Professional Psychology: Research and Practice
2011, Vol. 42, No. 5, 391–397

0735-7028/11/$12.00 DOI: 10.1037/a0024982

Establishing an Integrated Care Practice in a Community Health Center

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In a progressively complex and fragmented health care system and in response to the need to provide whole-person, quality care to greater numbers of patients than ever before, primary care practices throughout the United States have turned their attention and efforts to integrating behavioral health into their standard service-delivery models. With few resources and little guidance, systems struggle to gather the support required to establish effective integrated programs. Based on first-hand experience, we describe a working integrated primary care model, currently utilized in a large community health center system in Colorado, that encompasses universal screening, consultation, psychotherapy, and psychological testing. With appreciation for the way an organization's unique circumstances inform the best approach for that particular organization, we highlight the clinical-level and system-level variables that we consider necessary for successful practice development and address how our behavioral health program operates despite funding limitations. We conclude that organizations that aim for integrated primary care must mobilize leadership to implement systemic changes while making difficult decisions about program development, financing, staffing, and interagency relationships.

Keywords: integrated care, primary care, integrative medicine, health psychology, collaborative care

The health care system in the United States is facing a paradox of declining outcomes and rapidly increasing costs (Rabin et al., 2009). In 2008, mental health conditions accounted for $72 billion in expenditures, making them the third most costly group of conditions (along with cancer), exceeded only by heart conditions and trauma-related disorders or conditions (Agency for Healthcare Research & Quality, 2008). In an effort to improve the provision of health care, many experts and key organizations are lending support to the movement for integration of behavioral health into primary care settings (Blount, 2003; Institute of Medicine, 2001, 2006; Pincus, 2003; U.S. Department of Health and Human Services, 2006; World Health Organization & World Organization of Family Doctors, 2008). Numerous studies have demonstrated that integrated services can improve access to mental health care, enhance quality of care, decrease health care costs, improve overall health, decrease the burden on primary care providers (PCPs), and improve PCPs' ability to address patients' mental health needs (Butler et al., 2008; Chiles, Lambert, & Hatch, 1999; O'Donohue, Cummings, & Ferguson, 2003; World Health Organization & World Organization of Family Doctors, 2008).

The decision to organize integration efforts at our community health center was, in part, based on well-known data regarding primary care patients. For example, psychiatric conditions are common in patients who are seen in primary care practices (Cwikel, Zilber, Feinson, & Lerner, 2008) and many patients who have mental health needs seek treatment for these concerns through their PCP (Goldman, Rye, & Sirovatka, 2000; Petterson et al., 2008; Wang et al., 2006). Additionally, the majority of medical problems seen in primary care practices are undeniably linked with behaviors, and it has been estimated that 40% of premature deaths in the United States are attributable to health behavior factors (McGinnis & Foege, 1993; Mokdad, Marks, Stoup, & Gerberding, 2004). Behavioral health integration is an integral part of a solution to the complex health care needs of these patients.

Although the terms *mental health* and *behavioral health* are sometimes used interchangeably, we conceptualize them as different constructs. The term behavioral health applies to patients whose primary diagnosis is somatic and whose psychological symptoms, if present, are subclinical and related to the primary diagnosis. The term mental health applies when the focus of treatment is psychiatric; there may or may not be an accompanying

This article was published Online First August 29, 2011.

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medical condition. In this article, however, the term behavioral health will subsume both categories.

Integrated Primary Care at Salud Family Health Centers

Founded in 1970, Salud Family Health Centers (Salud) is a federally qualified community health center consisting of nine health care clinics covering eight counties in North Central Colorado. Salud is an important part of the health care safety net, providing population-based, fully integrated medical, dental, and behavioral health services regardless of finances, insurance coverage, or ability to pay–Salud focuses on the needs of the medically indigent, uninsured, and underinsured populations. The national distribution of payer sources for federally qualified health centers is 35% Medicaid and 25% Medicare or private insurance, with 40% of patients falling into the uninsured category (Adashi, Geiger, & Fine, 2010). By comparison, 30% of Salud's patients have Medicaid, 14% have Medicare or private insurance, and 56% are uninsured, leaving Salud to support the health care of a greater proportion of patients with no funding source.

Salud employs 540 individuals, including 60 medical providers, 14 dentists, 9 dental hygienists, and 15 behavioral health providers (BHPs). In 2010, Salud served more than 80,000 patients with approximately 300,000 visits, making it the second largest health care provider in a six-state region. The most common visit types include well-child checks, prenatal visits, diabetes, and hypertension. About 3,000 of Salud's patients are migrant and seasonal farmworkers, and 65% of patients are Latino, many of whom speak Spanish as their primary or only language.

In response to the extraordinary number of patients with behavioral health needs, immigration-related stressors, and limited financial means, Salud's move toward integration began in 1997 under the leadership of its medical director, who had received training in an integrated model. The need for integration was apparent, but it soon became clear that incorporating a team of behavioral health providers into an established medical setting was a more complex proposition than it initially seemed. The program started with one BHP in one clinic. PCPs who found value in the service vocalized their desire for an expanded behavioral health presence. As Salud hired more BHPs, it became necessary to build an infrastructure designed to support integration at an organizational level. We set out to create a service-delivery model and develop job descriptions, billing and coding practices, policies, protocols, standard operating procedures, and data tracking mechanisms. In order to accomplish these tasks, the focus shifted toward securing administrative support from key members of the organization. Over time, with the collective mission to provide quality health care—and with the implicit acceptance that behavioral health needs must be addressed as part of its delivery—efforts materialized into an integrated care program. In an effort to measure the effectiveness of our program, we recently have begun to work toward an information-technology-driven, outcome-based approach, whereby we collaborate with university partners to measure and benchmark our data through regional and national comparative effectiveness research networks.

In 2010, we developed a mission statement that reads: "To deliver stratified, integrated, patient-centered, population-based services utilizing a diversified team of behavioral health professionals who function as 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." The implications of this mission include that BHPs have the ability to see a patient at any time, for any reason, without requiring a consult request from a PCP. This approach requires a paradigm shift from a superior/subordinate mentality to one of implicit understanding of the unique skills that all persons involved in the patient's care contribute to the patient's overall well-being. It gives BHPs the latitude to determine which patients they need to assess on a given day, and providers see each patient as "our patient" not "my patient."

Components of Integrated Care

Over time, we have become familiar with many factors that influence the development, success, and sustainability of an integrated primary care practice. Below is a summary of what we have found to be essential components of integration, broken down into those variables related to clinical decisions and interventions and those related to system-level considerations.

Clinical Variables

One prospect of integration is the provision of *real time interventions*. As soon as a need is identified, a BHP is present to provide services. PCPs who might otherwise shy away from uncovering mental health issues are less likely to do so if they know they can call upon a BHP to address identified concerns. Just as some primary care visits are considered urgent, so are some behavioral health visits. Having a BHP available when these situations arise can mean that a patient actually receives care as opposed to falling through the cracks in a health care system in which timely access is often a problem (Pincus, 2003; Strosahl, 1998).

In any large primary care system, behavioral health services must be *population-based and not disease specific*. A population-based approach focuses on the needs of a defined community with an emphasis on evidence-based practice and effective outcomes as well as primary prevention (Ibrahim, Savitz, Carey, & Wagner, 2001). In order to meet the needs of an entire community, BHPs must be capable of assessing and addressing multiple presenting concerns of varying levels of severity. BHPs in primary care cannot be limited to utilizing interventions that target only a specific disease category, primarily because comorbidity is the rule rather than the exception (Klinkman, 2009). In response to this reality, treatment approaches must be geared toward the whole person, not the illness.

BHPs who work in a primary care setting need to have strong *generalist training*, with sufficient understanding of normal and abnormal developmental processes across the life span, and to be *flexible*. The nature of the setting requires BHPs to make instant connections with patients, to formulate quick assessments, and to communicate the relevant findings to the PCP immediately. From a logistical standpoint, BHPs must be willing to swap the comfort and controllability of a therapy room for the unpredictable and unsettling reality of seeing patients in the medical rooms, often with interruptions.

System Variables

Colocation is crucial for successful integrated primary care (Blount, 2003). For integration to be truly seamless, the BHP must be in the flow of the action occurring in the clinic and must be visible to patients and PCPs alike. Although 80% of patients with unexplained symptoms and psychosocial distress accept management by PCPs, only 10% will attend a psychosocial referral (Smith et al., 2003). Not having to travel to another facility or even a different area of the clinic to access behavioral health may help reduce the stigma associated with mental illness and thus increase the number of patients receiving services (Pincus, 2003; Strosahl, 1998).

Although the concept of a multidisciplinary team is not a new one, redefining the *team approach* to include PCPs and BHPs requires a willingness to accept a paradigm shift of shared responsibility for a patient. A reevaluation of the systems that maintain power differentials among providers at the expense of quality, comprehensive care is necessary, along with efforts to dismantle and rebuild those systems.

Using a *shared medical record,* in which PCPs and BHPs have access to each other's notes, can help support the paradigm shift. The Health Insurance Portability and Accountability Act (HIPAA) regulations clearly delineate the differences between *psychotherapy notes* and *progress notes* (Gillman, 2004) and it is the latter kind of note that we suggest BHPs use in integrated settings. Psychotherapy notes are granted special protection under HIPAA due to the likelihood that they contain particularly sensitive information, are considered the personal notes of the treating therapist, and must be kept separate from the medical record. Progress notes are limited to medication information, modality and frequency of treatment, and a summary of diagnosis, functional status, symptoms, prognosis, and progress to date. Unlike psychotherapy notes, these notes are part of the medical record.

An ideal integrated care system does not operate within a vacuum, but rather allows for *coordination of care within and across health care settings.* In order to achieve this goal, a service-delivery model must be defined. What patients will be referred out, to whom, and for what reasons? Similarly, what kinds of patients will be accepted from other agencies and for what reasons? In theory, patients with higher mental health needs are better-suited to receive treatment in specialized agencies such as community mental health centers (CMHCs). In practice, however, there are significant barriers to implementing this transition. These obstacles include patients' reluctance to go to a CMHC because of the stigma associated with mental illness, a previous negative experience, long waiting lists, limited transportation options, or failure to meet diagnostic or funding requirements. Moreover, some patients prefer having all health care needs met in one place even when the aforementioned barriers do not apply. Therefore, we argue that an integrated practice that emphasizes primary-care-level behavioral interventions must remain flexible enough to accommodate all patients, regardless of problem severity.

Putting It All Together: Salud's Integrated Care Model

There is tremendous variability in the kinds of behavioral health issues seen in our setting, and symptom severity in each patient is fluid rather than static. We argue that behavioral health is not a bimodal phenomenon determined by the presence or absence of health; rather, it exists along a continuum. We conceptualize this continuum as having four levels of severity; at any given time fewer patients fall into the more severe levels and more patients fall into the less severe levels. Conceptualizing our population in this fashion allows us to better allocate resources based on the distribution of patients.

Patients presenting at *Level 1* are in a state of acute need, requiring immediate referral to emergency departments and/or inpatient care. Examples include imminent suicidal depression, acute psychosis, and manic crisis. Because of the seriousness and visible nature of their symptoms, these patients are more likely to present to an emergency room or to be detained by police than they are to present to PCP offices. *Level 2* consists of patients who have severe and persistent mental illness. Although these patients can benefit from psychiatric follow-up in a specialized mental health setting, the need is not immediate. Many can be monitored in primary care settings when stable, especially when psychiatry consultation is available. Patients at *Level 3* present with problems that are chronic and of lower severity. They are common in primary care practice and include somatization disorders, nonpsychotic depression, acute stress disorder, and anxiety disorders where functional impairment is present but the symptoms are not completely debilitating. Level 3 patients frequently seek care in primary care settings, but PCPs are not always equipped with the expertise and knowledge to address their needs (Goldman et al., 2000). *Level 4* includes patients with temporary mental health and psychosocial problems, including concerns such as marital difficulties, parenting problems, bereavement, employment problems, financial stress, and so forth. Left untreated, Level 4 problems can progress, potentially leading to risky behaviors, unhealthy life choices, and worsening of chronic diseases. Last, at any given time, there are patients who do not qualify for assignment to a particular level but who nevertheless might benefit from educational and preventive interventions.

In an attempt to provide adequate services to the 80,000 patients in the Salud system in alignment with our mission, we grappled with how BHPs were going to spend their time. We wanted to maximize their ability to see a high number of patients while still maintaining a high standard of care. Based on the four-level model of severity just described, BHPs spend 30% of their time providing more traditional therapy services to Levels 1 and 2, the highest-needs patients, who make up a significant portion, though not the majority of our population. BHPs spend 70% of their time providing various integrated services to Levels 3 and 4 and the unassigned, whose symptoms are less severe or temporarily nonexistent but who make up a much larger portion of our patient population.

After careful consideration, we decided that the best service-delivery model for patients in our geographical area is a stepped-care approach. The initial point of contact with a BHP typically occurs during a medical visit. Of patients requiring follow-up care, some are referred out but many continue with onsite therapy services. Therapy appointments are scheduled separately from medical appointments and consist of a limited number of visits, which can be extended if necessary by department approval. Historically, referrals to CMHCs more commonly were driven by payer source (i.e., Medicaid) than by patient need, creating a dual standard of care whereby some but not all patients received inte-

grated care. Recently, we have determined that this standard is unacceptable and have made modifications to our care model to allow primarily clinical determinants to inform referral decisions. These clinical determinants include when a patient a) needs services for a longer period than we can provide; b) requires specialty services such as vocational rehabilitation, day treatment, wrap-around services, and so forth; and c) qualifies as severely and persistently mentally ill or severely emotionally disturbed.

Services Offered

BHPs at Salud offer a variety of evidence-based services, including screenings, consultations, psychotherapy, and psychological assessment. A report by the Institute of Medicine (2001) defined *evidence-based practice* in psychology as the "integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 147). Research suggests that sensitivity and flexibility in administering therapeutic interventions produces better outcomes than rigid application of manuals or principles (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010; Henry, Schacht, Strupp, Butler, & Binder, 1993; Huppert et al., 2001). Because clinicians with sound clinical judgment will be more effective when operating from treatment perspectives that are most consistent with their views (Benish, Imel, & Wampold, 2008; Luborsky et al., 1999; Wampold, Minami, Baskin, & Tierney, 2002), we encourage BHPs to utilize all of their clinical knowledge from an evidenced-based perspective, rather than limiting themselves to a narrow range of interventions.

As opposed to evidence-based practice, *empirically validated treatments* (EVTs) are specific treatments for defined groups of individuals who have particular disorders. We argue that, although there is certainly a place for EVTs in any setting, applying such interventions in a primary care setting is particularly challenging for several reasons. First, much of the work being done in primary care is brief, which can limit the ability of the BHP to provide the intervention in full-form. Second, the population in primary care is extremely heterogeneous. Primary care patients cover the entire life span, present with multiple comorbidities, and do not usually request treatment for a well-defined condition, thus making it extremely difficult to choose the appropriate EVT. Supporting evidence-based practice over EVT makes sense in an integrated primary care setting because it is research-based without being prescriptive. BHPs therefore have latitude to make difficult treatment decisions and to derive interventions from the research even when the available research does not fully address the population's clinical needs (American Psychological Association, 2005). The following section describes Salud's service-delivery model in greater detail.

Screening. The purpose of screening is to identify patients who may be at risk for behavioral health difficulties by detecting previously unrecognized symptoms. Establishing a smooth screening process that does not interrupt the workflow can be challenging. We found that there needs to be clear communication to all employees, including PCPs and support staff, of the expectation that the practice is integrated. Additionally, BHPs and PCPs must have open dialogues about workflow. Last, priority groups need to be established so that BHPs can decide which patients to screen first when it is not possible to screen every patient.

Screenings are intended to be structured and brief (5–10 minutes) and targeted at specific priority groups—for Salud, this includes pregnant patients, postpartum patients, new patients, and children. We designed our screenings to encompass conditions specified by the United States Preventive Task Force as well as those concerns commonly seen in our setting. For patients older than 16, we developed an eight-item prescreen the *Screen for Life Stressors*, containing Yes/No responses about symptoms of depression; anxiety; posttraumatic stress disorder (PTSD); tobacco, alcohol, and substance use; and safety in the current living environment. The questionnaire is a combination of items from the Primary Care Evaluation of Mental Disorders (PRIME-MD), a questionnaire designed to assist general practitioners in the diagnosis of minor psychiatric disorders (Spitzer et al., 1994); the Primary Care PTSD Screen, a 4-question screen for symptoms of PTSD (Prins et al., 2003); questions based on Screening Brief Intervention Referral to Treatment guidelines for substance use and abuse (Colorado Clinical Guidelines Collaborative, 2008); and questions we developed specifically for this purpose.

We typically administer the prescreen face-to-face to help establish a relationship with the patient and to provide the opportunity for immediate brief interventions. Positive prescreens trigger a more intensive screening with standardized instruments assessing depression, anxiety, alcohol abuse, substance abuse, and PTSD. Depending on the patient's literacy level, these questionnaires can be filled out by the patient or administered interview-style by the BHP. We currently use the following instruments: Patient Health Questionnaire - 9 from the PRIME-MD or Edinburgh Postnatal Depression Scale (Cox, Holden, & Sagovsky, 1987); Generalized Anxiety Disorder (7-item) Scale from the PRIME-MD; PTSD Checklist (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996); Drug Abuse Screening Test (Skinner, 1982); and Alcohol Use Disorders Identification Test (Saunders, Aasland, Babor, de la Fuente, & Grant, 1993). Children are screened using the Parents' Evaluation of Developmental Status (for ages 0–8; Glascoe, 2010) and the Pediatric Symptom Checklist (for ages 9–16; Jellinek, Murphy, & Burns, 1986).

Because false positives are inherent in any screening procedure, formal diagnoses are not based solely on the results of a screening. Screenings that turn into diagnostic assessments are documented separately. When patients screen positive, the BHP or PCP offers follow-up services, either onsite, if possible, or through an outside agency (Pignone et al., 2002).

Consultation. Although BHPs can see any patient at any time for any reason, PCPs will often ask a BHP to evaluate and/or treat a patient during a medical visit. Reasons for requesting consultation include but are not limited to psychoeducation or therapeutic interventions for a specific behavioral health concern, health behavior change interventions, and assessment for diagnostic impressions, suicide risk, and capacity to make health care decisions. PCPs also frequently request crisis management services and/or referral for onsite or offsite services.

Psychotherapy. Full time BHPs have the ability to schedule up to three patients per day for individual psychotherapy appointments. Patients seen in this capacity complete disclosure and informed-consent forms and work with their BHP to develop a treatment plan. The typical session length is 50 minutes, although some clinicians prefer shorter intervals. Scheduling is done either by the BHP directly or through a centralized call center. Given the

nature of a primary care setting, termination for no-shows/cancellations is determined on a case-by-case basis. BHPs need to be flexible when scheduling patients as many will not fall into the traditional once per week model.

Psychological testing. Psychological testing for adults is provided through Salud's psychology training program, which includes six postdoctoral fellows and several graduate-level practicum trainees. A licensed psychologist on staff provides supervision to any trainee completing testing. Reasons for testing include diagnostic clarification to inform medication management and psychotherapy, to rule out a learning disorder, to evaluate memory (e.g., normal aging vs. abnormal memory functioning; specify type of memory impairment), to determine need for intensive neuropsychological testing, and to assess intellectual functioning.

Patient Contacts

Using the reporting functions from our electronic health record and billing system, we were able to capture the number of patients seen in 2010. Table 1 shows the results of the prescreenings described above. Table 2 reflects the other behavioral health services rendered in 2010. The behavioral health team provided approximately 3000 screenings, 5500 consults, and 1800 individual therapy visits in 2010.

Financing

In a health care system characterized by barriers to integrated practice, especially financial ones, it is surprising that so many practices are making the move toward integration. We think integration is essential for comprehensive patient care consistent with a patient-centered philosophy, but cost-effectiveness is hard to measure. Higher levels of integration are more costly due to the staffing and administrative demands associated with more complex service delivery. Integration reduces costs for the entire health care system to a point (Chiles et al., 1999; Katon et al., 2006; Mumford, Schlesinger, Glass, Patrick, & Cuerdon, 1984), but primary care practices may not share directly in the cost savings from effectiveness. From a strict revenue-producing standpoint, Salud's integrated care team does not generate enough revenue to support its staffing. Nevertheless, the cost of funding integration must be compared to the cost of *not* funding integration.

As a federally qualified health center, Salud receives 20% of its $50 million/year operating budget from the federal government, 20% from state grants, and 60% from direct patient fees. Enhanced Medicaid reimbursements for medical visits help offset the costs of providing services to such a large percentage of uninsured individuals. Federally qualified health centers cannot receive any additional reimbursement from Medicaid for behavioral health services during medical visits because the Medicaid rate is a flat per-patient rate regardless of the number or type of services rendered during a particular visit. It is possible to bill Medicaid for services outside a regular medical visit by contracting with the behavioral health organizations that administer Medicaid. However, for the time being, we have chosen not to pursue this funding stream because the current regulations are not favorable to integrated systems. Salud generates a small amount of revenue through direct patient fees for therapy and assessment services rendered to non-Medicaid patients. Third-party payers are not billed because of paneling and credentialing requirements for providers, same-day billing restrictions, administrative burden, and internal costs associated with electronic claims. We thus decided to pursue other funding for our integrated program.

The behavioral health program remains viable through two ongoing Health Resources Services Administration (HRSA) grants, included in Salud's annual HRSA funding for operating as a federally qualified health center. The psychology training program is sustained through a combination of grants, including a large one dedicated specifically to postdoctoral training. Finally, many of our BHPs are employed through collaborative arrangements with our CMHC partners or similar agencies. In these cases, Salud does not pay the BHP's salary; the outside agencies benefit by increasing their Medicaid penetration rate and/or by demonstrating that they are reaching more patients.

Table 2
Other Behavioral Health Contacts, 2010

Service	Number of contacts
Consultation	5507
Diagnostic Evaluations	310
Individual therapy	1844
Family therapy	82
Group therapy	37
Smoking cessation	237
Alcohol/Substance Treatment	73
Child Screen	299

Conclusion

Primary care patients who have behavioral health problems are very expensive to the system (Petterson et al., 2008), and behavioral health affects overall health whether we address it or not. This

Table 1
Prescreening Results 2010

Dimension	Positive screen	Negative screen	Total	% Positive
Depression	1066	1924	2990	35.7
Anxiety	979	1865	2844	34.4
Trauma	338	2549	2887	11.7
Alcohol	302	2689	2991	10.1
Tobacco Use	879	1551	2430	36.2
Other Substance Abuse	105	2319	2424	4.3
Unsafe Living Environment	59	2845	2904	2

article has been an attempt to describe how these basic considerations have driven the evolution of an integrated care practice in a large community health center system that serves vulnerable populations across North Central Colorado. With the caveat that there is no one correct way to achieve integrated care, we have presented the various considerations and decisions made along the way in hopes that others who are considering or are in the process of establishing an integrated care practice might learn from our experiences. We have detailed our thoughts about the necessary and sufficient components of successful integration, with special attention to the role of evidence-based practice. We have also argued that paradigm shifts from a medically focused mentality to a patient-centered mentality must be made at the organizational level.

For practices considering integrating behavioral health into primary care, is value measured by dollars brought into the organization, provider satisfaction, patient satisfaction, decreased utilization, fewer emergency room visits, or improvement in physical markers? If the only way to generate revenue through behavioral health services is by moving from an integrated to a colocated model, is this approach consistent with the organizational mission? Do the administrative burdens and costs of billing fee-for-service outweigh the benefits? Do they impact the organization's ability to offer high-volume quality services? These are merely a few of the questions that will arise when setting up an integrated care practice.

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Received March 21, 2011
Revision received June 9, 2011
Accepted June 15, 2011 ■