Barriers to Physical and Mental Condition Integrated Service Delivery

ROGER G. KATHOL, MD, MARY BUTLER, PhD, DONNA D. MCALPINE, PhD, AND ROBERT L. KANE, MD

Objective: To assess pragmatic challenges faced when implementing, delivering, and sustaining models of integrated mental health intervention in primary care settings. Thirty percent of primary care patients with chronic medical conditions and up to 80% of those with health complexity have mental health comorbidity, yet primary care clinics rarely include onsite mental health professionals and only one in eight patients receive evidence-based mental health treatment. Integrating specialty mental health into primary care improves outcomes for patients with common disorders, such as depression. Methods: We used key informant interviews documenting barriers to implementation and components that inhibited or enhanced operational success at 11 nationally established integrated physical and mental condition primary care programs. Results: All but one key informant indicated that the greatest barrier to the creation and sustainability of integrated mental condition care in primary care settings was financial challenges introduced by segregated physical and mental health reimbursement practices. For integrated physical and mental health program initiation and outcome changing care to be successful, key components included a clinical and administrative champion-led culture shift, which valued an outcome orientation; cross-disciplinary training and accountability; use of care managers; consolidated clinical record systems; a multidiase, total population focus; and active, respectful coordination of colocated interdisciplinary clinical services. Conclusions: Correction of disparate physical and mental health reimbursement practices is an important activity in the development of sustainable integrated physical and mental condition care in primary care settings, such as a medical home. Multiple clinical, administrative, and economic factors contribute to operational success. Key words: collaborative/interdisciplinary care, healthcare delivery, medical home, mental health, administration/management of health care.

HMO = health maintenance organization; VA = Veterans Administration.

INTRODUCTION

Up to two thirds of patients with mental health and substance use disorders, hereafter known as “mental conditions,” are seen primarily in the general medical sector for mental health-related services (1,2). Many additional primary care patients have subthreshold mental health symptoms that complicate the presentation and diagnosis of physical health complaints (1,3,4). Nearly 70% of these medical patients with mental conditions receive no mental health treatment (3,5,6). Of the third who are treated, <13% receive care that would be expected to change outcomes (2,7,8).

Although the number of persons exposed to treatment for selected conditions, such as depression, seems to be increasing, rapid illness identification and evidence-based intervention for mental health and chemical dependence problems are often delayed for years (9). Primary care referral to mental health specialists is also twice as difficult to accomplish as for other specialties (10). Even when accessible, mental health specialist appointments are often delayed weeks to months, and patient “no show” rates are high. Importantly, no treatment or ineffective treatment bodes poorly for both physical and mental condition symptom improvement, predicts personal impairment, and increases physical health service use and cost (11,12). The Milliman, Inc. actuarial firm (13) projected that, without improved ability to address mental disorders seen in primary care, $130 to $350 billion annually will be spent for additional service use in patients with concurrent general medical and mental conditions.

Integrating mental health services into primary care is being promoted as a partial solution (14,15), yet most evidence supporting its value is gathered from large research fund-supported clinical trials that have many advantages not typical in traditional healthcare settings (16,17). There continue to be substantial barriers to implementing these models outside the research setting (18) because research funds are not replaced by sustainable support for integrated clinical services in the current reimbursement environment (12,19).

We know little about the characteristics of program success outside the clinical trial context, despite its importance if mental health services are to become an integral part of the patient-centered medical home. This research begins to build evidence in this area by examining practical aspects related to the development and continuation of programs that integrate mental health services in primary care settings.

METHODS

As part of an Agency for Healthcare Research and Quality-supported systematic literature review of health outcomes associated with integrated mental and physical health care in primary care settings, 13 nationally recognized sites were selected for case studies (20). Two of the sites involved programs that did not provide direct integrated care (Aetna and CorpHealth); therefore, they are excluded in the analyses presented here. Sites were identified from Internet searches, canvassing printed literature, nominations from staff at Federal Government agencies, and experts in the field. They were purposively sampled to represent diversity in organizational forms; financing structures; use of system-level integration tools, such as electronic medical records; and representation of tested integration models. Each site had a dedicated track record of attempting to support the coordination of general medical and mental health services for at least several years. Documented clinical “success” was not a criterion for inclusion. Key informants for each site were chosen based on their knowledge of program operation. Informants, from one to three per site, included administrators, clinicians, and

From the Departments of Internal Medicine and Psychiatry (R.G.K.), Evidence-based Practice Center (M.B., R.L.K.), Clinical Outcomes Research Center (R.L.K.), University of Minnesota, and the Division of Health Policy and Management (D.D.M., R.L.K.), University of Minnesota School of Public Health, Minneapolis, Minnesota; and Cartesian Solutions, Inc. (R.G.K.), Burnsville, Minnesota.

Address correspondence and reprint requests to Roger G. Kathol, MD, Cartesian Solutions, Inc., 3004 Foxpoint Road, Burnsville, MN 55337. E-mail: kathol001@umn.edu

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Dr. Kathol is President of Cartesian Solutions, Inc., a health management consulting company, which specializes in assisting with the development of programs for patients with health complexity and the integration of general medical and mental health care.

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care managers, who were directly involved in the development, implementation, and administration of the integrated care program.

Using semistructured interviews with predetermined open-ended questions designed to cover specific content areas, informants were asked about their working definitions of integrated care; the genesis of their program; the model of integration used, how interdisciplinary services were delivered; critical clinical and financial success components; and barriers to implementation, service delivery, and sustainability. Examples include the following:

- How is your program organized to integrate mental health and primary care?
- How can you tell if the program is working?
- What are your measures of success?
- What have been the barriers to keeping the program going?
- How did you address/overcome them?
- How is the mental health care paid for?
- Is there a business case for programs like this?
- What are the key ingredients in establishing a program like this?
- What are the key ingredients in sustaining it?

Semistructured interviews were chosen over structured interviews to encourage dialogue and discussion of content areas in an attempt to get to the heart of challenges faced by those participating in integrated approaches to care. This allowed discovery of issues of importance not prospectively considered before the informant interviews, such as “top-down” versus “bottom-up” program initiation and the desire by clinicians for access to assistance for multiple mental health conditions, not just depression.

Interviews were performed by telephone by two of the co-authors (M.B. and R.L.K.) in 2008. Two case studies also involved site visits (Washtenaw and Depression Improvement Across Minnesota, Offering a New Direction). The length of the interviews ranged from 60 to 120 minutes, with an average time of 75 minutes. Informants were given the opportunity to review the accuracy of their individual case study write-ups (20). New interviews were constantly compared with previous site case studies by the research team to check for newly emerging issues. After all interviews were completed, two co-authors (M.B. and R.L.K.) independently coded the interviews for overarching themes. Discrepancies were resolved by consensus among the entire research group.

As shown in Table 1, the programs included clinical delivery systems, staff model health maintenance organizations (HMOs), and research consortia. They represented rural- and urban-integrated programs serving both targeted (mainly depression) and general mental health problems in ethnically, financially, and culturally diverse primary care populations.

### RESULTS

#### Organizational and Operational Factors Related to Integrated Program Initiation

Table 2 provides information by site about the models used in the development of the integrated care programs, program genesis, and common challenges encountered in program implementation. Each accepted as a basic premise the complexity of chronic illness care, a biopsychosocial view of medical care, and the importance of collaboration among providers. Programs differed in care processes created and how clinics were readied for change (20). Most considered colocation of mental health staff in the primary care setting necessary yet insufficient for program maintenance. Programs championed at the staff level (bottom-up) generally described greater clinician enthusiasm and increased likelihood of program persistence through budget “blending” despite financial barriers.

Culture change was a common need mentioned by informants, i.e., acceptance that mental health was a part of total health; that medical staff were accountable for mental condition identification and treatment; that additional professionals, such as psychiatrists, psychologists, and care coordinators, in primary care were needed to assist in changing mental condition outcomes (21); and that adjustments in work processes for both physical and mental health personnel were required to meet mental health needs in primary care. A number of programs noted the importance of recruiting mental health practitioners willing to alter their practice style from undisturbed 50-minute therapy sessions to the responsiveness necessary for primary care clinician support in an integrated approach.

### Table 1. Programs Attempting to Integrate Physical Health and Mental Condition Services

<table>
<thead>
<tr>
<th>Case Study</th>
<th>Structure</th>
<th>Location</th>
<th>Mental Health Focus</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Health Cooperative</td>
<td>Staff model HMO</td>
<td>Washington state</td>
<td>Depression</td>
<td>Primary care patients, mainly in Seattle</td>
</tr>
<tr>
<td>RESPECT-D Research Collaborative</td>
<td>Medical groups and health plans</td>
<td>National</td>
<td>Adult depression</td>
<td>12 centers participating in depression research</td>
</tr>
<tr>
<td>Eastern Band of Cherokee Nation</td>
<td>Integrated system</td>
<td>Rural North Carolina</td>
<td>All mental conditions</td>
<td>Eastern Band of Cherokee</td>
</tr>
<tr>
<td>Tennessee’s Cherokee Health System</td>
<td>Care delivery system</td>
<td>Rural Tennessee</td>
<td>All mental conditions</td>
<td>Mainly indigent, Medicaid, and Medicare</td>
</tr>
<tr>
<td>Washtenaw Community Health</td>
<td>Care delivery system</td>
<td>Urban Michigan</td>
<td>All mental conditions</td>
<td>Indigent, Medicaid</td>
</tr>
<tr>
<td>Organization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haight Ashbury Free Clinics</td>
<td>Nonprofit provider clinic</td>
<td>Urban California</td>
<td>All mental conditions</td>
<td>Indigent, Medicaid</td>
</tr>
<tr>
<td>Intermountain Healthcare</td>
<td>Staff model HMO</td>
<td>Rural and urban</td>
<td>All mental conditions</td>
<td>50% of Utah’s health care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Utah, Idaho</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rural and Urban</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northern California Kaiser</td>
<td>Care delivery system</td>
<td>Northern California</td>
<td>All mental conditions; depression</td>
<td>300,000 primary care patients in southern Maine</td>
</tr>
<tr>
<td>Permanente</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIAMOND Initiative</td>
<td>Medical groups and health plans</td>
<td>Minnesota</td>
<td>Adult depression</td>
<td>Selected statewide primary care clinics</td>
</tr>
<tr>
<td></td>
<td>Integrated system</td>
<td></td>
<td></td>
<td>Veterans in most U.S. regions</td>
</tr>
</tbody>
</table>

HMO = health maintenance organization; RESPECT-D = Re-Engineering Systems for Primary Care Treatment of Depression; DIAMOND = Depression Improvement Across Minnesota, Offering a New Direction.
practice model. Physical health personnel also needed to share clinic space, facilitate access to mental health services for their patients, and participate in supporting mental health care through active communication with mental condition staff and care managers. Respectful, interactive, and supportive interdisciplinary relationships were considered critical.

Enhancers and Inhibitors of Operational Success and Sustainability

Although no case study claimed sufficient time or financial stability to count themselves as successful, a number of insights as to what would help or hinder success could be drawn. Table 3 highlights perceived operational success enhancers and inhibitors, and factors associated with sustainability. At a structural level, alignment with organizational values and overall organizational support, whether from internal leadership or external community partners, was consistently noted as important to a program’s success. An equally important process element included care or case managers to coordinate and follow up on treatment adherence and other barriers to improvement. Systematic patient tracking, when added to behavioral health care, improved patient outcomes at some sites, but not all programs were amenable to care systemization.

The consolidation of physical and mental health records was challenging for a number of programs. With few exceptions, successful programs were able to develop ways to open access to pertinent clinical information for all clinicians. In several programs, the primary care clinics hired their own mental health professionals, despite mental health sector service availability within their own staff model HMO, to correct the communication problem. Organizations with persistent separation of records noted that few physical health staff took the time to get information about the patient’s mental condition because of the hassle.

Success inhibitors generally involved inadequate time and/or resources to support outcome changing workflow activities, such as funding procurement, building cross-disciplinary relationships, educating staff in integrated care, or providing for controlled program expansion. Uncontrolled growth or poorly managed program implementation at new clinic sites often generated dissatisfaction among new participants. Clinicians in integrated clinical settings were also less willing to participate when only a portion of their patients could receive integrated support, e.g., only patients covered by selected health plans or patients with one mental condition, i.e., depression.

The main barrier to sustainability was financial. All but one site, the Veterans Administration (VA), experienced challenges. The most common financial barriers mentioned were: 1) prob-

<table>
<thead>
<tr>
<th>Organization</th>
<th>Integrated Care Model/ Location of Mental Health</th>
<th>Program Genesis</th>
<th>Program Implementation Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Health Cooperative</td>
<td>IMPACT Model (22), some colocated</td>
<td>Bottom up, research</td>
<td>Level of understanding of clinicians in cross-disciplinary processes, change in mental health specialist work habits</td>
</tr>
<tr>
<td>RESPECT-D Research Collaborative</td>
<td>Three Component Model (23)</td>
<td>Research</td>
<td>Level of understanding of clinicians in cross-disciplinary processes, clinician reluctance to commit time to communicate with case managers</td>
</tr>
<tr>
<td>Tennessee’s Cherokee Health System Eastern Band of Cherokee</td>
<td>Setting specific customized model, colocated Doherty’s Level of Collaboration Model (24), some colocated</td>
<td>Bottom up</td>
<td>Cultural change, finding mental health specialists willing to do collaborative care</td>
</tr>
<tr>
<td>Washtenaw Community Health Organization</td>
<td>Four Quadrant Model (25), Doherty’s Level of Collaboration Model (24), setting specific customized model, colocated</td>
<td>Bottom up</td>
<td>Cultural change, need to build and maintain interdisciplinary relationships</td>
</tr>
<tr>
<td>Haight Ashbury Free Clinic</td>
<td>Setting specific customized model, colocated</td>
<td>Bottom up</td>
<td>Cultural change</td>
</tr>
<tr>
<td>Intermountain Healthcare</td>
<td>IMPACT Model (22), Wagner Model (26), setting specific customized model, colocated</td>
<td>Top down</td>
<td>Work process change, need for management practices that build relationships</td>
</tr>
<tr>
<td>MaineHealth</td>
<td>IMPACT Model (22), Three Component Model (23), Intermountain Model above, colocated</td>
<td>Top down, research</td>
<td>Cultural change</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>Strosahl Model (27), IMPACT Model (22), colocated</td>
<td>Top down</td>
<td>Cultural change, change in mental health specialist work habits</td>
</tr>
<tr>
<td>DIAMOND Initiative</td>
<td>IMPACT Model (22), some colocated</td>
<td>Top down and bottom up, research</td>
<td>Work process change</td>
</tr>
<tr>
<td>Veterans Administration</td>
<td>CQI techniques, evidence based medicine to design programs, partners in care, some co-located</td>
<td>Top down and bottom up</td>
<td>Cultural change, work process change, need for management practices that build relationships</td>
</tr>
</tbody>
</table>

DIAMOND = Depression Improvement Across Minnesota, Offering a New Direction; CQI = continuous quality improvement.

TABLE 2. Organization of Interviewed Integrated Programs
<table>
<thead>
<tr>
<th>Organization</th>
<th>Operational Success Enhancers</th>
<th>Operational Success Inhibitors</th>
<th>Sustainability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Health Cooperative</td>
<td>Focus on financial and clinical outcomes, organizational support, use of case managers, research funding</td>
<td>Lack of common electronic medical record, misaligned with quality indicators</td>
<td>Integrated services financially unsustainable with independent physical and mental health billing procedures despite documented programmatic total health cost savings, selected clinics retained with internal cost shifting after research studies completed</td>
</tr>
<tr>
<td>RESPECT-D Research Collaborative</td>
<td>Initial organizational support, systematic mental health outcome tracking</td>
<td>Absent leadership, single mental illness focus (depression), selected population (only patients from one health plan), perceived additional primary care time commitment</td>
<td>Integrated services financially unsustainable with independent physical and mental health billing procedures, loss of support from leadership</td>
</tr>
<tr>
<td>Tennessee’s Cherokee Health System</td>
<td>Common electronic health record, integrated work processes, provider satisfaction with coordinated behavioral and chronic health care</td>
<td>Systemization of care not in alignment with practitioner care values</td>
<td>Integrated services financially unsustainable with independent physical and mental health billing procedures, persistent services with capitated contracts and use of low cost mental health personnel</td>
</tr>
<tr>
<td>Eastern Band of Cherokee</td>
<td>Common electronic health record, organizational support, provider satisfaction with coordinated behavioral and chronic health care</td>
<td>Lack of staff education in integrated care, time needed to build cross-disciplinary relationships</td>
<td>Integrated services financially unsustainable due to low federal funding for clinical services despite documented programmatic total health cost savings, selected clinics preserved with internal cost shifting</td>
</tr>
<tr>
<td>Washkenaw Community Health Organization</td>
<td>Common electronic health record, academic affiliation, community partnership, shared interdisciplinary financial investment, use of case managers, patient centered care</td>
<td>Lack of staff education in integrated care</td>
<td>Integrated services financially unsustainable due to low funding for clinical services and independent physical and mental health billing procedures</td>
</tr>
<tr>
<td>Haight Ashbury Free Clinic</td>
<td>Intensive case management, academic affiliation, organizational support, use of volunteers</td>
<td>Time needed to procure funding</td>
<td>Integrated services financially unsustainable due to low funding for clinical services and independent physical and mental health billing procedures, selected clinics preserved with internal cost shifting but need to adjust support approaches every year</td>
</tr>
<tr>
<td>Intermountain Healthcare</td>
<td>Aligned values and structure, associated with chronic care, organizational support, use of case managers</td>
<td>Too rapid growth</td>
<td>Cost neutral; integrated services financially unsustainable with independent physical and mental health billing procedures, special “granting” for new integrated programs being considered</td>
</tr>
<tr>
<td>MaineHealth</td>
<td>Aligned values and structure, organizational support, use of case managers</td>
<td>Absent leadership, shortage of mental health personnel</td>
<td>Integrated services financially unsustainable with independent physical and mental health billing procedures, selected clinics preserved with internal cost shifting</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>Integrated work processes, organizational support, use of case management functions, systematic mental health outcome tracking</td>
<td>Lack of systematic mental health outcome tracking for generalist model, too rapid growth, despite common electronic health record barriers to shared medical and mental health information</td>
<td>Two-tier mental health system, i.e., PC employed their own mental health specialists (common record) with most other mental health services offsite (separate record); routine integrated services financially unsustainable with independent internal physical and mental health budgets and payment</td>
</tr>
<tr>
<td>DIAMOND Initiative</td>
<td>Recent roll out; use of case managers, independent third party facilitated planning and implementation</td>
<td>Too rapid growth, patients unfamiliar with service process</td>
<td>Ongoing attempt to address payment issue through multiple independent and unaligned contracts with numerous providers and facilities, diversity and complexity of contract for mental health care in physical setting makes sustainability questionable after pilot despite excellent initial clinical outcomes</td>
</tr>
<tr>
<td>Veterans Administration</td>
<td>Common electronic health record, organizational support, use of case managers, independent third party facilitated planning and implementation</td>
<td>Too rapid growth</td>
<td>Special “granting” for new integrated programs from single internal budget, additional funding for mental health concerns related to Middle East wars</td>
</tr>
</tbody>
</table>

RESPECT-D = Re-Engineering Systems for Primary Care Treatment of Depression; DIAMOND = Depression Improvement Across Minnesota, Offering a New Direction; PC = Primary Care.
lems coding for mental condition services in the nonpsychiatric setting; 2) not knowing who to bill for services delivered (medical or behavioral payers); 3) nonpayment for same day physical and mental condition encounter billing; 4) nonreimbursement for care managers; and 5) low payment levels for mental condition services delivered in the medical setting.

Care delivery systems, research consortia, and provider clinics routinely stated that difficulties in coding and billing for mental health service providers influenced how programs were set up, who were chosen to staff them, and/or whether they would be continued after grant support or start-up funds ran out. Standard managed behavioral health organizations business practices typically: 1) required additional mental health billing staff for the separate coding and billing procedures from medical service billing; 2) prohibited mental health personnel from billing for services in the medical setting without complicated prior approval procedures; 3) were paid at levels for billed codes below workforce cost; 4) often encouraged rebilling for services, using codes paid from “nonbehavioral” benefits; or 5) simply excluded payment for mental condition services due to preset location-specific utilization management procedures. Even experienced staff model HMOs with published financial success metrics related to integrated service delivery continued to use traditional independent physical and mental health payment procedures. Programs closed, downsized, or required revamping to less-robust integration models due to “perverse and fragmented” reimbursement.

The Depression Improvement Across Minnesota, Offering a New Direction project, designed to disseminate depression treatment in primary care settings throughout Minnesota (28) by facilitating improved payment methods (29), is considered at risk by project staff for dissolution after their pilot phase for financial reasons (30). Despite independent contracts between each of the 59 participating clinics and each of the six health plans involved at the time of the study, limited levels of mental health personnel support continued. The complicated and inconsistent nature of customized reimbursement procedures associated with scores of individualized contracts was also overly burdensome (31).

DISCUSSION
Mental Health Service Delivery in the General Medical Setting

This article does not assess the components of integrated programs that lead to or are even associated with successful treatment of patients with concurrent general medical and mental conditions. That subject, the findings of which support the overall success of integrated programs, has been addressed in other publications focused on the quantitative impact of integrated clinical service delivery (20,32). Rather, this article discusses factors associated with enhanced or inhibited organizational success and the sustainability of integrated programs, as clinical and economic success often follows from the type of integrated services that can be operationally delivered. Table 4 consolidates the findings from the key informant interviews and tells a story of potential value to those wishing to develop whole person integrated patient-centered medical homes or other primary and specialty medical care programs that include mental health and substance use disorder services.

Financial Factors Related to Program Initiation and Sustainability

Virtually all locations indicated that the current reimbursement system and the separation of care that it fostered did not support the initiation or sustainability of integrated services. Autonomous payment for mental condition and physical health care from independent and competing budgets necessarily created and continued to perpetuate barriers to the integration of physical and mental health, whether 1) managed separately by a behavioral health organization and a general medical health plan, known as “carved-out” mental health; or

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**TABLE 4. Factors Associated With Organizational Success and Sustainability for Integrated Programs**

Consistently mentioned as critical success components
- Development of personal/professional relationships between participating physical and mental health leaders and staff
- Adequate training in the value of and how to provide integrated services, especially for complex patients—in physical health for mental health professionals and in mental conditions for physical health professionals
- Consistent longitudinal program champions (preferably from both physical and mental health disciplines)
- Physical and mental health staff colocation with active and sustained interaction
- Consolidated physical and mental health clinical records (preferably electronic)
- Professional physical and mental health staff respect for each other

Components mentioned that enhanced value
- Use of case and/or disease managers (care coordinators)
- Non-disease specific focus, e.g., broader mental condition assistance than for just depression
- All patients have access to integrated services, e.g., not just those with Medicaid coverage
- Triage which identifies patients with high complexity for participation
- Systematic involvement of psychiatrists, especially for supervision of care managers and as consultant to primary care physicians, e.g., IMPACT model

Factors that reduced clinic/practitioner participation
- Integration sponsored by a health plan (rather than with involvement of practitioners)
- Focus on a single mental health condition
- Focus on a subset of patients in a practitioner’s clinical practice, e.g., patients from a specific health plan only
- “Top-down” program development without “bottom-up” clinician participation
- Conflicting payment and coverage policies across payers
- Nonfinancial factors associated with poor sustainability
- Poor relationship between physical and mental health leadership and/or staff
- Too rapid expansion of program without attention to implementation of critical components
- Difficulty in recruiting mental health staff willing to adjust practice style for use in the medical setting
- Loss or change of program champion(s)
2) managed by a single general medical health plan, such as an HMO, that owned its mental health business but used comparable autonomous claims adjudication practices as carve-outs from internally segregated budgets, known as “carved-in” mental health (19). With the exception of the VA system, independent physical health and mental condition claims adjudication and associated utilization management practices are uniform nationally although with subtle variations, whether mental condition care is carved-out or carved-in. Each viewed integrated program indicated a need to overcome this financial barrier for program sustainability.

A telling example of the effect that segregated general medical and mental condition funding had on integrated care occurred at the time of transition from start-up and/or research support to traditional reimbursement practices. The sample interviewed represented segments of the health system that were diverse, yet with the exception of only one system (VA) in which physical and mental condition funding was adjudicated using uniform business practices, all indicated that the traditional independent approach to general medical and mental health service payment created the need to close their integrated care programs; to downsize and subsidize mental health personnel from physical health or institutional revenues; to identify less-expensive, albeit less-qualified, personnel to deliver integrated mental health services; or to accept predictable programmatic financial insolvency and absorb the loss administratively. Even research programs, which had demonstrated clinical outcome improvement and cost savings (33–34), were forced to maintain integrated clinical services only in selected locations to minimize clinic-based financial loss.

In staff model HMOs, some of which documented value to their members in terms of improved clinical outcomes and to the insurance company in terms of lower total healthcare costs, several had to create specialized payment approaches in order for integrated clinical services to remain operational. It was not possible for primary care clinics within their own systems to merely hire appropriate clinical staff and duplicate the value-added services of proven programs yet remain financially solvent due to continued independent and competing medical and mental health payment practices.

**Integrated Program Initiation**

Common themes emerged about what program participants thought brought staff cohesion, encouraged clinician participation, and improved patient care. The importance of the medical/mental health interaction, interdisciplinary relationship building, staff training in integrated care practices, effective leadership, and financial support were frequently mentioned. In general, the programs that were initiated at the clinical staff level (bottom-up) had more enthusiastic onsite advocates and were more likely to overcome clinical and financial operational challenges over time. Bottom-up programs, however, were not necessarily associated with evidence-based approaches to care. Personnel and/or fiscal constraints often dictated the type of mental health and general medical care available and who delivered it. For instance, many programs had limited psychiatrist availability due to fiscal constraints despite literature findings that psychiatrist involvement in integrated programs is more consistently associated with clinical improvement and cost savings (35).

Culture change—adjusting workflow, sharing limited space among personnel, and recognizing the importance of cross-disciplinary services—was a challenge for both physical and mental health professionals. An unanticipated barrier to program initiation, however, was the difficulty in finding mental health personnel trained in and willing to alter practice patterns to accommodate needs in the primary care setting, including psychiatrists, psychologists, and care managers. One program even initiated an integrated care psychologist training program at a regional university in an attempt to improve the number equipped and willing to work in integrated primary care settings. Similar training programs were considered needed for psychiatrists, care managers, and other personnel providing integrated services, including primary care physicians.

**Integrated Care Delivery**

Organizational factors (recognition by staff that integrated evidence-based services improved patient health, persistent endorsement and support by organizational and/or community leadership, and establishment of reasonable interdisciplinary workflows) were considered necessary for the ongoing ability to maintain staff enthusiasm and participation and to improve the quality of patients’ clinical care. Several programs indicated that they found it difficult to maintain clinician support when only selected patients qualified for integrated services, such as patients with a specific insurance product or those who fell in a certain age group. Others indicated that integrated programs that targeted only one mental health issue, such as depression, frustrated many primary care clinicians.

Numerous programs indicated that the addition of clinical staff, who assisted with care management, such as care coordinators, disease managers, or case managers, was a critical component needed for the continued success of their programs (36). The mandate, by default, for primary care physicians to treat mood disorders, anxiety, attention deficit and hyperactivity disorder, eating disorders, substance use disorders, and somatization, among others, supports this conclusion, because these very mandated and unassisted primary care physicians serve as “usual care” controls for integrated treatment studies showing clinical and cost improvement when care management assisted integrated care is provided (35). Estimates of the time needed to treat prevalence-based depression alone would compel a reduction in patient panel size by approximately a third if a primary care practitioner chose to deliver evidence-based depression treatment without care management assistance (21).

The key informants also mentioned a common physical and mental health record system as being associated with improved care. This turned out to be a contentious issue in several organizations, even after integrated practices were initiated. In most instances, resistance to a common medical record originated with mental health professionals. In part, this was due to nonrecognition that equally sensitive medical information on the physical health side was just as prevalent,
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e.g., sexually transmitted disease, erectile dysfunction, and alcohol intoxication and withdrawal, and was worthy of equally rigorous privacy protection. In part, it was due to failure to recognize the importance for treating clinicians to understand the whole health picture when dispensing care.

Defragmenting Mental Condition and Physical Health Services

In today’s health environment, the identification and treatment of mental conditions are add-ons to physical health care, i.e., extra services and costs. One can imagine what health care would be like if a similar management approach was taken for heart or kidney disease. Strong evidence suggests that disorders of the body and mind interact (12), particularly in patients with multimorbid illness (37) and health complexity. Barriers to improvement created by the interplay of biological, psychological, social, and health system factors, which typically require individualized care such as through a care manager, define health complexity (37,38). Ineffectively addressing these barriers leads to poor clinical, functional, and financial outcomes for patients and for society (33,34).

A promising option, as components of patient-centered medical homes are being formulated and for which the VA system can be considered an example, involves transferring mental health funds to physical health budgets and paying for physical and mental health services as a single package (19,39). This would allow the use of common coding and billing procedures; collocated mental condition with physical health staff; common provider networks; consolidated record systems; and importantly, increased access to coordinated physical health and mental health condition treatment in the primary care setting, where most patients with mental conditions are seen. In such a system, primary care practitioners, psychiatrists, medical specialists, and other mental health providers would become equally accountable for health, physical and mental, and could work together to achieve the best result.

REFERENCES


