Best Practices in Behavioral-Physical Health Integration

A Working Paper for the Behavioral Health Integration Learning Collaborative

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Health & Medicine works to improve the health of all people in Illinois by promoting health equity. Health & Medicine's Center for Long-Term Care Reform promotes a just system of long-term services and supports that enables people to live according to their own goals and values.

The Center is fortunate to have exceptional support from Health & Medicine's board of directors and our allies in the health advocate community. In conversation with those partners we recognized the need for an impartial policy voice on the behavioral health delivery system. In particular, we detected a need to better understand and learn from the interrelationships between behavioral and physical health providers and how they coordinate services.

Our first effort to respond to that need is the Behavioral-Physical Health Integration Learning Collaborative, an initiative we are launching to bring together community behavioral health agencies, primary care providers, facility-based behavioral health providers, and persons in recovery to share their experiences, participate in trainings, and develop evidence-based models that can be tested and continuously improved based on systematic tracking of processes and outcomes. Our aim is to have a practical effect on the delivery system, a goal that requires from a policy organization such as ours a certain humility if the project is not to become merely a product of the work-table, divorced from the on-the-ground experience of providers and people in recovery.

And so, taking the spirit of learning and collaboration seriously, our first step is to widely share this working paper which reflects our initial investigation of the current state of best practice in physical and behavioral health integration. The purpose of the paper is to solicit responses from experts and advocates with experience in this field who can advance our understanding of the current state of integration models and guide the direction of the Learning Collaborative. We hope the critiques and comments we receive will help evolve this piece into a refined best practice summary that can be used to launch the Collaborative of stakeholders of integrated health in Chicago.

We happily acknowledge the generosity of the Blue Cross Blue Field Foundation for its support of the Learning Collaborative. We were also fortunate to have the time of Natasha Soon Ahn, an MD/MPH student at Northwestern University, who compiled the research on best practices in behavioral-physical health integration that follows.

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Executive Summary

Mental illness affects millions of Americans of all ages and results in substantial disability and costs. The National Institute of Mental Health stated in a 2008 report that an estimated 26.2 percent of Americans ages eighteen and older suffer from a diagnosable mental disorder in a given year (NIMH). Further, 1 in 5 of those adults suffer from a serious mental illness (SMI), which interferes with their ability to perform one or more major life activities (NIMH). People with SMI die, on average, 25 years earlier than people in the general population; many of these deaths are caused by preventable conditions such as cardiovascular disease and diabetes (WHO). In response to these alarming statistics, a growing number of advocates are looking for ways to bridge the physical, policy, and cultural gaps that have traditionally existed between primary healthcare and behavioral healthcare.

This brief gives an overview of two exemplar studies that highlight the improved health outcomes of integration, an evaluation of the IMPACT model and RAND Health's evaluation of SAMHSA's Primary and Behavioral Health Care Integration (PBHCI) Grant Program. These studies support the well-established evidence for integrating behavioral health into primary care for people with depression or anxiety disorders and integrating primary care into behavioral health for people with serious mental illnesses (SMI). The brief then expands from investigating specific models to looking at broad types of models and the results of their applications in various settings across the country. Finally, the brief concludes by examining the principles that have been repeatedly present in successfully implemented models, and may serve as the basis for establishing foundational principles for the Learning Collaborative.

Exemplar Models that show integrated health care leads to better health outcomes

The following two national studies provide evidence for the improved health outcomes in integrating behavioral health into primary care and primary care into behavioral health respectively: the IMPACT evaluation and PBCHI Grant Study.

IMPACT study

Improving Mood: Promoting Access to Collaborative Care Treatment (IMPACT) is a team based approach for treating people with depression. IMPACT care incorporates a depression care manager, such as a nurse, social worker, or psychologist, whose role is to educate patients about depression, support antidepressant therapy, offer counseling, monitor depression symptoms, and complete relapse prevention plans with each patient that has improved. The PCP and care manager work as a team to implement the treatment plan, and a designated psychiatrist acts as a consultant to the team for patients who do not respond to treatments as expected.

The care managers measure outcomes regularly using evidence-based questionnaires, such as the PHQ-9, as a measurement tool for depressive systems. Further, the team practices stepped care, in which treatment is adjusted based on clinical outcomes and according to evidence based algorithm in order to aim for the least intensive and most effective therapy for an individual patient (University of Washington).

A 2-year analysis of 1,801 adults 60+ years old with depression in 18 clinics across 5 states (Washington, California, Texas, Indiana, and North Carolina) found that IMPACT's integrative model more than doubled the effectiveness of depression treatment, works in various settings and populations, and decreases costs (University of Washington).

The study found that with IMPACT care, at 12 months about half the patients reported a 50% reduction in depressive symptoms compared to 19% in traditional primary care. The IMPACT model was also tested in a variety of settings (HMO, fee for service, inner city county hospitals, and VA clinics) and was more

effective than "usual" care in all the systems. Further, the model appeared to be equally effective with African Americans, Latino and White patients, though the studies authors recommend additional research to test the model among lower-income, underinsured, and predominantly minority race/ethnicities. Finally, over a 4-year period, IMPACT patients had lower average costs of $3,300 for all medical care. However, total healthcare costs were higher for the IMPACT patients in the first year of the study, "suggesting that an initial investment in better depression care may result in long-term cost savings." Financing that initial investment and rigorously quantifying the timeline and magnitude of cost-savings are challenges that any integration model will need to address, especially for safety net providers (Unützer et al 2008).

Several groups have implemented different forms of IMPACT care. First, Kaiser Permanente of Southern California expanded the program to all adult patients and found that IMPACT patients averaged half the number of clinic visits and 1/3 of phone contacts as patients in the formal research study. However, despite this decline patients showed the same dramatic benefits after 6 months of treatment that were seen in the original study (University of Washington).

Sutter Health, a family of nonprofit hospitals and physician organizations that serve in Northern California, as well as the Institute for Urban Family Health, a federally qualified health center (FQHC) that serve low income, uninsured populations in NYC have both incorporated IMPACT care (University of Washington).

After evaluating the different settings in which IMPACT has been implemented, it has become clearer that the success of this form of depression care is rooted in two core components: systemic diagnosis and outcomes tracking, and stepped care. Both of these processes incorporate two new team members, the care manager and consulting psychiatrist, who support the primary care provider. The care manager is responsible for patient education and close follow up to make sure the patients don't "fall through the cracks," while the psychiatrist offers diagnostic consultation on difficult cases and caseload consultation for the PCP. Also, the stepped care component uses an evidence based algorithm to change treatment if a patient is not improving and is also used for relapse prevention (University of Washington). These two components of care, as well as the roles of the two new team members, are thought to be the drivers of the success the model has experienced.

PBHCI grant

The Substance Abuse and Mental Health Services Administration (SAMHSA) developed the Primary and Behavioral Health Care Integration (PBHCI) program in order to offer primary care to adults with SMI in community mental health centers and other community based behavioral health settings. Grant recipients received up to $500,000 annually to develop integrated services that included the following four core features: screening and referral for primary care, a tracking system for consumers' physical health needs and outcomes, care management, and prevention and wellness services. Over the course of three years, RAND was commissioned to examine 56 PBHCI programs. RAND evaluated the extent of integration of behavioral health and primary care services using the dimensions of colocation, shared structures and systems, degree of communication among different providers, and staff perceptions of how much they felt like they were a part of a team (SAMHSA).

The results showed considerable variation in the extent of integration, but on average, programs were most successful in co-location and creation of shared structures and systems, and least successful in creating an integrated practice culture. Reports showed that the barriers to integration for many programs were the challenge of creating integrated health records, long term financial sustainability (especially for non-billable services like wellness programs), recruiting and retaining qualified staff, and engaging consumers in integrated services over time.

The integrated programs reported early enrollment success with more than half of the consumers using integrated services in the first year; however, rates of service were not different for consumers with and without an identified physical healthcare need, suggesting programs were not successful targeting consumers that were likely to benefit most from care (Scharf et al 2014).

When RAND compared changes in physical and behavioral health indicators among consumers at three PBHCI sites and three comparable control sites, the results showed that consumers treated at PBHCI clinics had greater improvements in some indicators related to diabetes, dyslipidemia, and hypertension compared to those treated at the control sites. However, there was no improvement in indicators related to obesity and smoking (Scharf et al 2014).

After completing the study, RAND identified the following areas for improvement: performance measurement, fidelity to evidence-based practices, enrollment and engagement, and staff education. First, the team recommended the stakeholders develop clearer performance expectations, national quality indicators for accountability in integrated programs, and performance monitoring requirements. Second, it stated that programs can strengthen their wellness services by monitoring how faithfully evidence-based programs are put into action. Third, RAND recommended investing in strategies to improve access to care among harder to reach adults with SMI to increase consumer enrollment and engagement. Finally, it was suggested that educating staff about the nature and scope of integrated services available would enhance service integration (Scharf et al 2014).

Types of Models

Expanding from specific exemplar models, we now turn to the Millbank Memorial Fund's typography of eight types of overarching models that lie on a continuum based on the degree of integration: minimal collaboration, basic collaboration at a distance, basic collaboration on site, close collaboration in a partly integrated system, and close collaboration in a fully integrated system (Collins et al 2010). This broader classification allowed for analysis of the different varieties of integrative models that have been tried all over the country.

Model 1: Improving collaboration between separate providers

In the first model, there is little collaboration with behavioral health and primary care providers who have separate administrative and reimbursement systems; it requires the smallest amount of change from the traditional practice, and may represent a first step that many providers can embrace before higher-level policy changes (information exchange, reimbursement systems, etc.) facilitate deeper integration. There are a number of strategies that can be used in this model. Case managers may coordinate behavioral and physical health care, or a primary care practice may receive psychiatric consultation via telephone. For example, LifeWays, a behavioral health agency in Michigan, has case managers who transport patients to primary care appointments. The administrative staff meets annually with primary care practices to discuss ways to enhance communications.

There are significant cultural barriers in this model since many primary care providers have not developed many relationships with community behavioral health providers, making it difficult to agree on communication and management strategies necessary for coordinated care. Privacy laws also limit the sharing of clinical information and as long as they remain restrictive, agencies need the staff to track who provided consent for what reason, which imposes a financial burden on the practice. We cannot contemplate altering privacy and confidentiality requirements before making significant progress on eliminating the stigma of mental illness and substance use disorder among physical health providers. Enough research exists on the effects of stigma from health care professionals to make caution the rule in this area of policy (Thornicroft, 2007; Goldstone, 2015; Mental Health Commission of Canada, 2013).

Model 2: Medical services provided behavioral health setting

In this delivery model, the medical providers are *directly* involved in behavioral health service delivery. They diagnose a behavioral health issue using evidence based screening tools such as the Patient Health Questionnaire (PHQ-9) that is used to identify depression. If depression is confirmed, the primary care provider uses brief intervention algorithms called screening and brief intervention (SBI) for treatment. These brief interventions can be delivered by primary care physicians with minimal training. The Screening, Brief Intervention, Referral and Treatment (SBIRT) programs implemented by SAMHSA have been found to be effective in reducing the severity of mental health problems and the number of unnecessary emergency department visits and hospitalization (National Council for Community behavioral Healthcare 2009).

However, in implementing this model, primary care providers voice concerns about screening for behavioral health in a short appointment. Another source of provider resistance arises from the frequent difficulty ensuring access to behavioral health services within the community, especially for people with serious mental illness. Although there is evidence that depression and anxiety can be treated in the primary care setting, other serious mental illness may be best treated in specialty mental health agencies. Therefore, in order for this model to succeed, the PCP must know where in the community he/she can refer a person with SMI. Finally, consultation services with psychiatrists may be helpful, but providers will be reluctant to contact specialists with whom they have no prior relationship; opportunities to build those relationships such as "meet and greets" can serve to increase comfort levels.

Finally, to obtain financial viability for this model practices will need to improve their billing and coding knowledge to bill for these integrative services. However, there are services that do not yet have any code. For example, although primary care provider can receive reimbursement for some kinds of telephonic medical care coordination for which behavioral health providers cannot bill. Medicaid programs are currently exploring the costs and benefits of reimbursing for telephonic behavioral health consultation.

Model 3: Co-Location

This model uses specialty mental health clinicians who provide services at the same site as primary care. The two providers share space, but run as separate services. While this model is not fully integrated, physicians may prefer them because specialty mental health services are often difficult to access and having the service on-site is significant step forward (Strosahl 2005).

Emerging literature on collocated substance abuse treatment and primary care has shown that patients have better outcomes, with the most significant improvement for those with poorer health (Craven and Bland 2006). Medical costs may be reduced because patients use less medical care because of the simultaneous mental health services. Further, diagnosis and treatment may significantly improve in co-located model because behavioral health clinicians can take a more active role in teaching and coaching PCPs in their shared space (Koyanagi 2004).

However, this practice model is primarily a referral-based process, and patients must still migrate through a new organization with potentially separate intake processes. Having the mental health service on-site may increase the PCP's understanding of the referral process, but it may not improve the traditionally high patient no-show rates. Nevertheless, because of the close proximity, PCPs are more likely to introduce patients to the behavioral health provider at the time of the medical appointment; these "warm handoffs" may decrease the number of no-shows. Once both providers have established a treatment relationship and issues of consent have been addressed, the proximity can increase the exchange of relevant clinical information.

Model 4: Disease Management/ Chronic Care

Psychological stress and disability accompany many chronic illnesses and thus this model emphasizes the early identification in primary care of populations that are at risk for complex chronic diseases like depression, diabetes, or asthma. The model uses a care manager to provide education and help the PCP in implementing evidence-based algorithms for treatment. The disease management models have an organized approach of assisting lifestyle modification related to chronic illness. The case managers are hallmarks of this model. They may be nurses, master's level social workers, or paraprofessionals with appropriate training.

The specific implementation of a model can change the level of integration, and the disease management model in particular seems to roam across levels. Some programs operate at a basic level of collaboration on-site while others are closer to a fully integrated level of practice.

The IMPACT study described above is one example of chronic care management. The Depression Improvement Across Minnesota Offering a New Direction (DIAMOND) is a project that implemented the IMPACT model and features a care manager providing on-going assessment, a patient registry, use of self-management techniques, and the provision of psychiatric consultation. The project created a partnership between the Department of Human Services, medical groups, health plans, and employer groups. DIAMOND also included a case rate payment for depression care in which the Minnesota health plans pay a monthly per member per month fee (PMPM) to participating clinics for a bundle of services (including the care manager and consulting psychiatric role) under a single billing code. Patient outcomes have been superior to results seen under the usual care given currently by primary care.

Another successful example of this model has been in Utah and Idaho. Intermountain Healthcare has expanded its depression initiative to include a focus on evidence-based treatment algorithms. The program serves both children and adults. After a comprehensive assessment, patients are assigned to either low or moderate care. Low care is managed by a physician with support from a care manager and moderate care includes the entire interdisciplinary team.

Randomized control trials show that disease management models that use care managers are both clinically effective and cost effective. Meta-analyses showed that care managers can produce a cost offset of 20 to 40 percent for primary care patients who receive behavioral health services. Importantly, fewer hospitalizations result in significant cost reduction for patients with chronic physical illness and those with psychiatric diagnoses (Blount 2007). However, one point we would like to raise is that different implementations of this model have used different kinds of case managers (social workers, RNs, etc) who may be doing performing diverse tasks under their job description (phone calls, home visits, medication reconciliation/management, psychosocial assessment, coordination of housing, etc) to different extents. It would be useful to determine what kind of care manager and what kind of care manager activity is effective for different populations.

Model 5: Reverse Co- location

Typically, integration is considered from the perspective of integrating behavioral health into primary care. However, a reversed approach is also possible, and may be more effective when seeking to improve health care for patients with severe and persistent mental illness. Patients with SMIs have high level of medical co-morbidity compared to the general population, as well as increased risk for diabetes, obesity and high cholesterol due to the use of some antipsychotic medications. In the reverse co-location model, a primary care physician may be stationed part- or full-time in a psychiatric specialty setting to monitor the physical health of patients. The typical settings for this model are rehabilitation or day treatment programs, although these services may also be viable in outpatient mental health clinic programs.

Another variation of this model gives psychiatrists within the mental health setting additional medical training instead of bringing in new personnel (Mauer and Druss 2007). A randomized control trial of a Massachusetts program called Health and Education Services demonstrated a 42% reduction of ER visits and dramatic increases in screening for hypertension and diabetes.

Some of the implementation barriers of placing a PCP in a mental health agency are the same as regular colocation such as the issues regarding culture and space, consent to treatment and information sharing, maintenance of medical records, and referral processes.

Model 6: Unified Primary Care and Behavioral Health

Like model 5, this model targets persons with SMI, in which psychiatric services are part of a larger primary care practice. The hallmark of this model is the fact that not only are clinical services combined, but the administration and financing are also well integrated. At the clinical level, primary care and behavioral health staff interact regularly and on an administrative level, they have an integrated medical record and single treatment plan.

This model has been implemented in some FQHCs and VA outpatient programs and both typically offer full service primary care and full service psychiatric care in one place. Druss and colleagues (2001) studied the randomized control trials for this model and found that patients were less likely to have ER visits, reported better physical health status and were less likely to report a problem with continuity of care.

However, integrating full-service mental health in the primary care setting has many of implementation challenges. For example, a number of care processes need to be redesigned in areas such as coding/billing, IT systems, supervision, and liability. In particular, unlike the models discussed above, in which the primary financial barriers are the lack of codes, the financial barriers in this model incorporate much larger system issues since the model will need to support a behavioral health team that is employed by the primary care site. Although the ACA's essential benefits and parity requirements are driving some level of standardization in coverage, there remains a wide variation in mental health and substance use disorder coverage, codes, co-payments, and prior authorization requirements, which presents an additional administrative challenge for the unified model.

Cherokee Health Systems in eastern Tennessee was a community mental health center that expanded to become a FQHC that provides integrated behavioral and primary health care at 22 sites. It provides specialized services for persons with SMI in addition to comprehensive care, which includes case management, day programs, and substance abuse services. Cherokee may be an effective model for underserved areas where there is a lack of providers, and as an FQHC it is able to access special federal financial support. It uses an integrated paper-medical record and holds treatment team meeting regularly for patients with complex mental and physical health needs. The primary care physicians also use the brief interventions mentioned in Model 2 for more straight-forward cases.

Model 7: Primary Care Behavioral Health

In this fully integrated model, the behavioral health clinician is part of the primary care team in treating the individual, and co-manages cases with the physician, who makes the initial referral. This model shifts from specialty behavioral health care, in which the focus is on the individual, to population-based care, in which the entire primary care population is the target. Thus, the primary care behavioral health model uses a "wide net" approach aimed to serve the entire primary care population and emphasizes brief, focused intervention. The model does not aim to only address the needs of people with diagnosed illnesses, but also the needs of those who are at risk of becoming sick or who are sick and do not seek care.

The goal of the brief intervention in this model is to educate patients about their condition and to discuss different self-management strategies. Not surprisingly the greatest challenge for this model is the fact that it requires a complete redesign of the role of behavioral health within primary care. There will be a huge learning curve for the behavioral health providers who wish to practice in this fully integrated setting. The therapist who has practiced in a highly structure fifty minute appointment schedule will need to find a much faster pace in the primary care setting. To routinely accomplish in the fifteen to thirty minute sessions prescribed by this model, the behavioral health provider needs to eliminate time consuming assessments. Where behavioral health providers have used rapport-building, but time-consuming, assessments, the primary care behavioral health model prioritizes limiting the problem-focus and delivering functional interventions (Strosahl, 2005 p 36). "Just as a primary care provider who treats a patient for heart disease is not expected to practice the standard of care of a cardiologist, practice standards for primary care behavioral health should be derived from primary care" (Collins, 2013).

Further, national and state laws that were previously developed in the specialty mental health setting may conflict with the integrated model. Issues around informed consent, brief interventions in the absence of comprehensive psychiatric diagnostic interview, and sharing of medical records are barriers that will need to be further discussed to balance any benefits of the model with the rights and autonomy of consumers.

Buncombe County Health Center in North Carolina provides 85% of the safety net care for low-income county residents. The full time co-located behavioral clinicians work side by side with physicians, and a designated "behaviorist" is always on call and available to immediately triage patients. The physicians and clinicians use the same waiting room and medical records, and the clinician makes specific, evidence based recommendations to the physician. The behavioral health clinician is more of a member of the primary care team than a specialty mental health therapist.

Although the primary care behavioral health model has not yet been systematically evaluated, the research on brief intervention is increasing and highly encouraging. For example, Bernstein et al. (2005) found that meeting with a counselor just once briefly at the time of a routine doctor visit and receiving a follow-up telephone call can motivate abusers of cocaine and heroin to reduce their drug use.

We would like to add a cautionary note here. As mentioned before, there has been sufficient evidence that shows that less severe forms of depression and anxiety disorders respond better to models such as this one, in which behavioral health is integrated into primary care. However, there is a danger in mis-using this model for populations with more serious mental illnesses, who have been shown to respond better to models in which primary care is incorporated into behavioral health treatment. Unlike this model, the flip models allow for longer treatment and build more rapport and trust between the patient and provider team. Thus, it is important to always remember that there is no golden model; different models are effective for different populations, and all interventions should be person-centered and consider the specific goals, preferences, and needs of each individual receiving services.

Practice Model 8: Collaborative System of Care

The collaborative system of care has particular promise for those patients with SMI who require more specialized health services than primary care can offer. The model seeks to develop individualized care plans for high risk patients across multiple different services (medical, mental health, substance use disorder treatment, and social service agencies). Therefore, in this model, in which it is essential to engage a multitude of partners, there will need to be an effort to implement policy that allows seamless distribution of finances across an array of funders.

Rebuilding Lives PACT Team Initiative in Ohio integrates behavioral health and primary care and offers housing and community-based supports such as assertive community treatment (ACT) to serve the

homeless population in Columbus. The core model is care coordination provided by an FQHC, which has a comprehensive list of partners that provide supportive services.

Summary

This section summarized eight models that represent qualitatively different ways of integrating and coordinating care across a continuum from minimal collaboration to partial integration to full integration. Each model is not exclusive of the others; they represent the spectrum of possible interventions and may serve as one conceptual framework for integration.

The examples that are included in each model helps shed light on the success and barriers of each model and also highlights the importance of producing evidence to continuously test and revise models. Most of the current data are for fairly short-term outcomes, and we would like to see more information on the long-term outcomes of the patients who continue and discontinue integrated treatment. Finally, it would also be very useful to include an outcomes measure that incorporates the goals of the individuals receiving services as well. Most of the outcomes are measures of physical health and mental illness symptoms, but it would be useful to have a consistent measure that incorporates the "person-centeredness" of these models, such as a survey of quality of life before, during, and after treatment.

Principles of Successful Integration

As one can see from the section above, there is no one size fits all model or process for successful integration. However, a literature review found that despite the diversity of approaches and strategies for health systems integration, successful integration processes were associated with a certain general principles. These principles were independent of type of integration model, heath care context or population served. They define key areas of restructuring and allow organizational flexibility and adoption to local context.

1. Comprehensive Services across the Continuum of Care

One principle of integrated health care is the comprehensive scope of behavioral and physical health services covered. Integrated health systems assume the responsibility to plan for, provide/purchase, and coordinate all core services along the continuum of health for the population served (Leatt et al. 2000). These services include primary through tertiary care, and cooperation between health and social service organizations.

The degree of integration may be measured by factors such as the extent to which providers practicing in systems articulate similar goals, vision and mission, and the proportion of health services that are included in the integrated framework, however clear and validated criteria to define and evaluate the degree and success of integration (Simoens et al 2005).

2. Patient Focus

Integrated delivery systems are meant to meet the needs of individuals receiving services, and person-centeredness is both a normative and practical principle. A person-centered integrated model is both more respectful toward people it serves and more likely to succeed. It is very important for providers to determine whether and how people with SMI and SUD will seek a given service in a given practice context. Integrated services should demonstrate responsiveness to the changing needs and preferences of the people they serve to ensure they are receiving "the right care at the right place at the right time" (Shortell et al 2000).

In order to offer person-centered service, the team needs to have an efficient way by which individuals can communicate their personal health goals and preferences to all members of the integrated team. To

facilitate this level of engagement health systems should be easy for people to navigate and include various opportunities to provide input on how services are delivered and to what end.

Lingenkugel pointed out that it may be challenging for large systems to retain a patient focus, prompting a recommendation that smaller systems may have better chance at success. We would like to hear more input from those in the field who have opinions about the optimal size of these integrated systems.

3. Standardized Care Delivery though Interprofessional Teams

Standardized care delivered by interprofessional teams promotes continuity of care process. Within effective interprofessoinal teams, all professionals are considered equal members and incentives are provided to meet performance and efficacy standards. Each member of the team should be well aware of the roles and responsibilities of the other members to ensure smooth transitions. Shared evidence-based protocols and decision making tools are essential to standardize care across the different services and sites.

Integral to interprofessional collaboration is communication (Stewart et al. 2003). Barnseley et al. emphasized the importance of "an organic structure with diverse communication channels that efficiently transfer information across organizational boundaries" (1998). Co-location of services, frequent team meetings, and the use of shared electronic information systems can facilitate effective communication.

We have read about many different forms of interprofessional teams; they have included nurses, social workers, paraprofessionals, and peer recovery specialists. We would like to request input from readers about experience with and evidence base for these different roles within the team, and strategies to ensure that any team-based care maintains a meaningful person-centeredness.

4. Performance Management

Performance monitoring systems must include indicators to measure outcomes that reflect the the level of integration, the quality of services and the experience of the person receiving them. Performance management must involve a structured approach to analysis of performance issues and how they can be addressed. Ongoing measurement of care outcomes and reporting are important aspects of quality improvement; successful integrated health systems have mechanisms that link compensation to indicator-based performance. Having reward systems redesigned to identify, measure, and reinforce achievement of the organization's priorities is an effective way to promote cost effective high quality care.

Developing valid quality measures specifically addressing integration strategies to create effective incentives is necessary if successful integration models are to by widely implemented and scaled up to serve more people (Goldman, 2015). We welcome comments from readers on what incentives and disincentives currently exist to improve linkages between physical health and behavioral health providers, and what quality measurement and reimbursement strategies may stimulate improvements in integration.

5. Information Systems

Many of the processes discussed above are only possible with system wide computerized information that allows data management and effective tracking of utilization and outcomes. Quality information systems also enhance communication capacity and information flow across integrated pathways. The information system should also enable system-wide patient registration and scheduling coordination as well as management of clinical data.

Unfortunately developing and implementing inter-operable electronic information systems is time consuming, complex and costly and require an initial investment. Further, even after funding, it is

important to have technical assistance throughout the implementation of a new HIT, as the process of transitioning to a new system can be a source of turmoil and disruption.

It is also important to recognize that information-sharing has an unfortunate downside in physical-behavioral health integration. People with SMI or SUD may not consent to share information on their behavioral health diagnoses and treatment with physical health providers. Although the benefits of integration depend in large part on precisely that kind of information sharing, stigma regarding mental illness among health care providers remains a problem. We should be careful to address this reality and the valid concerns of people with mental illness regarding privacy and confidentiality as we move to expand information exchange between providers (Thornicroft, 2007; Goldstone, 2015; Mental Health Commission of Canada, 2013)

6. Organizational culture and leadership

Clashing cultures, such as the difference between providers of medical services and long term services and supports or between physicians and other service providers, is one of the main reasons cited for failed integration efforts. Thus, operation of an integrated model requires leadership with a unified vision as well as an organizational culture that is congruent with that vision.

The committed leadership also needs clear communication processes in order to promote the new mission of integration among their staff to help them take ownership of the process. Successful leaders give opportunities, resources, incentives and rewards for staff integrative learning and enable providers to take the time to obtain additional training (Hurst et al. 2002).

We would like to ask our readers for any input of examples where this kind of culture change has taken root, and what kind of leadership has been successful in this regard. Studying successful models of this culture will help us find the core components needed to thread this principle into different models.

7. Physician Integration

The perceived loss of power, prestige, income or change in practice style can result in physician discontent and resistance to change (Budettie et al 2002). For some physicians, working in an integrated model with shared decision making responsibility is "unpalatable" (Hawkins 1998).

It has been shown that to facilitate physician integration, it is important to take advantage of existing networks, informal linkages among practitioners and a strong patient focus. Further, integrating primary care physicians economically and ensuring their retention through compensation mechanisms, financial incentives, and ways to improve quality of working life have also been noted to be of critical success. Despite the number of barriers documented, it is believed that "stronger physician-system alignment is desirable and worthy of time attention, and resources" (Gillies et al. 2001).

8. Governance Structure

Bringing together organizations and services into an integrated model through contractual relationships or networks requires the development of governing structures that can promote coordination. These structures must be diversified so that they represent a variety of stakeholder groups. This structure would be responsible for making strategic alliances with external stakeholders, government, and the public, and it would create the financial incentives that influence providers' attentiveness to costs and quality of services rendered.

Behavioral-physical health integration models could learn from the experience of ACOs, and they could try to model the governing structures that have worked to align members and support other efficient and effective operations. Further, it should be once again noted that many of the smaller, community based

organizations that will be included in these integrative models will not be familiar with the complex organization of sophisticated governance structures; thus, it will be very important not only to support the resources needed for their transition into these models, but also to fund the technical assistance they will need to carry out the task.

9. Financial Management

Cost control was originally one of the greatest incentives for health system integration as it was thought it would result in savings in both administrative and clinical costs. However, many authors claim that integration process will result in increased costs before they provide savings (Coburn 2001). Therefore, the way services are funded is one of the most important considerations of integrated models.

A major barrier to integration in some jurisdictions is differentiated funding for long-term care, social services, mental health, and primary care. Financing mechanisms are needed that allow pooling of funds across services. For example, populations-needs-based funding will pay for all insured health (and specific social) services required by the enrolled population for a predetermined amount of time. The amount of money per enrollee is set prospectively and adjusted to ensure equitable distribution of funds using factors such as gender, age, or geography.

This aspect of management is another place we would explicitly like to ask the readers for input. We would like to hear about lessons learned on the field, and other challenges we may have missed for smaller organizations to adapt to new, often risk-based, payment methodologies. This input will help us identify the best ways to support and assist these organizations in making this shift.

Conclusion:

This first step into the world of integrated practice has made it clear to Health & Medicine that there is no golden formula that can be applied to transform a traditional model into an integrated one. We must make an initial investment into our system before reaping the economic and health outcomes the integrated model promises. Among other things, information systems need to be upgraded, staff must be trained, and financial reimbursement mechanisms must be reorganized. It is clear that the path to integration will be long, and it seems the most important aspect of this process will be a continuous measure of outcomes in order to ensure the system is moving in the right direction.

The current literature has measures for both patients (physical health evaluation, mental health symptom evaluation, hospital readmissions) and providers (questionnaires about practice culture, number of team meetings, etc.), but we wanted to receive more input from those on the field who know more about the variables that best reflect outcomes of integration in different settings. We would also appreciate criticism and feedback on our understanding of exemplar models, types of models, and principles of integrated care from those who understand what has worked on the field and what has not. We are in particular looking for more information on the success and failures of integrated programs within Chicago as we understand the outcomes of these models can vary by population.

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