2012 (HB12-1281). The selected proposal was developed by Rocky Mountain Health Plans, in collaboration with a number of community partners, including mental health centers. This program, called Medicaid PRIME, is being implemented in seven Western Slope counties.



A sign directs patients at New West Physicians, which is integrating behavioral health and primary care. BRIAN CLARK/CHI

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CASE STUDY

New West Physicians

Critical Decisions: Patients Served, Patient Needs and Funding

New West Physicians is a private practice group with 18 locations in the metro Denver area. Primary care physicians founded the group 20 years ago to deliver high-quality, cost-effective, patient-centered care in a physician-owned practice.

The idea of adding mental health care to the mix took shape a few years ago. New West Physicians estimated that more than half of its patients suffered from depression or anxiety that could not be adequately addressed in a primary care visit and that most weren't seeking treatment. So, the practice formed a partnership with three mental health counselors, adding a new dimension to its care.

New West does not have additional funding to support behavioral health integration. Counselors are not employees of New West. As independent providers, they do their own billing for services, though New West requires that they accept private insurance from at least the four biggest carriers. Many mental health providers in private practice don't accept insurance, but New West wants to accommodate patients with coverage.

New West also works with two psychiatrists. One, specializing in child and adolescent psychiatry, contracts with New West and bills private insurance. The other psychiatrist, who works with adults, is a full-time New West employee. This psychiatrist mostly oversees medication management for patients with complex needs and works closely with the counselors and primary care providers. New West bills insurance for the psychiatrist's services for adults. The practice is planning to hire a mid-level psychiatric provider very soon, as well as a neurologist who will work at the same location. New West plans to hire counselors within the next year, once it has finalized an agreement with insurers so New West can bill for those services.

Approach to Integration

The hub of New West's behavioral health initiative is its clinic in west Denver, although it will soon expand

into a new space as the number of behavioral health providers continues to grow. Both psychiatrists are based at the clinic. As an employee, the adult psychiatrist uses the same medical record system as primary care providers, allowing information to be easily and securely shared.

Currently, three counselors, each with a master's degree, rent space in the west Denver location, and collaborate with primary care providers. Two counselors maintain other office locations; the third works exclusively out of the New West space.

The counselors mostly provide short-term treatment — three to six sessions on average. They do not have access to New West electronic medical records, but do share notes with primary care providers if the patient agrees. Medical care is not provided at the west Denver counseling office.

Initially, it was a challenge to get patients who might benefit from therapy to make an appointment with a counselor. Primary care providers would give patients an informational brochure, but that approach had limited success; only about 40 percent of patients referred actually saw a counselor. So, New West tried a pilot program at a couple of clinics, creating a release form that patients could sign to allow the counselor to call them. The number of referrals that led to counseling appointments increased to approximately 60 percent.

Lessons Learned

New West is not formally evaluating this model of care. But primary care providers say they are more likely to refer patients to mental health services now that they have a specific place to send them. The fact that more referrals lead to appointments suggests that New West patients find these services helpful. The adult psychiatrist's schedule is now booked for several months, and New West plans to hire a mid-level psychiatric provider to handle demand.



Dr. Lindsey Harrison, left, meets with a patient at the New West Physicians office in Golden, the hub of New West's behavioral health initiative. BRIAN CLARK/CHI

Over the next year or so, New West intends to make counselors employees instead of contract workers. This would allow them to use the New West medical record system, which would improve communication and coordination with primary care providers. Counselors could potentially work out of several New West locations, making behavioral health services more convenient for patients.

But first New West must find a way to pay for such a move.

The stumbling block is the way insurers pay for behavioral health services. Generally, an insurance company contracts with a single provider organization and pays a set amount for each policyholder — a capitated rate. Even though New West is a large practice, it doesn't yet have sufficient

scale with any one insurer to get a capitated payment to hire counselors. That could change as New West continues to grow and negotiates with insurers on more sophisticated reimbursement approaches that reward integration of services and quality of care.

A more immediate step is hiring counselors who are credentialed by the organization that has the behavioral health contract, so New West can bill that organization for behavioral health services. This would allow New West to hire the counselors, likely within the coming year.

New West is committed to integrating behavioral health care. Ruth Benton, CEO of New West, says although the practice is losing money on these services, the value in providing better, comprehensive care is worth the expense.

CASE STUDY

Primary Care Partners

Critical Decisions: Patients Served, Patient Needs and Funding

Grand Junction, the largest city in western Colorado, is known for spectacular vistas, oil and gas development and an innovative health care system. The Grand Junction health care model has attracted national attention for the way physicians, hospitals and insurers work together to provide low-cost, high-quality care using a variety of approaches, including data-sharing and new models of payment. Researchers have identified leadership by the primary care community as one of the key features of Grand Junction's health care success.¹⁸

Grand Junction's largest provider of primary care is Primary Care Partners, a physician-owned private practice with more than 50 clinicians serving about 60,000 patients in three clinics. The partners use a medical home model, which is designed to provide comprehensive, patient-centered, team-based, coordinated care.

To better serve patients, the group agreed to try new payment structures to support behavioral health integration. Central to this approach is the long-standing relationship the practice has with Behavioral Health and Wellness, a group of independent providers that has shared a building with Primary Care Partners' largest family practice for a decade.

Three programs are supporting Primary Care Partners' behavioral health integration. The Comprehensive Primary Care initiative (CPC), a multi-payer program designed to strengthen primary care, provides a per patient per month payment, which is adjusted based on the health status of the patient. Primary Care Partners uses a portion of the CPC money to contract with Behavioral Health and Wellness, which places counselors in primary care clinics. Another program, Advancing Care Together (ACT), is evaluating the expansion of the patient-centered medical home model to include behavioral health. The third program, Sustaining Healthcare Across Integrated Primary Care Efforts (SHAPE), is testing a global

payment methodology — paying one lump sum instead an amount for each service.

Approach to Integration

Counselors spend a couple of days a week in a primary care clinic. They may be called in by a primary care clinician to provide brief interventions. For example, a doctor treating someone who wants to get off opiates may enlist a counselor to help the patient. Or a counselor may coach a patient on how to manage stress or make healthy lifestyle changes. This "warm hand off" approach better meets the patient's need and lets medical providers focus on what they are trained to do. If there has been a "warm hand off," the counselor will often be present at a follow-up medical appointment.

Besides such interventions, counselors also provide follow-up visits, up to four half-hour sessions a day. Patients who need more than a half-dozen follow-ups are referred to someone at Behavioral Health and Wellness or elsewhere based on their condition and insurance coverage.

The counselors have a variety of specialties and most hold master's degrees. Psychologists are available to participate in joint visits with a medical provider for patients with complex needs. At the two largest clinics, a behavioral health provider works with a dozen primary care providers. The ratio is one-to-seven in the smaller clinic. Primary Care Partners also employs one care coordinator for every four or five primary care physicians, plus one who works with patients coming out of the hospital. Patients can reach their care coordinator by phone, and the care coordinator can make referrals to either primary care or behavioral health services. A behavioral health provider is part of the team that oversees care coordination plans for high-risk patients.

To enhance communication, behavioral health providers enter notes in the Primary Care Partners'



Behavioral health clinician Cheryl Young, M.A., LMFT, talks to a patient at Primary Care Partners in Grand Junction, a medical home designed to provide comprehensive, patient-centered, team-based, coordinated care.

SPECIAL TO CHI

electronic medical record, which can be flagged as confidential. There is currently no sharing of electronic medical records between Primary Care Partners and Behavioral Health and Wellness, but patients can approve information exchange to improve coordination of care.

Lessons Learned

Primary Care Partners has found integrating medical and behavioral care to be challenging. Some counselors don't take to the rhythms and demands of primary care. Every time a new counselor comes in to a primary care clinic, relationship building starts all over again. The team approach is new for everyone, and establishing rapport between providers takes time.

The behavioral health providers work part time with Primary Care Partners, allowing them to continue practicing in a traditional mental health setting. Those with extensive experience tend to be most comfortable in the clinics. The practice has found that these veterans can more easily adapt to the faster pace of a primary care office and have the background to quickly assess a situation and refer the

patient to appropriate resources in the community.

This integrated model of care is expensive, mostly due to personnel costs. Primary Care Partners believes a fee-for-service model doesn't work for integrated care. That's why it likes the model currently being tested — a per patient per month payment to cover services such as care coordination and behavioral health integration. The model allows the practice to keep evaluating how best to provide holistic care in a financially sustainable way.

Despite challenges, Primary Care Partners reports promising results. Physicians have seen an increase in completed behavioral health referrals, lower rates of hospital readmission and no change in the generally low rates of emergency department use. That said, it's unknown whether these results are due to behavioral health integration, care coordination, or both. The payment model is being evaluated, but results are not yet available. Evaluators are looking at changes in utilization, patient satisfaction and improvement in physical and behavioral health as well as changes in overall cost of care, projected cost and financial sustainability. Details of the evaluation plans are available from SHAPE, CPC and ACT.^{19, 20, 21}

CASE STUDY

Kaiser Permanente Colorado

Critical Decisions: Patients Served, Patient Needs and Funding

Kaiser Permanente Colorado is the state's largest not-for-profit health plan, serving 623,000 Coloradans from Fort Collins to Pueblo. It is both the insurer and the provider of primary and specialty care, including behavioral health services. Kaiser Permanente Colorado does contract with providers in some communities, though most members see clinicians employed by the Colorado Permanente Medical Group.

Integrating behavioral medicine specialists into primary care started about three years ago, initially to collaborate with primary care teams in managing patients with mental health needs who frequently visited the emergency department.

As insurer and provider, Kaiser Colorado's premiums cover all costs — it doesn't bill an outside payer for specific procedures, although providers do record standard diagnosis (ICD-9) and procedure codes (CPT) in a patient's electronic medical record. Integrating behavioral health with primary care can trim overall costs. Addressing patients' behavioral health may reduce their need for more expensive emergency or inpatient services. On the other hand, the cost of care may increase if patients are referred to behavioral health for treatment that they may not have received before.

Approach to Integration

The Kaiser model simplifies many aspects of integration. For example, Kaiser Colorado has a shared electronic medical record system that all its providers can access. It has several integration projects underway and is evaluating different approaches to serve different populations.

The basic approach is this: Clinical psychologists, called behavioral medicine specialists, have an office in the primary care department. They consult with primary care providers, but also have appointments of their own. Patients may be referred by their

primary care provider or as a result of an automated screening that identifies a behavioral health problem such as depression or anxiety.

Behavioral medicine specialists encounter a range of conditions, including depression, anxiety, ADHD and severe mental illness. They don't have their own panel of patients and typically see a patient two or three times to provide assessment, diagnosis and brief interventions such as behavioral activation or cognitive behavioral therapy. Behavioral medicine specialists can refer patients to the prevention department, which provides a variety of psycho-educational material via classes, webinars and online resources, or to the behavioral health department for ongoing therapy and/or psychotropic medications. Kaiser Colorado has 11 behavioral medicine specialists, all with doctorate degrees. Most split their time between two clinics because there is not sufficient funding for a full-time behavioral medicine specialist at all 22 primary care clinics.

Behavioral medicine specialists are part of a larger approach to integration. Some serve on Kaiser's many care management teams, such as those for patients with chronic conditions, complex health needs or frequent visits to the emergency room.

All providers, behavioral medicine specialists, and members of the care management teams, communicate through Kaiser's electronic medical record system, which is a key component of integration. For example, a care manager may use the system to recommend a larger dose of depression medication for a patient. The primary care provider would review the suggestion and either approve it via the medical record system or follow up with the care manager with questions or concerns. Mental health information that is protected by law is not shared through the medical record system.

To be enrolled with a care management team, a patient must have a qualifying diagnosis, or a



Dr. Denise Hunter, MD, left, consults with Dr. Deborah Casuto, PsyD, at Kaiser Permanente's Skyline Medical Offices in Denver. BRIAN CLARK/CHI

combination of conditions. In a pilot project, Kaiser Colorado is providing integrated care management to patients who have depression as well as poorly controlled diabetes or cardiovascular disease. The project is called Care of Mental, Physical, and Substance Use Syndromes (COMPASS) and is funded by the Center for Medicare & Medicaid Innovation, with the goal of improving patient outcomes and reducing unnecessary hospitalizations. Initial results demonstrate improvements in depression symptoms, diabetes control and blood pressure. Results for hospitalizations are not available yet.

Lessons Learned

Kaiser Colorado is studying the reach and impact of having behavioral medicine specialists in primary care, using qualitative feedback from providers and patients, as well as tracking data on visits, assessments and referrals. Kaiser has already found that primary care providers are more likely to screen for depression and anxiety because they know behavioral medicine specialists are

ready to help. Some primary care providers have also reported referring patients to a behavioral medicine specialist instead of simply prescribing medication. The team approach helps primary care providers and patients become more familiar with the behavioral health department, increasing communication and minimizing stigma that may be a barrier to seeking treatment.

That said, there are challenges to integration. The clinical settings for primary care and behavioral health

are different, requiring orientation and adjustment for new behavioral medicine specialists joining primary care clinics. The primary care focus is on assessments, brief consultations and interventions. The pace is faster and there is more focus on immediate problem-solving. Behavioral health assessments can take longer than many primary care visits. Kaiser Colorado is still working to overcome these cultural differences.

The COMPASS evaluators are looking at whether this model is a sustainable way to improve the health and care experience for patients with complex medical and behavioral health needs and to trim costs by reducing unnecessary emergency and inpatient services. Complete evaluation results for COMPASS will be available in fall 2015.

Other evaluations are looking at the effects of screening, therapy groups and telephonic coaching on particular populations (for example, pregnant women with depression), as well as the use of electronic medical record data to identify high-risk groups for mental health care needs.

CASE STUDY

Salud Family Health Centers

Critical Decisions: Patients Served, Patient Needs and Funding

Salud Family Health Centers opened its first clinic in a Fort Lupton apartment in summer 1970 to serve migrant laborers in southern Weld County. It soon converted an onion warehouse across the street into a medical and dental facility. Today, Salud is a federally qualified health center with 10 clinics serving 10 Colorado counties, plus a mobile health unit that provides care to migrant and seasonal farmworkers and does community outreach.

The majority of patients are low-income rural residents with access to few, if any, other health services. Many are uninsured, prefer services in a language other than English and lack transportation. Salud uses a medical home approach, providing comprehensive and integrated medical, dental and behavioral health services and promoting prevention and early intervention. Salud served 70,000 patients in 2014 through 280,000 visits.

Salud's Director of Medical Services, Dr. Tillman Farley, led the integration of behavioral health and primary care beginning in 1997. Farley, who had worked with an integrated model before, saw that many of Salud's patients had behavioral health needs brought on by stress related to immigration and poverty. Integration has been incremental. A big step came in 2009, when Salud hired a director of integrated services to ensure that both a patient's mental and physical well-being were considered in all health and administrative decisions. A year later, Salud created a mission statement reflecting its approach to integration. It says the organization will strive to "deliver stratified, integrated, patient-centered, population-based services utilizing a diverse team of behavioral health professionals who function as primary care providers (PCPs), not ancillary staff, and who work shoulder-to-shoulder with the rest of the medical team in the same place, at the same time, with the same patients."²²

Salud is not reimbursed by insurance for behavioral health services. About a third of the cost is covered by grants, including funding for a psychology training

program; a third by Salud's general budget; and a third by in-kind services from community partners whose behavioral health staff work exclusively at a Salud clinic. Patients are not charged for behavioral health services provided in the context of a medical appointment. There is a sliding fee scale, based on family size and income, for uninsured patients. Colorado Medicaid contracts with behavioral health organizations (BHOs), so while Salud does provide behavioral health services to Medicaid clients, it does not bill for those services.

Approach to Integration

Behavioral health and medical providers work in tandem at Salud clinics. Patients have an initial medical screening, including measures of blood pressure, weight and height. Next, a behavioral health provider evaluates the patient for depression, anxiety, trauma, tobacco, alcohol, and drug use. The provider also asks about the safety of the patient's living environment. If there are concerns, the behavioral health provider inquires further and, if necessary, provides immediate intervention, referral and consultation with the medical provider.

The goal is for each Salud patient to have a behavioral health screening once per year, or more often if needed. A patient with a persistent problem can meet again with a behavioral health provider when returning to a clinic for a medical reason or make an appointment for a traditional therapy session. This continuing care is solution-focused with an average of five visits and rarely more than a dozen. For substance use disorders, Salud provides limited individual outpatient treatment and often refers to outside providers.

Behavioral health providers only spend about a third of their time doing traditional therapy. They hold master's degrees in disciplines such as social work, counseling and psychology, or doctoral degrees in psychology. Each provider works at only one clinic to strengthen



Physician Assistant Tara Clemens, PA-C, visits with a access to health services. SPECIAL TO CHI

the team approach. Salud's larger clinics have three or four behavioral health providers while smaller clinics have one. Depending on the size of the clinic staff, the ratio of behavioral health providers to primary care clinicians ranges from one to three to one to six.

Behavioral health providers typically see patients with mental health problems but their role may expand beyond this. Salud would like them to provide more coaching on health behavior changes, including pain management, eating and exercise patterns, medication compliance and more. But expanding those services is difficult. For one thing, behavioral health providers are busy serving patients with mental health needs. Some may lack training or interest to take on health behavior roles. Also, medical providers may not realize how a counselor or psychologist can help a person achieve healthier behaviors and often feel limited by time constraints and other workflow considerations.

Lessons Learned

Salud's data collection and analysis mostly focuses

on physical health. There is still work to be done in tracking behavioral health over time. Salud has recently adopted a measurement system for mental health outcomes, degrees of integration (i.e., collaboration between members of care team), as well as social determinants of health and the impact on physical and mental health outcomes.

Salud is evaluating a program that provides behavioral

health screening and treatment for high-risk pregnant women. Those who need ongoing support work with a psychologist regularly through the pregnancy and for six weeks postpartum. If the patient needs additional care, she is referred for follow-up services. The evaluation looks at screening, follow-up treatment and changes in severity of symptoms. It also includes qualitative data on the patient experience and feedback from the psychologist. This evaluation is part of the Advancing Care Together (ACT) program, which is testing promising models of integrating behavioral health and primary care across Colorado.

The Salud experience with integrated care underscores the importance of building relationships between different kinds of providers, clinic staff, clinic managers and with community organizations. The impetus for integration came from the medical director, not outside entities. This was important in establishing the culture and leadership to support the partnership between behavioral health and primary care.

CASE STUDY

Cortez Integrated Healthcare

Critical Decisions: Patients Served, Patient Needs and Funding

Axis Health System opened Cortez Integrated Healthcare in January 2012 in a new building in Cortez, a small city in the far southeast corner of the Colorado, minutes from Mesa Verde National Park. The clinic embodies six years of thinking on how to provide health care that meets all the patient's needs — for both body and mind.

This was such a significant change that the organization renamed itself to reflect the new approach to care. For 50 years it had been the Southwest Colorado Mental Health Center and had provided mental health and substance use treatment to residents of five counties. Axis added primary care services starting at the Cortez location; it also operates La Plata Integrated Healthcare, two School-Based Health Centers in Durango and three clinics that only provide mental health and substance use treatment.

Axis CEO Bern Heath and the Chief Clinical Officer, Pam Wise Romero, led the transition from traditional mental health center to integrated health care system. They knew that many people treated for mental health problems or substance use disorders did not receive sufficient medical care and vice versa. Initially, they embedded behavioral health providers in medical offices that partnered with Axis. Though helpful, the approach didn't reach the level of integration they wanted. So, Heath and Romero started from scratch. As Heath describes it, they decided to "bake a new cake" with all the ingredients of holistic care — mental health, primary care, substance use disorder treatment and wellness.

Three years after opening, the Cortez clinic is serving nearly 2,700 patients. The goal is to serve more than twice that many when the clinic is operating at full capacity.

The clinic receives separate reimbursements for behavioral health services and medical care. As the Medicaid behavioral health provider in the area, Axis Health Systems is paid on a capitated basis for Medicaid patients. Medicaid insures about half of

the clinic's patients, a number that increased after Colorado expanded eligibility in January 2014. Slightly less than a third of patients have private insurance, just under 10 percent are enrolled in Medicare and nearly 18 percent are uninsured and pay on a sliding fee scale.

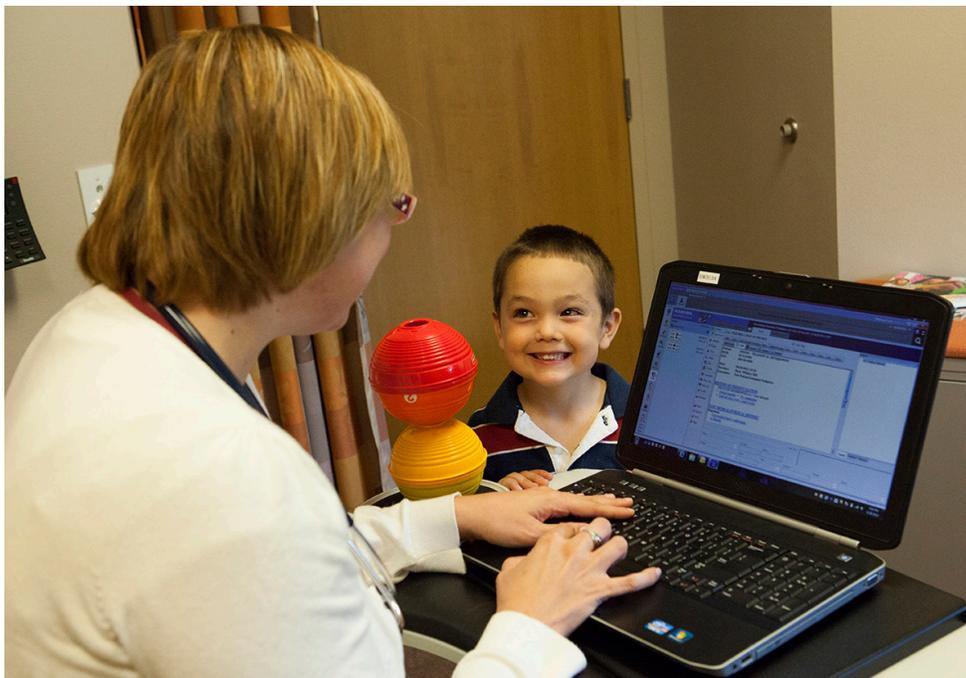
For medical care, the clinic bills Medicaid, Medicare and private insurance on a fee-for-service basis. Those without insurance pay a sliding fee scale. Care provided by therapists who are teamed with a primary care clinician is billed differently, depending on the situation. Sometimes it is classified as a complex physical health visit, sometimes as a behavioral health visit and sometimes it is not eligible for insurance reimbursement.

The Cortez clinic is still figuring out how to financially sustain its version of integrated care. A global capitated model of payment would better support its operations, but insurers currently won't reimburse that way. Becoming a federally qualified health center — which has already happened for the Axis La Plata clinic in Durango — would also help, because such a designation would allow the Cortez clinic to receive an enhanced Medicaid payment and grant money to subsidize care for the uninsured.

Approach to Integration

Patients can make an appointment for behavioral health care, medical care or both. About 80 percent receive integrated care; the rest receive behavioral health services but stay with their outside medical provider, though more are turning to the Cortez clinic for their physical health needs. The clinic continues to accept behavioral health referrals from other medical providers.

New patients complete a variety of screenings. They use a digital tablet to fill out a questionnaire about their physical and behavioral health. The results are scored electronically and reviewed by the provider and patient on an electronic "Health Tracker" that shows a graphical representation of the data. This



Dr. Whitney Pack, a pediatrician at Cortez Integrated Healthcare, interviews a young patient before beginning a physical exam. BRIAN CLARK/CHI

system, developed by Axis, merges information from medical and behavioral electronic records to provide comprehensive, “real time” information to guide care decisions. It is available at touch screen monitors in exam and consultation rooms. Patient screening is repeated regularly.

At the first medical appointment, the patient is introduced to a therapist who teams with the primary care provider. This therapist might briefly talk with the patient about, say, changing their habits to improve health or setting up a series of counseling sessions. Patients who need longer-term therapy, beyond a half-dozen visits, may be referred to a different behavioral health provider at the clinic.

The number and composition of the medical staff has fluctuated. The Cortez clinic currently has four primary care providers, most working part time. There is a family practice physician, a physician’s assistant and two pediatric providers. There are nine behavioral health providers, most with master’s degrees. They are employed by Axis at the Cortez clinic, although a few split their time between Axis clinics or work part time. There is one psychologist at the Cortez clinic. A psychiatrist works in the clinic part time for consultation and to see patients. A

full-time psychiatric nurse practitioner provides consultation and follow-up care, and a child psychiatrist is available via teleconference for consultation.

Lessons Learned

The Cortez clinic is participating in two Colorado studies on implementing and funding integrated behavioral health care. The Advancing Care Together (ACT) program supported development of Health Tracker and is evaluating how it helps guide care decisions. The Sustaining Healthcare Across Integrated Primary Care

Efforts (SHAPE) is evaluating the impact of different payment models on integrated clinics and if a global payment approach — paying one lump sum instead of individually for each service provided — would financially sustain integrated care.

Internally, the clinic tracks a patient’s health status. For adults, it records information on body mass index (BMI), blood pressure, depression, alcohol use and health-related quality of life. Similar measures are tracked for adolescents and children. Axis has seen improvement on most of these measures. Notably, early analysis suggests patients treated for depression in the integrated clinic make as much progress as patients treated for depression in the traditional mental health clinics Axis runs, even though the treatment in the integrated care setting is less intensive.

The Cortez clinic illustrates the complexity of moving from the concept of integrated care to practice.²³ Transitioning to an integrated care clinic required collaboration between behavioral health and medical providers. It took quite some time and a good deal of turnover before Axis assembled a full team ready to work together. The time, energy and effort required to fundamentally change how care is delivered should not be underestimated.

CASE STUDY

Union Square Health Home

Critical Decisions: Patients Served, Patient Needs and Funding

The Union Square Health Home is a program at the Union Square Health Plaza building in Lakewood. The building, owned and operated by Jefferson Center for Mental Health, houses mental health emergency and wellness services on the first floor and integrated medical and behavioral health services on the second. The Jefferson Center, a community mental health center, has served the metro area west of Denver and mountain communities in Jefferson, Clear Creek and Gilpin counties for more than 50 years. Jefferson Center partners with Metro Community Provider Network (MCPN), a federally qualified health center providing medical care, and with Arapahoe House, which offers substance use disorder treatment.

Jefferson Center bought the Union Square Health Plaza building in September 2012. This new space allowed the center to expand a successful pilot project it started a couple of years earlier. Jefferson Center developed the pilot after a review found that 2,000 of its adult Medicaid enrollees who were receiving behavioral health services did not have a regular source of medical care. So, Jefferson Center and its partners deployed primary care and substance use treatment providers to three of Jefferson Center's largest clinics, making it easier for patients to access treatment for substance use disorders, hypertension, high cholesterol, diabetes and more. Those clinics were designed to be entry points to primary care and had very limited capacity. Jefferson Center applied for a grant from the Substance Abuse and Mental Health Service Administration (SAMHSA) to develop a more fully integrated, long-term program for adults with serious mental illness. This led to the creation of Union Square Health Home.

The Health Home serves roughly 450 people with serious mental illness, providing both behavioral and medical care. To qualify, patients must be residents of Jefferson County and not have a primary care provider. They have been diagnosed with a serious mental illness, agree to receive all their care at that

clinic and allow various measures of their health to be tracked. Jefferson Center expects to have 600 patients enrolled by the end of 2015.

Behavioral health and medical services are reimbursed separately. For behavioral health, Jefferson Center receives capitated Medicaid payments — about 65 percent of Health Home enrollees are covered by Medicaid. That proportion grew due to eligibility expansion. Private insurance and Medicare are billed for patients with those kinds of insurance. They account for about 15 percent of Health Home patients. Local, state, federal and foundation grants cover behavioral health care for uninsured individuals, who account for just over 20 percent of enrollees. Substance use treatment is paid for through a contract between Arapahoe House and Jefferson Center. The Metro Community Provider Network is reimbursed for medical services by private insurance and receives Medicaid payments as a federally qualified health center. Some of the SAMHSA grant supports primary care for the uninsured who can't pay for services and for some specialist care when there is no other payer sources. Mostly, the SAMHSA grant supports services that currently are not reimbursable by any payer, including care coordination, health coaching, data management and evaluation.

Approach to Integration

Collaborative care planning is key to the model. Care coordination is provided by a registered nurse or social worker. The coordinator explains the program to patients, helps them enroll if they choose to do so and works with them to develop a care plan that includes their health goals. In addition to hallway consultations, every week all providers meet to discuss patient needs and identify areas of concern or follow-up. The coordinator maintains patients' integrated collaborative care plans in each of four domains (physical health, mental health, substance use and wellness) and shares these documents



Health Coach Gabriela Pena meets with a patient at Union Square Health Home in Lakewood.
BRIAN CLARK/CHI

with providers for review and update as needed. The Health Home is exchanging continuity of care documents electronically and hopes to expand its participation in electronic health information exchange through the Colorado Regional Health Information Organization (CORHIO) in the future.

The care coordinator regularly telephones patients, answers their questions and handles scheduling. Patients often come to the Health Home for one reason — a regular therapy appointment, for example. But if they need medical care as well, the care coordinator makes appointments as close to the therapy session as possible. In addition, a peer health coach generally meets with the patient once a month, although these meetings can be more or less frequent depending on the needs of the patient.

Most Union Square mental health therapists have master's degrees and are licensed. The Health Home staff also includes psychiatrists, a psychiatric nurse and a psychiatric medical assistant. Substance use treatment is provided by a licensed addiction counselor. Medical care is provided by a family nurse practitioner and a medical assistant. More medical providers will be added as the number of patients at the Union Square Health Plaza grows.

All providers, including the care coordinator, peer health coach, and primary care and behavioral

health clinicians, meet once a week to discuss patient needs in a holistic way. Approximately five cases are taken up per meeting and usually involve patients with more complex health care conditions.

Health Home enrollees receive other services: Members of Jefferson Center's navigation team help patients with benefits enrollment, housing, vocational assistance and connects them to other community resources. Wellness services, including nutrition, exercise and individualized health coaching, are provided by the wellness team. Peer specialists are also part of the Health Home team.

Lessons Learned

Jefferson Center hired an independent evaluator to assess Union Square Health Home's effectiveness. The evaluator is looking at individual outcomes for all Health Home patients, including measures of physical health, such as blood pressure, BMI and blood sugar, as well as hospital admissions and emergency room visits, nights spent in jail or homeless shelters, tobacco and other substance use and how patients perceive their own health. At the population level, evaluators are measuring whether patients are using more or fewer high-cost services such as hospital admissions, readmissions or emergency room visits. The evaluators will provide progress updates to Jefferson Center; the final evaluation will be completed in 2017. Early results show that the Health Home has been effective at reducing depression and suicidal thoughts. They also show improvement in physical health, with fewer patients at risk of metabolic syndrome after being enrolled in the Health Home for six months. Although data are limited, there has been a decrease in hospitalizations, use of detox services, jail time and emergency room visits for behavioral health needs.

Creating infrastructure to support integration, such as sharing electronic records and an electronic care plan, has been challenging and time consuming. Union Square Health Home has grant funding to continue development of this integrated approach over the next couple of years.



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