Integrating Primary Care into Mental Health Settings for Adults with Severe and Persistent Mental Illnesses

Initial Descriptive Report

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DSRIP-funded Primary Care Integrated into Mental Health Care Settings:

Initial Descriptive Report

Executive Summary

This report summarizes findings from visits to ten sites integrating primary care into mental health care settings through the Texas Healthcare Transformation and Quality Improvement Program Delivery System Reform Incentive Payments pool (DSRIP), within what is commonly known as the Texas 1115(a) Medicaid waiver.

Key Findings:

Primary care volume at integrated sites was often initially low. This allowed staff to spend more time with patients. In general, both professionals and patients believed that having more time to communicate about patients' health needs, health behaviors, and self-care was valuable.

Integration tended to be characterized by differences in both administrative processes and organizational cultures between primary and mental health care. Integration was much easier when primary care and mental health care providers had immediate access to the same health records. However, even at sites without common records, staff were refining processes for making relevant information available to all clinicians in a timely fashion.

Both recruiting and retaining the "right kinds" of primary care personnel was a significant challenge for many sites. Four sites experienced either delayed or paused operations after losing a primary care provider; this affected projects with and without external partners.

Integration projects clearly enabled Community Mental Health Centers to address pressing physical health needs. However, only a minority of patients appeared to receive recommended specialty care from other providers. Reasons for the limited specialty care included extreme patient poverty and reported hesitance among some providers to accept patients with Medicaid or without insurance. Poverty also appeared to reduce medication adherence, even when co-pays were as low as $3 - 5.

Providers believed that integrating primary care into mental health care facilitated more holistic treatment, which most commonly appeared to center around medication management. As vital as these advances in practice are, the research team also perceived such patient-centered integration to create a more challenging context for clinical practice, as providers were now more aware of each other's medication prescriptions in particular, and began recalibrating accordingly.

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Background

Severe and Persistent Mental Illness

In Texas, almost five percent of the state's population are diagnosed with serious mental illness. Of these, a subset are classified as having severe and persistent mental illness (SPMI) because diagnoses such as schizophrenia, major depression, or bipolar disorder limit their ability to live independently and have either persisted for more than a year or resulted in psychiatric hospitalizations (NAMI, 2010). These individuals have priority for community mental health services. Recent research indicates that individuals with SPMI die an estimated average of 25 years earlier than individuals who do not have these conditions (AHRQ, 2014; Gierisch et al., 2013; Parks et al., 2006). This gaping disparity is related to an increased risk for metabolic syndrome among people with SPMI (Brunero & Lamont, 2010), health behaviors such as smoking and diet (Chwastiak et al., 2013), and lower levels of primary care (Golomb et al., 2000; Hall et al., 1982). Managing co-occurring mental health and chronic health illnesses for people with SPMI can be complicated by the separate provision of physical and mental health care. Individuals with SPMI tend to receive some type of psychiatric care, but limited primary care (Bradford et al., 2008). Hence, expert consensus supports bringing physical health care into mental health care settings for this population, a configuration which has been described as "reverse co-location" (Kaiser, 2011).

Bringing primary care services into behavioral health settings can enable primary care providers to address the needs of people with SPMI more effectively (Collins et al., 2010). For instance, individuals with SPMI often have complex medication plans with a high risk of interactions and side effects (Parks et al., 2005). Collaboration with behavioral health care providers can also help primary care providers become more comfortable working with individuals who have SPMI (Alakeson, 2010). Lack of understanding of SPMI and inexperience working with this population can lead to misinterpretations such as symptoms being classified as delusions instead of medical conditions, and can also negatively impact consumer-provider interactions (Cabassa et al., 2014). Co-location of health care services is also a convenience for patients, allowing multiple health needs to be addressed in the same facility and sometimes on the same day; this is especially important for people with SPMI because of their frequent difficulties with securing transportation, especially in rural areas (Decoux, 2005; Nover, 2014; Scharf et al., 2013).

The World Health Organization (2008) spelled out seven reasons why mental health care should be integrated in primary care. Listed below are these principals adapted to describe the potential benefits of the reverse, i.e., integrating primary care into mental health care, for individuals with SPMI.

1) Mental illness creates economic and social hardships for society as a whole (Schroeder & Morris, 2010, p. 300).
2) Mental and physical health are interwoven (e.g., Citrome et al., 2005).
3) People with SPMI receive inadequate physical health care and have greater difficulty navigating the health care system compared to individuals who do not have SPMI (Bartels et al., 2013).
4) Reverse co-location can improve access to primary care (Scharf et al., 2013).

5) Given stigma related to mental illness, a health care setting in which patients feel comfortable is essential (Kaufman, 2012).
6) Integrated care can be affordable and cost effective, especially when the cost of psychiatric hospitals and the emergency department visits is considered (Department of Mental Health and MO Healthnet, 2013).
7) Integrated care can improve health outcomes (Druss et al., 2001).

(World Health Organization, 2008)

The Texas Healthcare Transformation and Quality Improvement Program as an Opportunity to Improve Care for People with SPMI

Through the Texas Healthcare Transformation and Quality Improvement Program, otherwise known as the Texas 1115(a) Medicaid waiver, the state has sought to improve access to health care, increase the quality of care, and reduce costs by expanding Medicaid managed care, revising the Uncompensated Care system, and creating the Delivery System Reform Incentive Payment (DSRIP) pool. Hospitals and other participating providers, including Community Mental Health (MH) Centers (also known as Local Mental Health Authorities [LMHA], Community MH/IDD Centers, or Community Mental Health Mental Retardation [MHMR] Centers), may earn DSRIP payments for projects that improve system performance in various ways approved by the Texas Health and Human Services Commission (HHSC) and the Centers for Medicare and Medicaid Services (CMS).

Texas mental health care leaders have identified DSRIP funding as a means of implementing a range of initiatives to meet the needs of people with mental health conditions, including those with severe and persistent mental illness (SPMI). The current report focuses on "reverse integration" DSRIP projects, whereby primary care is offered at mental health care sites. As outlined above, the rationale behind these projects is that lack of primary care was among the reasons for premature mortality among people with severe mental illness (Colton & Manderscheid, 2006).

Prior research has found substantial variability in the nature of primary-mental health integration (US DHHS, 2013; Bauer et al., 2011). In addition, there is evidence that integrated sites with better quality indicators have better outcomes as well, albeit from integration of mental health care into primary care (Bauer et al., 2011). The purpose of the current study is to examine a range of ways Community Mental Health Centers in Texas are integrating primary care into mental health care for people with SPMI, and – in the next stage of this project – to identify which configurations are associated with specific desired outcomes.

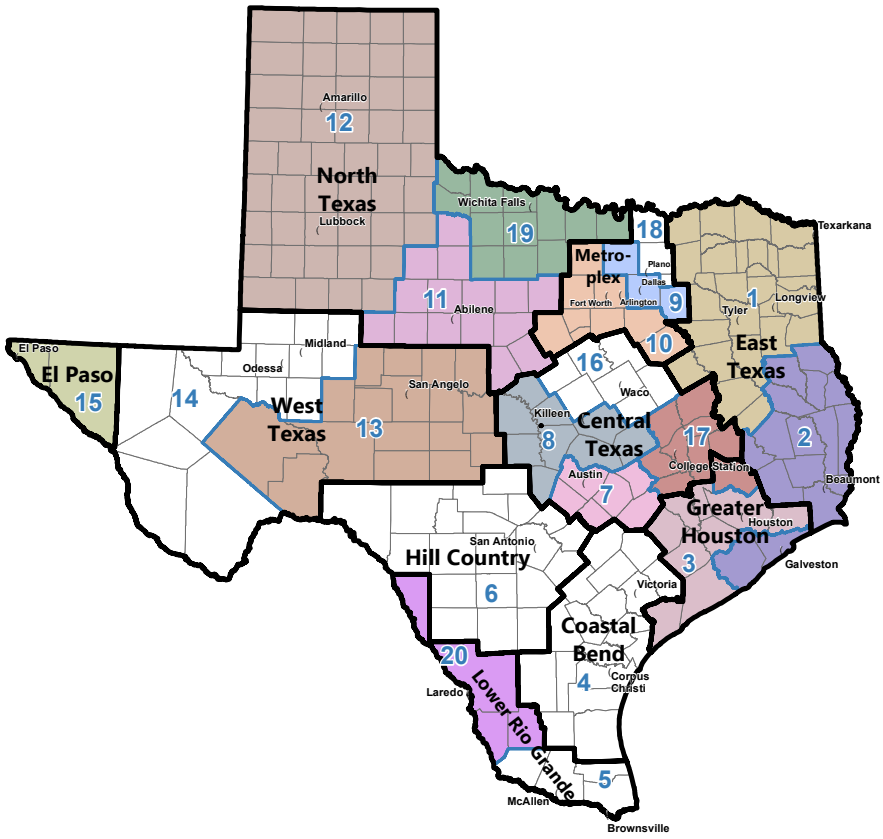
Methods

Site Selection

The research team, HHSC, and Meadows Mental Health and Policy Institute (MMHPI) agreed that the sample needed to include sites in all major regions of the state and include a mix of rural and urban service areas because of potential differences in population needs, provider supply, and local infrastructure (e.g., transportation).

This report includes findings from 10 sites that integrated primary care into a mental health care setting (Figure 1). Two of the projects were not operational at the time of the initial site visit. However, the study team interviewed professionals at both sites to include their experiences in this initial report, and will have conducted both final patient focus groups by the summer of 2015.

Figure 1: Regions Included in Study



Project sites are in Central Texas, West Texas, Metroplex (two projects), Lower Rio Grande, Coastal Bend, The Valley/Hill Country, East Texas, North Texas, and Greater Houston.

To be included in the list of eligible projects, sites had to meet the following criteria:

1. Funded through DSRIP
2. Focus on adults with SPMI, although not necessarily exclusively
3. Led by a mental health care provider (typically Community MH Center)
4. The focal population of the lead organization is current mental health care clients
5. The project should provide (not just refer to) primary care
6. The integration should bring primary care services into mental health care settings

UT – School of Social Work researchers shared a list of projects identified through their Meadows Foundation-funded inventory of DSRIP behavioral health initiatives that they thought might fit the criteria above (29 category 2.15 projects, five 2.19 projects, and 41 from other categories, for a total of 75). After iterative review of all of the projects UT-SSW had identified as well as 21 projects independently identified by the UT-A&M School of Public Health research team, 33 projects were found to fit the specified criteria. Projects that were excluded typically had a limited focus and were not providing true comprehensive integration of primary and mental health care. For instance, among projects excluded were those that provided peer support only, health screenings only, health education only, and workforce development projects. Two of the ten projects initially selected were replaced with alternatives from the same respective regions because additional information after initial recruitment indicated that one or more of the inclusion criteria were not met. The generality of these study findings is unknown because the ten selected projects may not represent statewide efforts overall.

The ten projects were chosen in part based on local context of the counties in which the projects were based (Table 1), although sometimes the service area extended beyond that base county. The United States Department of Agriculture's Economic Research Services Rural-Urban Continuum Codes (RUC Codes) classify counties by their population and level of urbanization. For instance, RUC code two is for metropolitan area counties that have between a quarter of a million to a million residents (USDA Economic Research Service, 2013).

Relative to Texas as a whole, the counties in the current study had very similar percentages of people living in poverty, African-Americans, Hispanics, and percentages of people enrolled in Medicaid. Table 1 includes the RUC code of sites, in addition to demographic information for the county as a whole, to depict both the composition of the counties' residents (indicated here by race and ethnicity) and local general socio-economic status (as indicated by poverty and Medicaid enrollment).

After concluding that the nature of integration varied in part according to what types of organizations were involved, the study team placed the projects into three mutually exclusive categories:

> **Community Mental Health Center only**: The organization providing mental health care services hires or contracts with a primary care provider, who functions as a member of the staff, i.e., reports to the Community Mental Health Center.
>
> **Community MH Center + Federally Qualified Health Center (FQHC)**: The organization providing mental health care services partners with an FQHC; the FQHC provides the Community MH Center patient population with primary care services.
>
> **Community MH Center + Other Primary Care**: The organization providing mental health care services partners with a non-FQHC primary care provider; this organization provides the Community MH Center patient population with primary care services.

Table 1: Local Contexts of Participating Sites

	Rurality	Overall County Demographics, Not Limited to Patients				
Site Type	**RUC Codes 2013[1]**	**Percent in poverty[3]**	**Percent White[2]**	**Percent Black[3]**	**Percent Hispanic[3]**	**Medicaid Enrollment (January 2013)[3]**
Community MH Center only (n=4)	1, 1, 2, 4	16%	55%	8%	34%	14%
Community MH Center + FQHC* (n=4)	1, 1, 2, 3	22%	45%	7%	45%	16%
Community MH Center + other primary care (n=2)	1, 3	19%	39%	17%	38%	15%
Overall	2	19%	48%	9%	39%	15%

* Federally Qualified Health Center (FQHC)

Qualitative Interviews

To learn how projects were initially designed and operating, members of the research team visited each site between October 2014 and January 2015. Professionals interviewed held varying roles within these projects, including administrators, registered nurses, and physicians, with varying educational backgrounds (Table 2). Interview transcripts were checked by members of the study team for accuracy and removal of all identifying information.

One or more professionals at each site walked the study team members through the patient experience of receiving integrated care at their location. The team created an overall narrative summary for each site, as well as prepared a flow chart of that site's typical patient care experience (Figure 2; GOAL/QPC, 1988). At each site, one mental health care provider and one primary care provider were each separately asked to summarize the de-identified experiences of three patients who had received integrated care: the patient who had benefitted the most from integration, a typical patient, and the patient who had benefitted the least from integration. The same individuals also completed a questionnaire on the quality of the coordination with the other discipline (i.e., primary –mental health care coordination) (Gittell et al. 2005), as described immediately below. Research team members also took notes on their observations at each site.

[1] For the complete definition of RUC codes see the ERS website: http://www.ers.usda.gov/data-products/rural-urban-continuum-codes.aspx#.UYJuVEpZRvY

[2] US Census Bureau: http://quickfacts.census.gov/qfd/index.html

[3] Texas Health and Human Services Commission and the Texas Department for State Health Services http://www.hhsc.state.tx.us/research/MedicaidEnrollment/ME/201301.html

https://www.dshs.state.tx.us/chs/popdat/ST2013.shtm

The findings presented in this report represent the initial results found by research team members through thematic coding within and across sites (Miles, Huberman, and Saldana, 2014), as well as the walk-throughs of patient encounters, questions about how primary and mental health care providers experienced their work with each other, and samples of patients described by each type of provider.

Instruments Administered

Relational Coordination Scale

The Relational Coordination Scale has been extensively validated to measure inter-disciplinary health care teamwork quality (Gittell et al. 2005; Noel et al., 2013). In the current study, at each site one mental health provider and one primary care provider, respectively, was asked to complete this survey to characterize their experience working with the other 'side of the house.'

The scale is comprised of eight items, whose responses are assigned values ranging from 0 (never) to 4 (all of the time).

1. When you need information from them, how often do you get it?
2. How often does [PC/MH care provider] give you information as quickly/timely as you need it?
3. How often do you think the information [PC/MH care provider] gives you is accurate?
4. When there is a problem, how often does [PC/MH care provider] work with you to solve the problem?
5. How often do they know about the work you do?
6. How often do they respect the work you do?
7. How often do they have the same goals as you do for taking care of patients?
8. How often do you have a say in what they do with patients?
    a. This was not in the original Relational Coordination Survey, but Dana Weinberg found this additional item to have high predictive validity in her research, and so it was added for the current study.

In the current study, an additional prefatory question was also added ("How often do you need information from [PC/MH care provider] to serve patients in this care integration project?") in order to discern interdependence.

Patient Focus Groups

To understand the patient experience with these integrated care projects, the study team has conducted nine focus groups thus far, eight of which are reported here. The ninth occurred just before this report, yielding similar results to those from the first eight. The tenth will occur in the summer of 2015. A nominal group technique was used in an effort to encourage equal participation. Patients were given a prompt and responses were collected, round robin style, and recorded in a document projected onto a screen or written on a poster for the group to see.

The following questions were used to guide the focus group. To develop this guide, the research team used the Tri-West Patient-Centered Healthcare Home Fidelity Scale, which in turn was based in part on Mauer, B.J. (2010) and SAMHSA-HRSA Center for Integrated Health Solutions (2012). The final set of prompts was:

1. Can you tell us what types of medical care have you received since [location] started offering these services?
2. What has been most helpful or working well about this program?
3. How would you like to see this program improve?
4. Since this site started offering physical health care, have you changed the way you take care of your physical health or mental health?
5. Has your physical or mental health – how you feel – gotten better or worse?
6. How well do you truly understand what your new medical doctors or nurses [in this project] are saying to you?
7. Have primary care services at this location helped you with any other parts of your life?
8. Do you think [this program] (i.e., receiving both primary and mental health care) has affected how much control you have over your own health?
9. Has [the program] helped you with any other parts of your life?

These sessions included two moderators, one to facilitate the session and the second to record patients' responses. If a patient's response was unclear the moderator would ask for clarification and permission to alter the original statement being displayed in the projected document (e.g., "When I first came here, I was having a little mental problems because I was hurting so much. I got in touch with both doctors here in the same facility. And, this has kept me from going to the state hospital or the hospital. That's because they've always helped me at the same time. I've got my mental medication plus medication for my pain" was changed to "[the participant] was having mental problems because she was having physical pain and doctors addressed both"). Once all the prompts had been discussed and the listing of patient responses had been collected in the projected document, the moderator read each response displayed and asked patients to indicate how relevant each was to him or her individually, using a three point scale (applies a lot, somewhat applies, does not apply). These individual patient responses were collected by written survey (without identifying information).

After the initial eight focus groups were completed, the research team compiled responses across all of these sites, eliminating duplicates. The compiled list was then mailed to all focus group participants who had expressed an interest in participating in this additional survey. After patients in the final site have had the opportunity to participate as well, the research team will compile responses from all participants. This will make it possible for the research team to quantify relative salience of various issues for the statewide sample.

Results

Professional Interviews

Professional interviews (n=63) were conducted members of the study team; all but two of these interviews were recorded and transcribed. Extensive notes were taken during and immediately after the two unrecorded sessions. A $75 dollar gift card was given to professionals at sites whose leadership allowed this token of appreciation for participation.

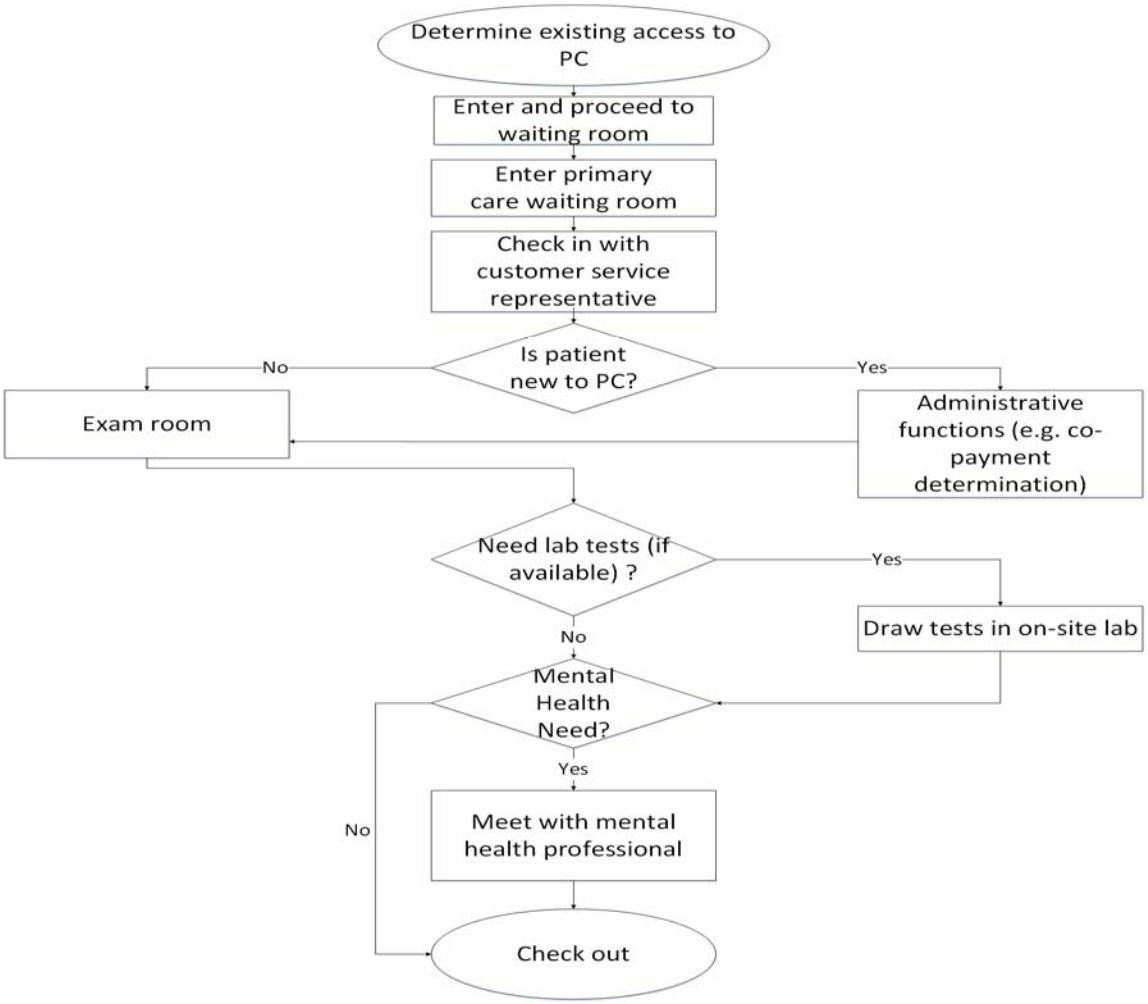
Table 2: Summary Statistics for Professionals Interviewed
(n=63 at eight sites)

Race (n=63)	**Total**
White	44 (70%)
Black	8 (13%)
Hispanic	7 (11%)
Other	4 (6%)
Education (n=63)	
High School diploma	3 (5%)
Registered Nurse	5 (8%)
Bachelor's degree	14 (22%)
Licensed Clinical Social Worker	4 (6%)
Other master's degree	20 (38%)
Nurse Practitioner, Physician Ast	4 (6%)
MD	12 (19%)
Other doctorate	1 (2%)
Bilingual (n=60)	
Spanish speaking	16 (27%)
Speak other languages	22 (31%)
Mean Tenure	
Tenure at the organization (n=63)	7 years
Tenure in current position (n=58)	3 years

Care Integration Process

Physical layouts of integrated care varied widely because of constraints imposed by the structure of the existing facilities. For instance, some sites had separate primary and mental health care check-in desks and/or waiting rooms because they otherwise would have had bottlenecks. The proximity and physical separation of primary and mental health care also differed. However, the process of receiving primary care was generally similar across sites. Even though the vast majority of patients were already Community Mental Health Center clients, they did have to provide initial administrative and clinical information when they began primary care. At least nine sites drew blood and urine samples on site and sent samples out for testing, with reports sent back the next day. Some sites were able to provide same-day primary care for people with urgent unmet physical health care needs. Both primary and mental health care providers used each other sometimes for immediate consultations relating to patients with intertwined or ambiguous physical and mental health needs.

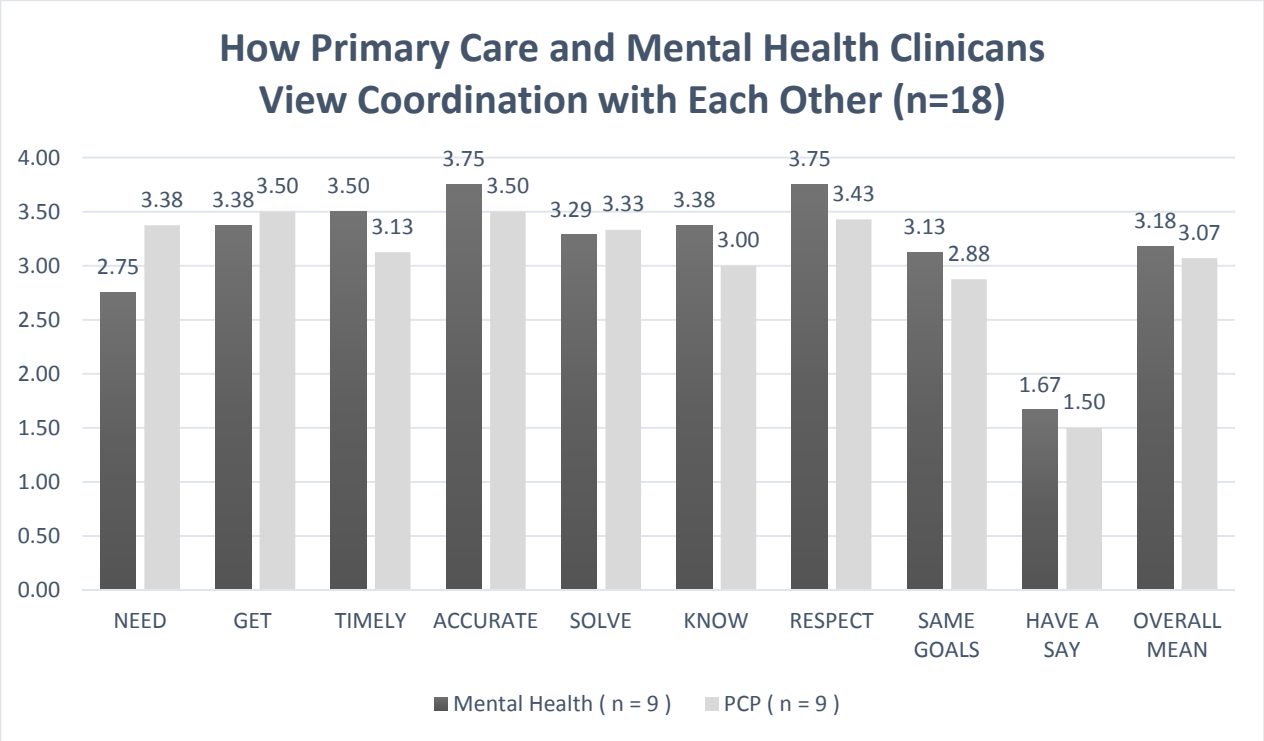
Figure 2: Process Walk Through of Typical Care Integration



How Primary Care and Mental Health Providers Assessed their Coordination

Results of the Relational Coordination scale indicate that mental health care providers perceived somewhat less frequent need for primary care providers (2.75, on a 0 – 4 scale) than primary care providers perceived for mental health providers (3.38). Because of the very small sample size, no tests were conducted for statistical significance. The overall quality of coordination between primary and mental health care providers was good, with a mean score just above 3 (most of the time) on the 0 (never) – 4 (all of the time) scale, relative to questions such as 'When you need something from [specified key partner – e.g., primary care], how often do you get it?' and 'When there is a problem, how often does [specified key partner] work with you to solve the problem?'. The lowest scores were assigned to the extent to which each discipline had a say in what the other discipline did for patients, reflecting the differing foci of the two types of care. In other words, mental health and primary care providers were often conferring with each other, but not necessarily seeking to control what the others did.

Figure 3: Relational Coordination between Primary Care and Mental Health Providers in Integrated Projects



Key Project Attributes

As shown on the next page in Table 3, Cherokee's Blended Behavioral Health and Primary Care Clinical Model was cited by half the study sites as a model upon which their integration was based. One of the reasons such a high proportion of sites used Cherokee as a model could be limited alternative exemplars of successful integration of MH and PC services. The Cherokee Health Systems model includes a behavioral health consultant on the primary care team, behavioral health consultations available to primary care providers (PCPs), and behavioral interventions in primary care, and encourages patient responsibility for their health/lifestyle (Cherokee Health Systems). Of the five facilities that used Cherokee's model, one site's representative described making substantial adaptations to the Cherokee model to fit their facility's capacity. Leadership at another of those five sites explicitly modeled on Cherokee also noted that they participated in the Substance Abuse and Mental Health Services Administration (SAMHSA) webinars to learn about best practices in integration, which was a common practice among participating sites. Another site with a distinct physical plant structure gleaned ideas from a national conference. Among the other projects not described as modeled on Cherokee, the primary care provider at one site described their model as collaborative care and the mental health care provider characterized their model as integrated care. Of the two remaining sites, one site described their model as the Four Quadrants model (SAMHSA), and the other as based on medical homes principals.

All of the projects renovated space to accommodate the new primary care providers rather than building at new locations. Most renovation was within existing Community Mental Health Center space.

All of the Community Mental Health Centers that added primary care without external partners had integrated primary-mental health care records. As the Meadows Mental Health Policy Institute staff have found in other settings, in the absence of pre-existing integrated health records, project leadership at these sites made their own adaptations to incorporate primary care information into systems designed for behavioral health care. None of the projects with external partners had integrated health records, although staff used a variety of work-arounds to share patient information.

Four of the ten sites reported previous failed attempts at integrating primary and mental health care, with those failures generally attributed to resource constraints. These experiences were perceived as helpful to leadership of the current projects in understanding the complex issues in this form of service improvement.

At the time of the site visits, three of the ten sites offered primary care to individuals who were not current Community Mental Health Center clients and did not necessarily have any behavioral health conditions. This relatively low proportion is likely due to both overall resource constraints and to how newly operational the projects were as of winter 2015. However, attracting non-Community Mental Health Center patients was viewed as a way of serving more people in need as well as potentially sustaining integrated services through additional earned income from patients with insurance.

The challenge of recruiting primary care providers for mental health care initiatives is well known (US DHHS 2013), and was also specifically referenced in eight of the sites within this study. In addition, four of the ten sites had to delay or suspend operations for a number of months after losing primary care providers; this had happened for different reasons across locations. Two other the sites also reported some primary care turnover in the first several months of operations. Hence, overall, more than half the projects experienced significant non-operational periods because of PCP turnover; this affected projects both with and without external partners.

Table 3: Project Key Attributes
(total n=10)

Site type	Modeled on Cherokee	New facility	Shared health records	Prior integration attempt	Serve non-Community MH Center patients	Primary care delayed or paused due to PCP loss	Other primary care turnover in first year
Community MH Center only (n=4)	50%	0%	100%	25%	25%	50%	25%
Community MH Center + FQHC* (n=4)	75%	0%	0%	50%	25%	25%	25%
Community MH Center + other primary care (n=2)	0%	0%	0%	50%	50%	50%	0%
Overall	50%	0%	40%	40%	30%	40%	20%

*Federally Qualified Health Center (FQHC)

Emergent Themes - Interviews with Professionals

Low initial volume allowed valuable additional time between clinicians and patients

Demand for integrated services varied across sites, especially directly following implementation. As typifies new projects, primary care providers frequently reported a low number of clients initially, which allowed for longer encounters with patients. Providers saw this as a chance to allow patients more time to ask questions and build rapport. This slower start-up time also appeared to enable primary care providers to adapt to patient needs, for instance, simplifying communication to improve understanding.

Sites varied in the specific ways staff capitalized on time available to communicate with patients. For instance, at one site, the Primary Care Supervisor talked with patients while they were in the waiting room after checking in, to convey information about primary care services and the related costs so that the patients would know what to expect.

> "When I first started, a good day for us was six patients. Now we'll see ten or eleven patients a day [on a good/busy day]." *Primary Care Provider*

> "Honestly, I don't see a stress level for the primary care side. I think if let's say for instance we were seeing 20, 30 patients a day, then, yes, that can be a stressful load. We're not handling that type a load, so it's more balanced where they're actually able to handle it easily." *Primary Care Administrator*

Another site had an encounter rate nearly double that anticipated, which the research team attributed to patient pent up unmet need.

> "They want to come see the doctor." *Administrator*

The Meadows Mental Health Policy Institute has found some other integration sites to struggle with gradually increasing demand. The research team did not find that in the current set of projects, likely because they were relatively new at the time of the site visits.

Common health records greatly facilitated inter-disciplinary communication

Some sites reported successfully adding primary care information to electronic health records (EHR). For instance, one site had added an insulin template to the EHR allowing both primary and mental health care clinicians to monitor patient insulin status. Immediate access to all prescribed medications was also described as useful. At another site, the primary care RN was able to look up a patient in the EHR immediately before seeing an individual referred from mental health care, and an administrator showed physicians how they could click a pending option that would cue other physicians to sign off on a single treatment plan. Common health records access was more common at sites run through a single organization, although that did not guarantee satisfaction with ease of use. Similarly, prior research has identified fewer but often nonetheless substantial challenges when information systems were combined (US DHHS 2013).

> "[Our] worst frustration with the whole system is they have the worst EMR I've ever seen … We think it probably came over here on Noah's Ark." *Primary Care Provider, Community MH Center only site, with a common EHR*

At sites with separate mental health and primary health records, staff developed a variety of work-arounds to ensure that each discipline had adequate information when meeting with patients. Sometimes, this involved printing out hard copies of extracts from these records.

> At a site that collaborated with a non-FQHC organization to deliver primary care services, the mental health providers did not have access to the EHR: "The primary care physician kept saying, 'You need to give them access because I need to know the medications they on for behavioral health.'" *Administrator*

"… when [the mental health liaison] is out, or at training, or something like that, it's really annoying because I'll have to walk over here all the time and ask them [for patient records]." *Primary Care Provider, Community MH Center-FQHC site*

"In the beginning we weren't integrating the medical records. We had a big problem there, because we were sending them, but not printing them out and getting them upstairs. Or then they were getting in the wrong hands, so we had to refine that and get it down to—okay, we're going to give it to the nurse who is going to give it to the provider, because it … wasn't getting there, or it was getting lost in translation. We had to really work on that process of getting the labs, the meds, and all that." *Administrator, Community MH Center-FQHC site*

"Now, we're getting copies of the labs. The problem is, we don't have a way to integrate them into the health record. We have a separate records system than [the PC org] does. We don't have access to their system, and so it makes it a little difficult for us because it's two separate records. We get these copies, but then I have to match these to the chart. That's a lot of work to do that." *Administrator at a Community MH Center-FQHC site*

"We can't necessarily always parse the substance abuse data from the other behavioral health data." *Administrator at a Community MH Center-FQHC project*

Differences between primary and mental health administrative processes challenged staff

As in previous research (Bao, Casalino, and Pincus, 2013), Community Mental Health Center partnerships with independent primary care providers contended with different payment practices as well as reporting requirements. For instance, although both Community Mental Health Centers and primary care providers charged on sliding scales, Community Mental Health Center fees were per month, whereas primary care providers charged per encounter, and appeared to require often higher out-of-pocket costs. Such differing payment policies were confusing and sometimes off-putting to Community Mental Health Center patients.

Other common initial challenges for integration projects were an inability to bill Medicaid and/or Medicare because managed care contracts had not yet been approved, and integration of primary and mental health billing systems. This is in keeping with a recent study of programs with integrated primary-mental health programs that found only 18% to have integrated records (US DHHS 2013).

"We're not worrying about billing right now, because right now we can't even share records with each other." *Community Mental Health Center Director*

"Another thing billing-wise was submitting the correct information on the claim forms. For our system it was developed based on the mental health side, and so there are definitely configuration changes needed to adhere to a primary care setting claim." *Primary Care Administrator*

"When you go to bill, you have to change the diagnosis and then change it back after you bill. For billing purposes, it's not the best." *Administrator*

In fact, in some instances billing may be simpler when primary care is provided by a separate organization, thus obviating the need to reconcile separate billing systems and, with FQHC partners, allowing them to capture higher reimbursements:

> "With [PC org], it's very simple. If they go to primary care, [PC org] has a way to subsidize that medication. We don't have to do anything. They don't have to bill us. We don't have to bill them. They just make the referral. If the client needs primary care medication, [PC org] will provide that." *Primary Care Administrator*

> "The FQHC is billing at their enhanced rate. That helps. That's why I was more than glad, "You guys do the billing. Go take responsibility for it." Whatever you earn in third-party revenue will just come off their invoice to us." *Community Mental Health Center Director*

Staff frequently described using 'warm hand-offs' from one stage of a visit to another, sometimes as an adaptation made after realizing that patients were not otherwise getting to the next step in care. For instance, at one site, when a patient did not show up after the communication between the primary care and mental health care front desks, a medical assistant from the primary care clinic would physically go to the mental health clinic and call for the patient. Some sites also had staff members exclusively focused on care coordination. For instance, care coordinators at different sites followed up on referrals made by any other staff member; monitored patient progress; made additional referrals as needed (e.g., to primary care or a peer counselor), helped with transportation to medical appointments, and sometimes attended patients' primary care appointments for purposes of education and medication management and reconciliation. At another site, a primary care-based care coordinator reported working closely with the mental health physician assistant to educate people about disease self-management. As found in previous research, different sites used different titles for similar coordinative positions (US DHHS 2013). In subsequent interviews, the research team will clarify which individuals at each site have care coordination roles, and how they affect integration.

> "At first we took for granted that if you just said 'Hey, I'm going to send this patient down, they walk around down here maybe, and then if they didn't find [the PC office] right away, then they would leave … We started examining the number of people we referred that actually penetrated into primary care. We were like, 'Ah, it's not good enough.' We took it down and said, 'Hey, you have to actually warm handoff them.'" *Mental Health Director*

Differences between primary and mental health cultures challenged staff

Some participating sites recruited primary care doctors and nurses, only to lose them soon thereafter. One reason appeared to be the number of alternative jobs available, with higher pay and lower stress. Another apparent reason was differences between physical and mental health care cultures, perhaps especially within public mental health care such as the Community Mental Health Centers that were in charge of these projects. Cultural differences appeared somewhat more common at sites involving two organizations than at those in which Community Mental Health Centers had hired primary care staff.

Although both primary and mental health care staff shared a strong commitment to quality health care, there sometimes appeared to be tension between the relatively slower pace and lower stress of primary care and the greater pressure to meet patient encounter volume goals and higher general stress of mental health care.

> Regarding primary care: "They work with us, they're part of us. We don't see them as a program distinct from us. They're really not. We're all [name of MH organization]." *Psychiatrist at a Community MH Center-only project*

> From a project in which the Community MH Center hired primary care staff, regarding communication between primary and mental health care: "The nurses talk and they provide support to each other." *Mental Health Center Director*

> "We're now on our third nurse practitioner, in a short period of time. That's been a difficult integration." *Administrator at a project managed between a Community MH Center and a non-FQHC PCP*

> "One thing is finding the right providers. We went through a couple of people who just didn't seem to be working out very well. You really need somebody that is a part of the whole team." *Medical Director at a Community MH Center partnering with an FQHC*

> On the greater amount of time available to communicate with patients on the FQHC side of the integrated project: "Here it's more, let's take time, let's spend time with them and get to know them." *Administrator at a Community MH Center partnering with an FQHC*

> At one site, the PC org was perceived as being "tight" with information about shared patients, especially at the onset of the integration project's implementation.

> "Our overall goal is to provide safe, useful, effective service to our consumers … Underneath that philosophy, though, there are people that are very worried about numbers, that we make a certain number of contacts and we meet our contractual agreements with the state and the milestones we've set." *Community Mental Health Center Administrator*

Professionals repeatedly stressed the importance of communicating actively between primary and mental health care to build trust and mutual understanding. At one site, instant messaging had been effective, whereas in others a close relationship between a mental health staff member and primary care staff member seemed to provide the principal communication bridge between the two disciplines. Other sites had face-to-face joint mental health-primary care meetings as often as weekly. These findings are in keeping with prior research indicating that a sense of belonging is important to professionals in integrated programs (US DHSS 2013).

> "Communication is the number one thing because we're dealing with two separate entities in two separate systems of care." *Care Coordinator*

> "We do team huddles so coordinating those, making sure all the doctors and everyone's coming for those, making sure our milestones and metrics are met." *Administrator*

"I mean, because it gets down to communication. Where their client's here, I'm used to them as patients. You're referring to the same thing, but it's like, 'Oh, wait, wait, wait.' Then when they say 'MI,' it's motivational interviewing. To me, that's myocardial infarction. It's like, 'Okay.' It's all the acronyms and stuff and just getting the communication down and terminology. It's been a learning curve for me. Like, 'What are you talking about?'" *Administrator at a Community MH Center – FQHC site*

Patient physical health medication and specialty care follow-through were generally low

Patient poverty limited the use of prescription medications for physical health conditions as well as recommended follow-up with physical health care specialists. One site estimated that about 20% of their patients followed through with referrals. Reasons cited included hesitance of specialists to accept uninsured patients or even those with Medicaid, patient lack of transportation, inability to meet out-of-pocket expenses, and patient skepticism about the need for recommended care. Often chronic health conditions were not under control, despite provision of primary care. One administrator literally called every area specialist from the yellow pages to ask if they would see their patients. Very few said yes, but they now have one or two for most specialties who have agreed. They have also discovered that some specialists who have not committed in generic terms will agree to see a specific patient when told of that situation. When a participant at another site was asked if specialists were declining to see patients because of their mental illness, he said no, that they were declining based on insurance status even before mental health status was discussed.

"$5 is hard for a lot of people." "If there's a bigger problem and they have to see a specialist … then everything comes to a screeching halt." *Behavioral Health Consultant*

"They got the care that they needed, but they didn't have the funds for the medication… Even if it was $3." *Administrator*

"… and she's unfunded, and I can't do anything for her. I try to optimize her medication, try to keep her on all medicines she's supposed to be on, give her a nitro pill. If the pain gets bad, go to the emergency room." *Primary Care Provider*

"I've seen noticeable differences in things like blood pressure control, blood sugar control has gotten better, that type of thing. Pain management? Not so well because we don't do that. That gets referred out, and I don't know what happens to that." *Mental Health Physician Assistant; the PCP at this site also reported success in blood pressure control*

The reason for doing all this: Providers perceived better access and more holistic care

Professionals at participating sites perceived that given integration, some Community Mental Health Center clients started receiving preventive care that they had not previously found truly accessible, even if it was theoretically available. For instance, prior to this integrated project, an administrator observed that patients "were recommended to other clinics… A lot of times these patients wouldn't go, or they'd end up in the ER." The PCP noted that one patient didn't follow up because she was not comfortable with crowds or waiting for extended periods of time to see a primary care doctor. The research team believes that this was not so much due to the waiting

time per se, (given that this was also common in Community Mental Health Centers) as to waiting in an uncomfortable setting.

Clinicians believed that triangulating information across disciplines allowed for more accurate diagnoses. For example, for people with substance use-related issues, physicians believed that they were now more accurately diagnosing the root cause of requests for pain medication as dependency versus pain.

> Prior to integration, psychiatrists had been frustrated with patients' inability to monitor physical health conditions: "We can't get them to go get their labs. If they don't get their labs, then we're stuck in between this rock and a hard place of do we continue prescribing some very strong medications to them without any labs to inform that process?" *Community MH Center Director*

> "Especially if you have a psychiatric issue, there are lots of problems with that. Just multiple things. We get this, and then now we try to make some sense out of it. This is where getting with the internal medicine or the family physician is helpful. That's going to make a lot more sense. Here's a lady who has all of these medical issues, and she comes in and says, 'I'm fatigued.' Really? Why wouldn't you be? 'I just don't feel good. I can't explain why.' It could be the fact that you've got multiple medical issues going on, and it isn't all psychiatric. The patient comes in, 'I've been feeling dizzy. I think it's that Depakote.' Okay. What about the 14 other meds that you're taking? … It turns out to be a lot better for them if they understand that, I know you're taking other meds and there's other things here, and maybe we need to address this medically and not psychiatrically." *Mental Health Physician Assistant*

In keeping with prior research (Chwastiak et al., 2013), providers noted that most of the physical diseases experienced by patients were at least in part a product of lifestyle. In addition, patients' inability to access primary care can allow mild health issues to become emergent (e.g., wounds becoming infected). Hence, preventive physical health care may improve patient health as well as save medical costs. Some providers also reported benefits extending beyond clinical indicators to quality of life factors such as re-employment. For instance, several providers reported that patients receiving integrated care were making lifestyle changes:

> "We have seen patients' sugar level come down to normalcy; levels of 100 from 600. Some no longer have headaches, and they're eating better and making changes" *Primary Care Provider*

> "We have stories of patients that have improved so much that some of them are back home with their families that they had been away from because of their behavioral health conditions, but because we're addressing their health needs they're feeling better and they're doing better. We have patients that are now back at work that for years have been out of work. The housing assistant, the job employment assistance that we have here have been able to get them back to work because they want to." *Director of Primary Care*

Clinicians also seemed to benefit from having ready access to colleagues with complementary expertise:

> "Something else that's really important to me, to help give some sense of security, so to speak, is that so many of our medications cause side effects. They drop your white count, your neutrophils. They can affect your liver function and so forth, and it was always good to have this doctor around, that we could sit down and say, 'What do you think about this white count? Is it getting low enough that we need to intervene, change mediations,' but work together with him on taking care of the patient, who is having some medical issues due to the medication." *Psychiatrist*

> "I think the biggest issue for our more intense clients, the primary care docs, they get a little frustrated with them and they don't want to deal with them. Having the case manager in there with them, they can kind of work it as a team. That has really helped our truly chronically mentally ill population." *Community MH Center Director*

> "Integration is about not missing things. It allows that the problem list of the patient becomes and continues to be updated and accurate…Again I'm not prescribing or I'm not practicing medicine blinded by some medical condition that I don't know about because the patient doesn't have a primary care doctor to investigate that. To me, that's what this is all about – that integration." *Psychiatrist*

Although the research team believed providers considered the attendant additional effort required to provide integrated care to be worthwhile, in some respects such mutual recalibration between primary and mental health care appeared to make clinical practice more challenging.

> "Sometimes it seems like every time I see a patient, they're on a completely new set of meds… and that I'm having to re-deal with those side effects" *Primary Care Provider*

Concerns about sustainability loom large

Although some executives outlined plans to sustain at least some integrated services through earned income if the 1115 waiver funding ends, the majority saw a need for continued government support.

> "This project is at risk because indigent clients simply can't pay for their care. So someone, Medicaid, or the state, or the federal government, needs to pay." *Administrator*

> "I think our schedule breaks out $0.00, and then the next step up is $3.00, and then $5.00, and then $10.00, which probably not exactly sustainable at those rates." *Administrator*

> "In the absence of some sort of Medicaid roll out, it's going to difficult for anybody who has one of these projects." *Medical Director*

Recent communications between CMS and HHSC about Texas's potential Waiver Program renewal or extension make these issues even more salient (Walters, April 20, 2015). Such concerns about sustainability appear to be common for integrated primary-mental health programs nation-wide (US DHHS 2013).

Patient Focus Groups

Although patients were unaware of many of the challenges of implementing integration, focus group participants echoed professionals' perceptions of improved communication with providers, reduced barriers to care, and improved health and well-being. However, another common theme between professionals and patients was continued substantial unmet health needs.

Table 4: Summary Statistics for Patients Who Participated in Focus Groups
(n=64)

Age (n=63)	
Mean	49
Race (n=64)	
White	24 (38%)
Black	13 (20%)
Hispanic	25 (39%)
Other	2 (3%)
Education (n=64)	
No GED / equivalent	10 (16%)
GED	22 (34%)
High School diploma	13 (20%)
Some college	16 (25%)
College degree	3 (5%)
Mental Health Diagnosis (n=64)	
Bipolar	24 (37%)
Schizophrenia	17 (27%)
Depression	49 (77%)
Primary Care Diagnosis (n=64)	
Hypertension	36 (56%)
Diabetes	25 (39%)
COPD	12 (19%)
Asthma	7 (11%)
Income (n=56)	
0 - $14,999	54 (84%)
$15,000 - $34,999	2 (3%)

Table 4, Continued

Access to Transportation (n=64)	
Yes	21 (67%)
No	21 (33%)
Homeless (n=64) (within the last year)	
Yes	27 (42%)
No	37 (58%)

Emergent Themes – Patient Focus Groups

Below are listed illustrative quotes from the most salient themes emerging from the eight focus groups conducted at projects that were operational by early spring 2015. Research team members probed for patient experiences of integrated care and impact on health behaviors and health and functional outcomes, as well as areas for potential future improvement.

Comfort receiving primary care at Community MH Centers

A number of focus group participants commented on feeling more comfortable getting primary care at Community MH Centers than from providers in traditional PC settings, in part because of familiarity and in part because of what the study team interpreted as a Community MH Center culture of caring.

> "When I come in they know my name."
>
> "I don't feel condemned or judged here."
>
> "I look forward to my appointments."
>
> "They feel like family."

Convenience

Many participants commented on the ease of accessing primary care located within their Community MH Centers. In addition to seeing providers, being able to pick up prescriptions for both physical and mental health at the same place was cited as a benefit for integration.

> "I'm not missing appointments now. It's easier to come to appointments in one place."
>
> "The in-house pharmacy is convenient."
>
> "They ordered my medicines here, and I really appreciate it."

Quality of communication with providers

Prior evidence suggests that communication is difficult for people with SPMI in most general health care settings (Cabassa et al., 2014; Irwin, Henderson, Knight, & Pirl, 2014). Focus group participants commented favorably on the quality of their communication with primary care providers in the integrated settings based in their Community Mental Health Centers. As noted elsewhere in this report, this may in part reflect low initial primary care volumes that allowed more time for communication. Projects may be challenged to continue allowing sufficient time as patient volumes increase, especially if sites feel pressure to increase the number of paid encounters. One potential lesson for other mental health providers planning integration of primary care may be to allow for a deliberately slow start-up that allows sufficient time for both providers and patients to become acquainted with the integrated approach. Subsequently, the amount of time per encounter might be tapered downward.

> "Because you can go see the doctor you can understand what's wrong and learn how to prevent it or make it better."

> "I mean every doctor in here, if there is a problem they see the expression on your face."

> "The staff here develops relationships with their patients and makes you feel like a person."

Reduced financial cost for physical health care

The extreme poverty of many of the individuals served by DSRIP integration projects made even small decreases in cost important to some patients.

> "I have access to low cost/free medications."

> "This integrated care program has affordable co-pays and payment assistance."

Impact on health care use and health behaviors

Some patients reported taking better care of themselves because of partnerships with their new primary care providers.

> "My physical health needs are now met; it had been years since I'd seen a doctor."

> "I am keeping medication consistent, and am able to get refills so that I don't have to come back to the doctor all the time."

> "My doctor really interacts with me and I really like it and I'm taking better care of myself as a result [eating better; taking steroid shot]."

Impact on health and well-being

Participant comments included references to alleviated anxiety about physical health conditions as well as reduced physical symptoms and feeling able to live fuller, more positive lives.

> "When you don't know what's going on with your body it's scary. Just being able to get the information about my medical needs has been great."
>
> "I'm sleeping better now."
>
> "I'm eating better."
>
> "I'm getting out more. I'm walking more. All around I'm doing more because I feel better."
>
> "They give me hope."

Remaining unaddressed needs

A limited number of participants reported negative experiences with integrated care. More common were comments about additional needs that remained unmet because they were beyond the scope of the integration project and were thus financially inaccessible to patients.

> "I don't think she means to, but she talks down to me like I don't know what's going on. I may not have the medical training, but I know what I am going through."
>
> "It's difficult for me to understand my doctors and nurses, but I do understand now that they are here to help me."

Not all projects included in this evaluation can cover the complete cost of prescribed medications for patients of the integrated care programs; some require a minimal copay, which may not be feasible for indigent patients, while others cap the number of prescriptions covered due to the associated financial burden. Sometimes prescriptions are based more on medication prices instead of optimal treatment choices.

Services often unavailable to integrated care patients include specialty services and specialist diagnostic imaging. Providers and patients noted severe unmet dental health needs among their patients. One site provided on-site dental care. However, dental care was an otherwise frequently cited unmet need. Other unmet needs identified included transportation, specialty physical health care, imaging, and vision care.

Next Steps

The first draft of this report went out on April 15, 2015, allowing the study participants, the HHSC evaluation team, MMHPI, and the Texas Council of Community Centers to provide input. This is the final and public draft of this interim report; anyone receiving this draft is welcome to email/contact Rebecca Wells (Rebecca.S.Wells@uth.tmc.edu; office phone 713-500-9184; cell phone 919-259-4367). You are also free to share this report with whomever you choose.

In August 2015, the research team would like to meet with representatives of participating sites to debrief on initial results and discuss common measures to share for correlational analyses. The Texas Council of Community Centers will again facilitate this meeting. After that meeting, the research team may get initial quantitative data from each site (or possibly directly from the Texas Department of State Health Services (DSHS)) and examine to identify any potential concerns and ensure comparability across sites for common measures.

Between October 2015 and January 2016, the research team will call the main contact at each site to get an update on project evolution since the site visit. These calls should take about 30-60 minutes.

In the spring and summer of 2016, the research team will collect final quantitative data from all sites/DSHS for correlational analyses.

By September of 2016, the research team will share the first draft of the final report that includes correlations between project structure and outcomes with study participants, the HHSC evaluation team, MMHPI, and the TX Council of Community Centers. The research team will contact participants for feedback.

In November 2016, the research team will distribute the final report to all of the above.

Conclusion

Texas ranks 48th in spending per capita on mental health services in the nation, averaging $41 per person, trailing only Florida and Idaho, and far below the U.S. average of $120 (Kaiser Family Foundation, 2012 and 2013). This program turned out to be a long awaited opportunity to improve public mental health care. As one Community MH Center executive commented, "…we had been watching the national landscape and knew that integrated care was definitely the way to go. In the State of Texas, there was no way to fund that. Once we heard of the 1115 waiver, [the Director] says, 'That's one of the first things I want to have done.'"

This report describes major innovations in care for people with SPMI occurring through a combination of a substantial new funding opportunity and agency leadership around the state who were willing to try a particularly challenging change in practice. Key findings include both provider and patient reports of enhanced access to care and some improvements in health outcomes; pros and cons to Community MH centers hiring PCPs versus working with external providers; and challenges in hiring and retention, information sharing, and team-building

between mental and primary care staff. Community Mental Health Centers that hired PCPs had the major benefit of common information systems and appeared to have generally greater initial success in integrating the PCPs culturally to public behavioral health care. Partnering with FQHCs enabled the projects as a whole to benefit from higher reimbursement rates for some primary care services. These initial findings are all congruent with those from prior research on primary-behavioral health care integration (e.g., US DHHS 2013). This study's final report will include correlations between different program configurations and outcomes of interest. Long-term sustainability of any such outcomes will hinge on adequate and predictable funding.

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