



Texas Council
of Community Centers

Integrated Care: A Community Solution

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Across the country and in Texas, there is a growing acknowledgement and understanding of the interrelated nature of physical health and behavioral health conditions. A person's physical health and behavioral health (mental health and/or substance use) conditions do not exist in isolation from one another, and the existence of multiple conditions impact health outcomes and cost throughout the healthcare system. Integration of physical and behavioral health care has the potential to improve the quality of care, control costs and improve the patient's experience in receiving care.

What is Integrated Care?

Integrated care holds great promise, although the practical issues in realizing that promise can be complex. In concept, integrated care means a person with mental illness and/or a substance use disorder, along with other physical health conditions such as diabetes or high blood pressure, will receive holistic care from health care providers that work together to treat all conditions. Integration represents a systemic and coordinated approach to treatment that addresses co-occurring illnesses at the same time.

As integrated projects are developed, they may range from agreements on consultation and referral to full collaborative care where provider practices have the skills and abilities in one place to treat both physical and behavioral health.

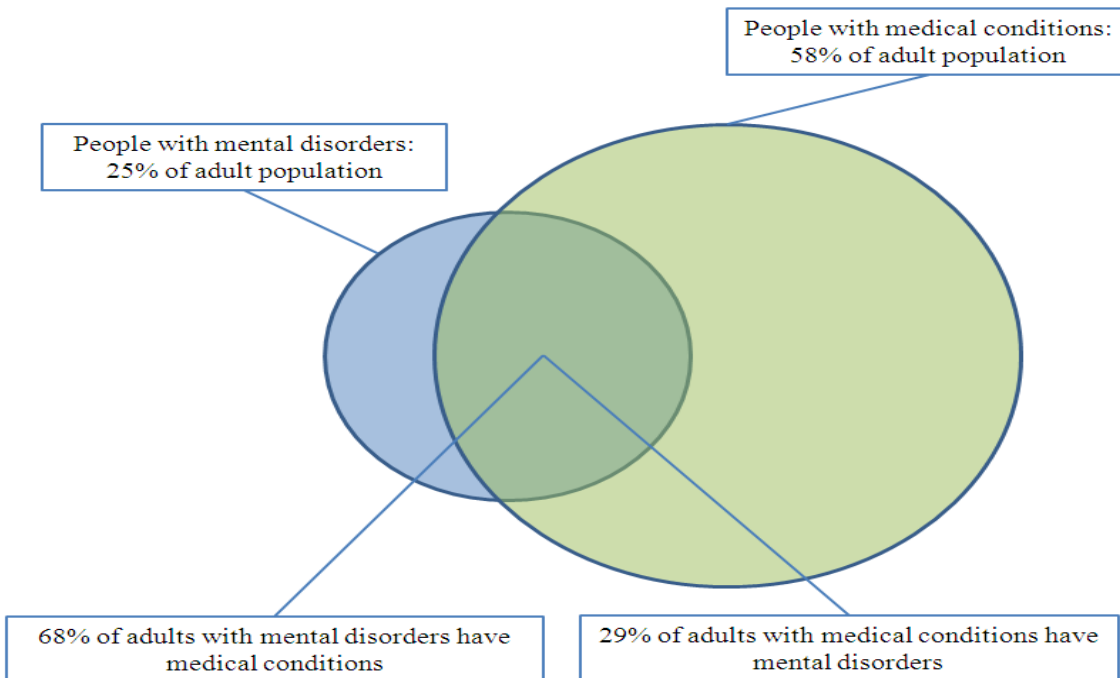
TYPES OF INTEGRATION



- **Consultation and Referral.** Mental health experts are available by telephone or video to provide consultation for behavioral health issues and primary care physicians are available for physical health issues. Referral procedures between providers are well-documented.
- **Cross-training and Screening.** In addition to consultation and referral, providers participate in cross-training between professional disciplines. Basic screenings are done for primary care and behavioral health care in both settings.
- **Co-location.** Primary care and behavioral health providers are located in the same office; however, providers may be employed by separate organizations. Does not guarantee collaboration or an integrated approach to treatment.
- **Collaborative Care.** Primary care and behavioral health providers are part of one provider organization and care is co-managed. A patient receives a comprehensive approach for screening, assessment and treatment.

Why is integrated care important?

Co-occurring mental and physical health issues are common in the general population but are significant for persons with serious mental illness. Data shows, on average more than 68% of adults with a mental disorder had at least one medical condition, and 29% of those with a medical disorder also had a mental health condition. People with schizophrenia and bipolar disorder are up to three times more likely to have three or more chronic conditions compared to people without these disorders.



National Comorbidity Survey Replication, 2001-2003

Mental health problems exacerbate physical health issues. Moreover, people with co-occurring conditions tend to utilize higher intensity medical services at greater cost to the healthcare system. The chronic physical health conditions that often affect people with mental illness may be significantly influenced by the side effects of psychotropic medications, which are associated with obesity, elevated cholesterol and high blood pressure.

Eighty seven percent (87%) of years of life lost are due to medical illnesses –especially infectious, pulmonary and cardiovascular diseases and diabetes. In addition, symptoms associated with mental illness can make following the treatment regime for the physical illness difficult. For example, non-compliance rate for medical treatment is three times higher for depressed patients than non-depressed patients. The results of multiple chronic conditions are well documented, people with mental illness die twenty-five (25) years younger than the average person.

Treating the mind and body as two separate conditions without acknowledging the impact each have on the other is the norm in medical practice. The separation of treatment has not demonstrated successful health outcomes or manageable costs for persons with physical and behavioral health conditions. More than forty (40) randomized controlled trials have found that collaborative care interventions improve quality and outcomes for persons with physical and behavioral health issues compared to traditional care methods.

The following table compiled by StarCare (formerly known as Lubbock Regional MHMR Center) for their federal integration grant shows the prevalence of co-morbid physical and behavioral health diagnosis among adults with serious mental illness receiving services through the Center.

**StarCare Specialty Health System
Adults with Serious Mental Illness**

Behavioral Health Diagnosis	Physical Health Diagnosis
33% have major depression	17% have diabetes
29% are bipolar	43% are obese
34% have schizophrenia	35% have hypertension
34% have co-occurring substance abuse problems	28% have asthma
53% smoke cigarettes	

In Texas, the high cost of multiple chronic conditions is evident when looking at preventable hospital readmissions. Readmission is 15% more likely for adults and 35% for children, when a patient also has a serious mental illness or substance use disorder as secondary conditions to medical and surgical readmissions, compared to people without a mental health or substance abuse diagnosis.

Integration sounds right, why not just do it?

Separating physical and behavioral health care has been the norm in healthcare delivery, financing and policy for many years. As a result, developing integrated care models often requires breaking down the barriers in provider practice culture, financing mechanisms and delivery infrastructure that arose after decades of fragmented approaches to care. Dismantling these barriers requires hard work by committed leaders, and often also requires financial commitments and policy changes at the State and National levels.

- Culture.** Provider organizations for medical and behavioral health have different cultures. Merging these two types of organizations can often be a challenge in developing policies, procedures and financing approaches that both groups believe lead to efficient and effective care. In addition, the professionals within the organizations have different training and practice experience leading to different treatment approaches. Blending physical and behavioral health treatment means blending treatment philosophies of primary care physicians, psychiatrists, nurses and social workers to support the philosophy of an integrated care approach.

- **Financial barriers are significant.** Important functions in an integrated setting are often not reimbursable in the current financing environment: case management, consultation between providers, telephone consultation with patients, screening services, preventive mental health services, same day billing and the Primary Care Physician (PCP) providing a service only related to a behavioral health service. Some of these functions are compensated for in the beginning stages through grant funding, but long-term viability rests on changes to allowable billing practices.
- **Information Technology.** Integrated care requires effective communication across the treatment team of physical and behavioral health providers. Modern medical practices increasingly rely on information technology to communicate, bill and document care. As a result, information technology may hold the key to full integration but changes to electronic health records can be expensive and often systems designed for primary care are very different than those designed for behavioral health.
- **Office space.** Primary care clinics are not designed and do not serve the same purpose as behavioral health clinics. When full integration occurs, funding is often required to redesign space to be appropriate for the service being provided to facilitate communication and interaction across the treatment team.

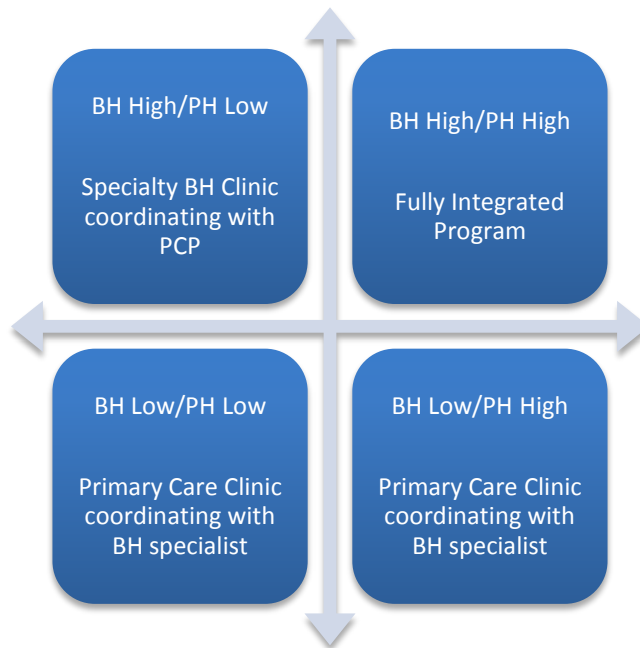
What will promote full integration?

Across the country, healthcare communities are in the process of defining how integration can work at the local level often with support of federal or state partners. The development of integrated projects range from agreements on consultation and referral to full collaborative care, where medical practices have the skills and abilities in one place to treat both physical and behavioral health.

The ability to form a fully integrated, Collaborative Care model is often dependent on funding. In the Texas models where office space has been redesigned, both medical and behavioral health clinicians are one team in one office, cross training and case staff occurs regularly and attempts at medical record integration have begun, the key is funding. These sites received new grant funding from the federal government to develop integrated practices. When new funding is not available, providers must be creative with what they have and often start with a smaller project that improves integration with the resources currently available.

What are local Texas communities doing today?

In local communities throughout Texas, health care providers are coming together to find integration strategies that maximize the potential for better outcomes based on available resources. Much of the integration is based on the concept that where care is best delivered depends on the severity of both the individual's behavioral health and physical health needs. **In general, people with low behavioral health needs can be appropriately supported in an integrated health home in a primary care clinic while people with high behavioral health needs are better served through an integrated health home in a behavioral health clinic.**



Note: Coordination may be done through staff employed by the clinic, co-location of specialty care or consultation and referral. This model is known as the Four Quadrant model, promoted by the National Council on Behavioral Healthcare.

Although this may be the model of care, all healthcare services are delivered locally and the local availability of providers may alter the course for integration in some communities. In addition, the choice of the individual seeking care may change the primary location for services depending on individual preference.

Texas Community Centers have partnered with other health care providers in their communities to begin to more holistically address the physical and behavioral health needs of individuals. These partnerships are promoting improved coordinated care through either integrated clinics, co-location of professional staff and/or established consultation patterns and referral services. In some cases additional funding has been made available through grants to establish new programs while others are combining resources without additional funding.

Successful integration efforts require dynamic, committed leadership.

--Hogg Foundation for Mental Health, December 2008.

Successful integration efforts require dynamic and committed leadership. The leaders of the projects contained in this report made a commitment to integrating and improving care, often without the benefit of additional funding to support the efforts. Ultimately, the commitment to integration is good for the patient and leads to better clinical outcomes, more convenient access to care and reduced costs.

In the next section, you will find brief descriptions of programs currently operating with Texas Community Centers and their local partners.

Program Descriptions

Eighteen (18) Community Centers throughout the state of Texas have partnered with the physical healthcare community to offer more integrated care for persons with mental illness and/or substance abuse disorders. In a survey conducted in November 2011 by the Texas Council of Community Centers, eighteen (18) Centers responded representing twenty-one (21) different integrated care programs. The programs represent a broad spectrum of integration projects including Consultation and Referral; Cross-training and Screening; Co-location; and Collaborative Care.

The following information provides an overview of program components described in the survey. In addition, a short description for each Center follows the survey data.

Program Component	Responses
Assures regular screening and registry tracking/outcome measurement at the time of psychiatric visits for all individuals receiving psychiatric medications – check glucose and lipid levels, blood pressure, BMI. Track changes and response to treatment, and use the information to adjust treatment.	79% yes 21% no
Co-locates primary care professionals in behavioral health facilities and provides routine primary care services in the behavioral health setting.	47% yes 53% no
Use of telemedicine to co-locate primary care professionals in behavioral health settings.	11% yes 90% no
Co-locates behavioral health professionals in primary care facilities and provides behavioral health services in the primary care setting.	42% yes 58% no
Use of telemedicine to co-locate behavioral health professionals in primary care settings.	21% yes 79% no
Identify a primary care supervising physician to provide consultation on complex health issues for the psychiatrist or other behavioral health provider, if there is no primary care physician practicing at the behavioral health site.	42% yes 32% no 27% not applicable
Processes for referral and follow-up for needed treatments not appropriately provided in a primary care or behavioral health setting.	95% yes 5% no
Creates wellness programs and utilizes proven methods and materials for engaging individuals managing their health conditions which are adapted for use in the behavioral health setting.	67% yes 33% no

Austin Travis County Integral Care

Community Partner: CommUnity Care

Austin Travis County Integral Care (ATCIC) has two integrated programs, E-Merge and HIP. Both programs are in collaboration with CommUnity Care.

The E-Merge program brings behavioral health care services into the primary health care clinics. The goal of the program is to help patients achieve both improved physical and mental health by addressing these needs together through:

- Specialty behavioral health care and/or chemical dependency treatment services as needed, and
- Psychiatric consultation services as determined by a behavioral health consultant to address patient needs.

E-Merge has licensed mental health professionals with who work with CommUnityCare's care staff to ensure quality health care. Behavioral health consultants can offer mental health evaluations, education regarding mental health issues and treatment in the form of counseling. Behavioral health consultants work collaboratively with patients on goals and changes to improve their lives, health and relationships. E-Merge also works with other professional clinic staff to provide health management and wellness groups.

The "Health Integration Project" or HIP, brings primary care into ATCIC's behavioral health clinic. There is a team working at the clinic including primary care medical staff and support staff. This team is not only responsible for providing primary care within the Center, but also to develop and introduce wellness programs into the Center. Wellness is a term used to describe the concept of client centered treatment planning that considers multiple areas of need including psychological as well as physical, vocational, social, intellectual, financial, environmental, and spiritual needs. The HIP program is currently funded by a federal grant awarded to ATCIC as a part of a large scale initiative to learn how integrated care works.

Bluebonnet Trails Community Services

Community Partners: Community Health Centers of South Central Texas
Lone Star Circle of Care
Tejas Healthcare
Smithville Community Clinic

Bluebonnet Trails Community Services has partnered with four local primary care clinics to integrate care for adults with serious mental illness. There are two integrated models underway: (1) behavioral health provider in the primary care clinic and (2) primary care provider in the behavioral health clinic.

The partner organizations identify common individuals in each practice and determine the most appropriate integrated program based on the needs of the individual.

The partners are increasing integration through co-location and are committed to an integrated electronic medical record between agencies. By enhancing both primary and behavioral healthcare services, Bluebonnet Trails expects to see overall improved health of the individuals served. In addition, specific outcomes include:

- Prevention of medical and psychiatric deterioration, hospitalization and crisis
- Increased medication adherence through psychosocial interventions
- Reduction in poverty-related destabilizing events, such as eviction prevention

The Center for Health Care Services

Community Partner: CentroMed and Methodist Healthcare Ministries

An integrated outpatient clinic is under development with funding from Methodist Healthcare Ministries. The current plan would include co-location of a primary care clinic in a large outpatient behavioral health clinic and in a children's mental health clinic. The goal would be to have the co-located program operational by January 2012. The project funds a renovation of a site in downtown San Antonio in which CHCS will locate all adult psychiatric services. The renovation will be designed to include co-location of the primary care clinic.

The immediate project is to identify a limited number CHCS patients who are experiencing high utilization of primary and specialty care services for conditions such as diabetes, hypertension, and increased use of emergency room services due to mental and physical health conditions.

Community Partner: University Health System (UHS) of the Bexar County Hospital District

CHCS partners with UHS in the Baby University program. This program provides pre-natal care to pregnant women participating in methadone maintenance with CHCS. It also provides a medical home for the entire family by expediting enrollment in the UHS Carelink program. Baby University provides wellness services and classes to prepare women to care for their babies and linkage to UHS nurse midwife, labor and delivery services. CHCS provides methadone maintenance, counseling and case management to participants in the program. CHCS's psychiatrists and addictionologists frequently provide expert consultation to the OB/GYN who is managing the woman's pregnancy.

Community Partner: University of Texas Health Science Center San Antonio (UTHSCSA) Medical School

The Metabolic Syndrome Monitoring Project is a research project jointly designed and executed between the Medical School Department of Psychiatry under a National Institutes for Mental Health

grant and CHCS. The project investigates how to improve testing and evaluation of Metabolic Syndrome for those patients on atypical anti-psychotics and evaluates the results of two different methods for providing follow up care, compared to the traditional after care program.

In CHCS' largest outpatient clinic, an LVN draws blood, maintains records and identifies laboratory values for the physician. A case manager provides follow up care including referrals and working with the patient to keep appointments and monitoring proper follow up. A Doctor of Pharmacy provides follow up and treatment for metabolic syndrome, function as the primary care provider in the behavioral health clinic.

Center for Life Resources

Community Partner: Cross Timbers Community Health Clinic

Center for Life Resources and Cross Timbers are recipients of a Hogg Foundation for Mental Health grant to promote integration. The partnership is still in the beginning phase. The plan is to place a behavioral health clinician in the medical clinic once or twice a week to see primary health care patients. Today, the Center for Life Resources does routinely perform weight checks and BMI in the behavioral health clinic, and may order laboratory tests for glucose and lipid levels if prescribed psychotropic medications are known to cause physical health issues.

Central Plains Center

Community Partners: Regence Health Network and Covenant Hospital, Plainview

Regence Health Network has two primary care clinicians located in the Central Plains Center's behavioral health clinic once a week. Central Plains Center is also in the planning process with Covenant Hospital for a project that integrates behavioral health clinician in the hospital setting.

Coastal Plains

Community Partner: Community Action Corporation of South Texas

Coastal Plains Center and Community Action Corp. will begin an integration project in 2012. Community Action will provide primary care services in all but one of the Coastal Plains behavioral health clinics. In 2012, the two organizations will also begin construction on a new service site together. The new site will co-locate all services for Kleberg County. As the project becomes fully functional, both organizations

are also interested in exploring a shared electronic medical record, along with potential reimbursement strategies for both medication and psychiatric services.

Community Healthcore

Community Partners: East Texas Border Health
Wellness Point

Community Healthcore has partnered with two FQHCs in the East Texas area to provide primary care services to persons with serious mental illness. The East Texas Border Health integration project includes collocation of clinical staff for primary and behavioral health services including psychiatric services for persons with mental illness and providing physicals for persons in Substance Abuse Inpatient programs. Community Healthcore has a referral agreement with Wellness Point for primary care for persons receiving behavioral health services at Community Healthcore.

Emergence Health Network

Community Partner: Centro San Vicente Familiar de Salud

In 2009, the Hogg Foundation awarded a one-year grant to Mental Health America of Houston to create a statewide learning community on integrated health care. The El Paso learning community is represented by Emergence Health Network and Centro San Vicente. Through the learning community, members collaborate in person and online to share information and experiences with implementing different integrated healthcare models, components and strategies. Emergence Health has contributed information and experiences related to co-location and health information exchange.

Heart of Texas Region MHRM Center

Community Partner: Centro San Vicente Familiar de Salud

The Center meets quarterly to staff difficult cases with the Family Health Center FQHC and has a working arrangement to refer cases in either direction. The Center typically accepts cases from the FQHC that require case management or those with complicated treatment objectives. The FQHC accepts cases where the individuals are stable and primarily need medication services. The Centers agrees to take any referred individual back into the Center's treatment team if problems occur after transfer to the FQHC. The Medical Directors of both agencies are available to mediate any issues that come up in treatment of individuals served. A memorandum of understanding for the release of information between agencies is

in the process of being signed. A more formalized project is under consideration, including discussions of the potential for a shared clinic.

Helen Farabee Centers

Community Partner: Wichita Falls Community Healthcare Center

Helen Farabee Centers participated with the Wichita Falls Community Health Center in an Incubator Project with several other community health centers in Texas. Sponsored by the Texas Association of Community Healthcare Centers, the effort focused on developing a behavioral health component in the primary care setting, an expedited hand-off/referral process for individuals meeting the Centers' target population and substance use services that could not be adequately treated in the primary care setting. In addition, the Helen Farabee Centers participated in ongoing training and consultation with the Community Health Care Center.

Metrocare Services

Community Partners: Los Barrios and Martin Luther King Jr. Family Center

Metrocare partners with two primary care clinics to increase the community's capacity for integrated physical and behavioral healthcare through both consultation and co-location. Metrocare Services provides consultative psychiatric services on-site at the Los Barrios and Martin Luther King Jr Family Center for four hours per week. Services are provided to train primary care physicians on the assessment and treatment of mental illnesses and to increase the physician's ability to appropriately refer to specialty care when needed. In addition, Metrocare provides a behavioral health nurse practitioner to the Los Barrios Primary Care Clinic sixteen (16) hours per week.

In addition to psychiatric consultation for primary care physicians, Metrocare's Westmoreland Outpatient Treatment Center has primary care services on-site four hours per week.

MHMRA of Harris County

Community Partners: El Centro De Corazon

In the beginning of the MHMRA Harris County and El Centro De Corazon integration project, MHMRA Harris County was transporting patients needing physical healthcare services to El Centro, which is located within about twenty blocks of one of the behavioral health clinic sites. As the service grew in

popularity, it became apparent that it would be more efficient to bring the primary care staff into the behavioral health clinic than to continue to transport the patients. In essence, full integration of services would more likely occur through co-location of the services.

At the MHMRA Harris County clinic, five offices were converted into a small medical clinic including exam rooms and a small on-site lab. Based on the success of the initial partnership, MHMRA and El Centro entered into a memorandum of understanding (MOU). The MOU provides an agreement for the construction and operation of primary healthcare clinic inside a second behavioral health clinic. MHMRA underwrote the construction costs and has agreed to provide utilities, housekeeping and maintenance on an ongoing basis. El Centro has purchased all the supplies and equipment for a six exam physical health care clinic that will service adults and children. El Centro has agreed to provide sufficient staffing to meet patient demand, laboratory and business office personnel. The second integrated clinic operation began November 28, 2011.

MHMR of Tarrant County

Community Partners: MedStar of Tarrant County

MHMR of Tarrant County's mobile crisis outreach team (MCOT) works in close partnership with the local medical emergency ambulance response organization to assure that individuals in Tarrant County are served in the least restrictive services. When MedStar discovers through their response team that an individual experience a mental health crisis does not qualify for inpatient care, MHMR of Tarrant County's mobile crisis program is contacted. Conversely, mental health crisis patients identified by the MCOT team are able to coordinate home-based medical monitoring treatment with the MedStar program for patients being followed with an identified medical and mental health need.

Community Partners: HealthSpring

MHMR of Tarrant County has two licensed master social workers co-located with HealthSpring, a managed care company located in Bedford, Texas. This unique and innovative partnership has fostered a comprehensive evaluation and coordination of the physical and mental healthcare needs of HealthSpring members. This relationship has assured that care is coordinated, comprehensive and cost effective. As a result, there has been a decrease in hospitalizations and an increase in early detection and intervention of mental and physical healthcare needs of HealthSpring's members.

Pecan Valley Centers

Community Partners: Sylvana Parodi-Utz, Community Health Worker
St. Stephen Catholic Church, Weatherford
Ruth's Place, Grandbury

“Sowing Hope” is a program developed by Pecan Valley Centers to provide the Hispanic community with nutritional information directed at taking care of an individual’s mental illness, as well as physical condition. The program focuses on treating the mind and the body with the goal of better overall health. Mental health screening and education occurs along with nutritional screening and education. There are three focus areas within the program:

1. Mental Health education
2. Mental Health screening and referral
3. Physical Health education

Ruth's Place provides free health care to the indigent and coordinates with Pecan Valley psychiatrists for consultation and laboratory testing.

StarCare Specialty Health System

Community Partner: Larry Combest Center

The StarCare Speciality Health System (formerly known as Lubbock Regional Mental Health and Mental Retardation Center) was awarded SAMHSA grant for a Primary and Behavioral Health Care Integration Project. StarCare works with the Larry Combest Community Health and Wellness Center to operate a clinic integrates primary medical services into psychiatric/mental health services provided to consumers who have serious mental illnesses. An agreement is also in place for this project with Texas Tech University Health Sciences Center and the Combest Health and Wellness Center Community Alliance.

The purpose of this project is to operate a clinic where primary care is fully integrated into StarCare outpatient psychiatric services, using the Chronic Care Model to guide the process. The full range of primary medical and behavioral health services are provided in the new clinic, as well as chronic disease management, health maintenance, health and wellness, and referrals for advance care. The population focus for this project is people with series mental illness who live in the Texas South Plains counties of Lubbock, Cochran, Crosby, Hockly and Lynn. Currently, StarCare serves over 1300 adults with serious mental illness. Of those adults many have both serious behavioral health and physical health diagnosis.

Tri-County Services

Community Partner: Lone Star Family Clinic

Tri-County Services provides psychiatric and counseling services in the Lone Star Family's primary care clinic to all individuals indicating a need for behavioral health services. If an individual at the primary care clinic is determined to meet the clinical requirements for intensive behavioral health services at Tri-County Services, referrals and follow up appointments are given.

Tropical Texas Behavioral Health

Community Partners: Nuestra Clinica Del Valle
Texas Learning Community on Integrated Health Care

Tropical Texas Behavioral Health (TTBH) and Nuestra Clinica Del Valle (NCDV) has executed a memorandum of understanding to collaborate on a project to integrate the delivery of primary and behavioral healthcare services to shared clients with mental illness in the Rio Grande Valley. The project's preliminary goals are to improve access to necessary healthcare services and achieve optimal clinical and quality of life outcomes for identified clients through identification and referral of shared clients, information sharing and cross-training of clinical staff.

The project is in its early stages of development, however TTBH and NCDV are discussing a planning retreat in January 2012 to further define project goals and develop an action plan. Among the topics planned for the retreat are:

- Developing a data file matching system to identify shared clients
- Determining a process for sharing client information
- Developing a coordination of care system for identified clients
- Exploring options for co-location, or contracting for, primary and behavioral health services
- Developing a client education strategy
- Developing cross-training curriculum for clinicians

Spindletop Center

Community Partner: Gulf Coast Health Center
Baptist Hospital
Medical Center of Southeast Texas
Wood Residential Group

Spindletop Center has referral agreements in place with its four community partners. The Spindletop Center psychiatrist provides behavioral health services for persons receiving primary care from the Gulf Coast Health Center.