Systems Challenge: Integrating Behavioral Health Care into the Primary Care Setting

Introduction

Although medicine has for many years extolled the virtues of treating the whole person, that concept will never be fully realized until mental health care and chemical dependency care are integrated into the primary care setting. Replicated research has shown that 50% to 70% of patients seen in primary care settings on a daily basis are coming in for psychosocial reasons and not for underlying organic medical problems. We are also aware that many common psychiatric problems, such as depressive and anxiety disorders, are frequently undiagnosed in the primary care setting. The cost to patients' health and happiness, family members, and employers is very high as a result of these treatable but frequently untreated illnesses.

"Our challenge is to study the effects and benefits of this integration, both to individual patients and to society as a whole."

Robin Dea, MD
Dr. Dea became Chief of the Department of Psychiatry at Kaiser Permanente Medical Center in Redwood City in 1981. From 1987 to 1989 and from 1991 to the present, she has been the elected Chair of the Chiefs of Psychiatry for Northern California Kaiser Permanente.

We are now moving to rectify this problem as an organization by means of primary care integration. Our challenge is to study the effects and benefits of this integration, both to individual patients and to society as a whole.

—Robin Dea, MD

Colorado

Carolee Nimmer, PhD
A Supervising Psychologist and the co-chair of the Quality Assurance committee for the Behavioral Health Department, she currently supervises one of four Mental Health clinics in the Rocky Mountain Division.

Arne Beck, PhD
Dr. Beck is the Research and Development Director in the Rocky Mountain Division, and Assistant Clinical Professor in the Department of Preventive Medicine and Biometrics at the University of Colorado Health Sciences Center.

"The mental health clinicians spend at least 30% of their time consulting with primary care clinicians on these or other cases; the rest of their time is spent providing direct patient care."

In the Rocky Mountain Division, we have been piloting an Integrated Care Program funded by two different grants—an internal research grant for the first year of the program, which we implemented in a small clinic; and a Garfield Memorial Fund grant for the second year, to be used in a larger clinic. The Integrated Care Program was designed by a group of mental health and medical providers as well as research staff. The primary goal of the Program was to develop a highly collaborative way of working with patients that would be more than a referral guideline. The Program's first year has been completed, and initial results suggest a high degree of success. We are optimistic that we can replicate these results in a second clinic that serves a higher number of patients.

The Integrated Care Program places two mental health clinicians into the Family Practice and Internal Medicine Departments. The clinicians meet on a weekly basis with both the medical staff and the department head to address concerns regarding collaboration, management of difficult patients, and medication management issues. Primary care clinicians identify patients in need of Mental Health Services and refer them for screening. These patients receive the Quick Psychodiagnostic Panel, a computerized instrument that assesses depression, anxiety, substance abuse, and several other psychiatric disorders. The instrument is scored immediately and reports a DSM-IV diagnosis and severity rating. The clinician then interviews the patient. Patients who are identified as having a depressive or anxiety disorder are asked to enroll in the study. Agreement to enroll in the study gives permission to conduct follow-up assessments for one year. Whether or not they agree to participate, patients are given a Shared Decision-Making Form that describes available treatment options as well as the advantages and drawbacks to each option delineated in the medical literature. Patients are then allowed to select medication, psychotherapy, or both as an initial treatment choice. Patients who select psychotherapy are scheduled to return to see the mental health clinician for a series of brief 30-minute sessions designed to teach cognitive behavioral techniques for reducing symptoms. For patients who choose medication, the primary care clinician writes a prescription for appropriate medication. If the mental health clinician on site in the Primary Care Department determines that more intensive treatment is needed, the patient is referred to the Mental Health Department for follow-up. The mental health clinicians spend at least 30% of their time consulting with primary care clinicians on these or other cases; the rest of their time is spent providing direct patient care.

The preliminary results have been positive. At the three-month follow-up evaluation, patients enrolled in the Integrated Care Program showed a clinically significant decrease in depressive and anxiety symptoms as measured by the ZUNG scales of symptom

severity and indicated a high level of satisfaction with their care on a patient satisfaction measure. On the Shared Decision-Making Form, only 2% of patients selected medication as their initial treatment option; 58% selected a combination of psychotherapy and medication and 40% chose psychotherapy only. The medical staff reported that they were highly satisfied with the Program. Medical utilization data have not yet been analyzed.

The group working on the Integrated Care Program has expressed consensus that this model is critical to patient care. The patient population being served by mental health clinicians on site in the medical offices is a population not being seen in the Mental Health Department. We believe that integrated care can address this gap by providing high-quality Behavioral Health Services to meet the needs of this population.

Georgia

Howard Gould, MD
Dr. Gould has been with TSPMG since 1995 and has been the Chief of the Behavioral Health Department since May 1997. He is a Board certified adult and geriatric psychiatrist with a strong interest in promoting integrated health care.

Ellen Strugatch, LPC
Ellen Strugatch is the Georgia Regional Administrator for behavioral health and has been active in the integration of behavioral health assessment and treatment in the primary care setting.

We believe Behavioral Health care is Primary Care. Researchers have estimated that between 50% and 70% of a primary care physician's normal caseload addresses medical ailments that are primarily related to psychologic factors.[1] In addition, patients with mental disorders visit their primary care physicians twice as frequently, on the average, as patients without mental disorders.[2] The highest 10% of Primary Care utilizers account for 29% of all Primary Care visits, 53% of all visits to specialists, 40% of all days spent in the hospital, and 26% of all prescriptions written.[3] Despite this utilization pattern, however, only 4% to 5% of our members currently use Behavioral Health Services. Statistics such as these strongly support the possibility of financial gains being realized when Behavioral Health Services (including Chemical Dependency Services) are appropriately integrated into the primary care setting, but, more important, the statistics show that we have an opportunity to greatly improve the quality of care delivered to our patients. In the Georgia Region, our ultimate vision is threefold: 1) to maintain our present departmental structure of clinical office sites; 2) to expand both our treatment of somatization disorders and our focus on the psychologic aspects of medical illness; and 3) to include a behavioral health/chemical dependency clinician in each Primary Care Services Health Care Team.

The role of the behavioral health/chemical dependency clinician on the Health Care Team would be multifaceted. We envision that this clinician would assist in identifying behavioral health/chemical dependency problems; provide ongoing education; act as a consultant to primary care practitioners; facilitate referrals to behavioral health and alcohol and drug programs; enhance patients' adherence to treatment regimens; help manage difficult patients; and provide direct treatment. We also would attempt to identify high-risk patients so that we could intervene earlier and provide preventive care.

In February 1998, we began a pilot study integrating Behavioral Health Services into Primary Care Services. A behavioral health clinician joined the Primary Care Services Health Care Teams at one of our facilities to help identify depression in diabetic patients and provide treatment for depression directly within Primary Care Services. This study will look not only at screening and treating depression within Primary Care Services and its cost offset but also at the model of integrating a mental health clinician into the Health Care Team. Preliminary results indicate that 28% of the diabetic population is depressed, and that most had not been receiving treatment for this depression before the study began.

We have also created an Integration Committee to function within the Behavioral Health Services Department. The Committee's first task was to increase the visibility of Behavioral Health Services within Primary Care Services. Consequently, members of the Behavioral Health Services Department met with each Health Care Team to introduce themselves to primary care clinicians by explaining who the Behavioral Health Services Department members are, what they do, and how to access the Department. This interaction will be led by the Integration Committee on an ongoing basis. In addition, we have created a brochure describing our Behavioral Health Services (including substance abuse care), have distributed it to the Medical Group, and now plan to make these brochures available for distribution to patients by the Health Care Teams.

"The group working on the Integrated Care Program has expressed consensus that this model is critical to patient care."

"Researchers have estimated that between 50% and 70% of a primary care physician's normal caseload addresses medical ailments that are primarily related to psychologic factors.[1]"

Other proposed projects to be conducted in collaboration with Primary Care Services include screening for depression in patients hospitalized for certain cardiac conditions and training pediatric clinicians to more effectively diagnose and treat depression in adolescent patients. We are also creating a pilot project wherein a behavioral health clinician and primary care clinician will jointly lead group visits with patients whose tendency to somatize leads to frequent utilization of services and who thus contribute a large portion of the physician's caseload. At several of our Behavioral Health Offices, we have also created groups who focus on managing chronic pain and living with chronic illness.

Given that we practice in a group-model health maintenance organization, we are already providing integrated care; however, we have the opportunity to further extend the concept of integration inasmuch as we can consult with our colleagues from all KP Divisions and Regions and can learn from their experiences. By integrating Behavioral Health Services (including chemical dependency clinicians) into Health Care Teams and by expanding treatment modalities within the current departmental structure of Behavioral Health Services, we believe that we can significantly improve quality of care delivered to our members.

" ... we have the opportunity to further extend the concept of integration inasmuch as we can consult with our colleagues from all Kaiser Permanente Divisions and Regions and can learn from their experiences."

Massachusetts

Joel Feinman, PhD
Dr. Feinman has been with NPMG as Director of Behavioral Health Care for Massachusetts since 1987. He has been active in helping to coordinate the Division's Clinical Practice Guideline efforts for several years.

As the Northeast Division continues to change (ie, by combining the former Northeast Permanente Medical Group Behavioral Health staff with staff of the Community Health Plan in Massachusetts to form the new Northeast Permanente Medical Group), we have focused on two primary objectives: to make new sense of our inherited mixed-model delivery system and to achieve integration with our Primary Care Services so that we satisfy our members' needs for preventive and acute care and enable our practitioners to provide that care effectively and efficiently.

The Behavioral Health Care Services delivery system in the KP Massachusetts Region is now composed of our health-center-based staff and a large "affiliated network" of behavioral health clinicians in private solo or group practice. The affiliated network was inherited from the former Community Health Plan and represents for KP a new way of doing business. However, this mixture of Permanente staff (health-center-based clinicians) and affiliates sometimes caused confusion among patients and KP practitioners about our approach to delivery of care. The solution: identify the greatest strengths of each part of the delivery system and use those strengths to the advantage of our patients and staff. The strength of the affiliate network is that it gives patients a wide choice of practitioners and subspecialists. The strength of our staff system is our ability to coordinate complex care for patients who are emotionally ill and to collaborate with primary care clinicians to prevent mental disorders and use proven behavioral approaches to enhance treatment of somatic complaints and illness.

Primary care has been undergoing redesign in our area for several months: for example, Health Care Teams are forming to care for patient panels, and behavioral health care clinicians are being included on these teams in adjunct positions. Ultimately, our goal may be to include Behavioral Health Care Services as a component of Primary Care Services, thus providing integrated preventive and acute care for mental disorders and stress as well as screening for alcohol abuse, depression, family violence, and somatization. This goal can be accomplished only by full integration with Primary Care Teams. We would maintain our specialty Behavioral Health Care Services for patients who identify themselves as needing and requesting those services, but we would provide behavioral health intervention in the Primary Care Departments for patients who are reluctant to be seen in a mental health setting.

Several "natural experiments" are now in progress and include some behavioral health clinicians who have been involved in our integrated approach from the start of the Health Care Teams' training. Other clinicians are being added later because of scheduling difficulties. Some behavioral health clinicians are being located in primary care settings, where time is dedicated to working with Health Care Teams. Other behavioral health clinicians are serving in more traditional consultant roles. During the next few months, we will examine utilization of services, the impact on patient care, and primary care and behavioral health clinicians' satisfaction with each of these experiments.

We have been working from a model described by Strosahl and others[4-6] at Group Health Cooperative of Puget Sound. Several of our clinicians

have read this material and have attended conferences to obtain further training. We are also establishing peer supervision for behavioral health clinicians working in Primary Care Services, and our behavioral health clinicians will attend Primary Care Team meetings.

Several initial "barriers" and challenges have been identified. These include management of two patient panels by each behavioral health clinician, ie, the clinician's primary care panel (which mainly requires consulting and very brief interventions) and the clinician's regular patient panel in specialty care; achieving proximity of behavioral health clinicians and primary care clinicians in the health centers; and "cross-cultural" (Primary Care and Behavioral Health) training and experience.

Perhaps the ultimate level of integration would be to embed behavioral health knowledge and practice into the ongoing work patterns of primary care clinicians. To aid this process, our Division's *Clinical Practice Guidelines, 2d ed.*, contains "Guidelines for the Identification and Treatment of Depression in Primary Care" as well as "Identification of Risky Drinking in Primary Care." Our Personal Health Improvement Program (PHIP), a group-based program aimed at patients who somatize and patients who have chronic physical illness, is run by clinicians from both Primary Care and Behavioral Health Services and has resulted in improved health status for participants and more appropriate medical utilization. In addition, PHIP trains Primary Care clinicians in proven, effective techniques of brief cognitive and behavioral therapy useful for managing symptoms and promoting health.[7]

North Carolina

Kenneth G. Schooff, MD
Dr. Schooff is the Regional Chief of Mental Health for the CPMG. His background includes 15 years as Chief of Psychiatry in a 600-bed general hospital with full residency programs in family practice and internal medicine as well as surgery.

The Carolina Permanente Medical Group is continuing its involvement in various efforts to integrate Mental Health Department Services with its Primary Care Services. These efforts have included provision of regular inservice opportunities to primary care staff, placement of mental health providers into Primary Care Modules, and training of nursing staff to provide behavioral interventions. Inservice activities include a monthly Balint group—a Primary Care Team discussion of patients' problems with a behavioral health specialist participating—run by one of the lead psychiatrists in the Triangle Market Area. The group hosts regularly scheduled presentations by another Triangle Market Area lead psychiatrist during the Primary Care Services Department inservice training conferences. The lead psychologist in the Triangle Market Area trained all our primary care clinicians in screening and treating depression last year, when the clinicians reorganized into teams. In addition, we actively encourage communication about mutual patients with our psychiatrists and mental health clinicians.

In two of our market service areas, we have placed behavioral health staff in Primary Care Offices. In the Central Carolinas Market Area, a therapist spends two days per week in each of two satellite Primary Care Offices, seeing patients in consultation and running therapy groups. Within the Triangle Market Area, one psychiatrist and one therapist have been based at another Medical Office site for more than two years, working alongside the primary care clinicians to provide both traditional Mental Health Department Services and informal consultation to the Primary Care Team. Last year, we created Diabetes Care Teams and staffed them with nurses trained to provide behavioral health interventions. We are also exploring other options to coordinate our Behavioral Health Care with two nurse practitioners experienced in both Primary Care and Psychiatry Practice—one recently hired to work in our Triangle Market Area Mental Health Office, and another hired to work in the Central Carolinas Market Area.

At a regional meeting held to set our agenda for 1998, the Mental Health Department identified integration with Primary Care Services as a priority for the year. In keeping with this goal, we have applied for grant support from the national KP Depression in Primary Care Project to fund two pilot projects which will conduct depression screenings for patients who have cardiac disease and patients who have diabetes. Patients for whom the screening result is positive will be encouraged to participate in a depression treatment protocol through the Mental Health Department. These protocols—coordinated with researchers from Duke University and from The University of North Carolina—seek to measure the impact exerted on both health outcome and overall medical care costs when patients in high-risk categories receive active depression screening. We expect to continue our search for other opportunities to integrate Mental Health care into Primary Care.

"Perhaps the ultimate level of integration would be to embed behavioral health knowledge and practice into the ongoing work patterns of primary care clinicians."

"These protocols—coordinated with researchers from Duke University and from The University of North Carolina—seek to measure the impact exerted on both health outcome and overall medical care costs when patients in high-risk categories receive active depression screening."

Group Health Northwest

Michael Erikson, MSW, LCSW
Michael currently serves as the Director of Behavioral Health for Group Health NW. Prior to this, he was with Kaiser Permanente, NW for nine years, with five years as the Director of Outpatient Clinical Services, Dept. of Mental Health.

Because its geographically large service area—Southern, Central, and Eastern Washington as well as Northern Idaho—includes many rural communities, Group Health Northwest uses a "hybrid" or combined staff and network delivery model. This staff-model delivery system is centered in the Spokane, Washington/North Idaho area and serves one third of the membership, or about 50,000 people.

"In the staff model, six of the seven health care centers employ a behavioral health specialist, a therapist who acts as direct liaison to the primary care clinicians (predominantly family practice physicians)."

In the staff model, six of the seven health care centers employ a behavioral health specialist, a therapist who acts as direct liaison to the primary care clinicians (predominantly family practice physicians). These behavioral health clinicians provide immediate access to Behavioral Health Services. The behavioral health therapists carry pagers and expect to be interrupted to see patients in the primary care clinician's examination room—with or without the physician present—to respond to patients' behavioral health questions or concerns, or to provide behavioral health intervention. These encounters are not charged against the patient's allotted benefit (ie, the encounter is not metered, or tracked by prescribed number of visits or maximum allowed dollar amount). Documentation is added to the patient's medical (paper) chart. The encounter may constitute a one-time service to address a primary care clinician's expressed concern, or the behavioral health clinician may facilitate referral to the Behavioral Health Services Department (including Psychiatry, Outpatient Therapy, or Chemical Dependency Services). Patients can leave the Primary Care Office with a Behavioral Health Services Department appointment in hand.

Informal interviews with primary care clinicians indicate that they like this service and see the behavioral health clinicians as part of the Primary Care Team. Correspondingly, the behavioral health clinicians enjoy being closely connected with primary care clinicians because the physician can assist with appropriate prescription of psychotropic medications and can answer medical questions as needed. No objective measures of patient or clinician satisfaction nor clinical outcome data are available, but the general belief expressed has been that the integration of behavioral health care and primary health care is useful and promotes quality of care and efficiency.

The network delivery system contractually permits a member's current primary care clinician to authorize behavioral health specialty care so that behavioral health clinicians are included in the patient's treatment plan from the beginning. Behavioral health specialists are contractually required to communicate their findings to the primary care clinician in writing within 10 business days after consultation.

In geographic areas served by few or no psychiatrists, medication issues are addressed by primary care clinicians. This scenario highlights the communication and mutual dependence between the network behavioral health specialist and the primary care clinician. Anecdotally, this communication and joint planning shows a "closer" integration than I have experienced in KP staff-model systems and might be facilitated by the limited availability of behavioral health specialists and psychiatrists in Eastern and Central Washington (ie, this scarcity creates the necessity for primary care clinicians to have a high degree of familiarity with behavioral health problems, including diagnosis and treatment of mental disorders).

Oregon/Washington

Mark F. Leveaux, MD
A Board Certified adult psychiatrist, Dr. Leveaux is the Chief of Kaiser Northwest's Mental Health Dept. He has been active in primary care integration efforts as both an administrator and as a clinician.

Brad Anderson, MD
Dr. Anderson, who has served as the Chief of Kaiser Permanente's Recovery Resources since 1995, is a Board Certified family practitioner. He completed a fellowship in Addiction Medicine at Case Western Reserve.

The Northwest Market Area of the KP NW Division extends approximately 100 miles from Salem, Oregon (in the South) to Longview, Washington (in the North) and serves more than 430,000 members. In past years, the groundwork and infrastructure for introducing greater integration of Behavioral Health Services (including Mental Health and Chemical Dependency Services) with Primary Care Services was

laid by the following developments:

• Commitment to a predominantly staff-based delivery model for all outpatient Behavioral Health Services;

• Dispersal of Mental Health and Chemical Dependency Teams from centralized locations into multiple full-service Primary Care Office sites, and establishment of local informal relationships with primary care clinicians;

• Introduction of integrated electronic information systems that give all medical clinicians access—with appropriate safeguards—to key elements of mental health and chemical dependency records, and facilitate asynchronous (ie, electronic and voice-mail) communication;

• Establishment of a regional Psychoeducational Group Program to meet many behavioral health and life skill needs of primary care patients who have no major psychotherapy diagnosis (ie, no DSM-IV Axis I condition);

• Using national benchmarking information provided by consultants, initiation of ongoing "core competency" discussions with primary care leaders to distinguish between Behavioral Health Services that should be provided in Primary Care Services from those that should be referred to Mental Health and Chemical Dependency Services specialists;

• Development of consultation services by Chemical Dependency staff at the three largest community hospitals (one owned by KP);

• Continuous quality improvement of depression treatment and follow-up guidelines, in collaboration with primary care practitioners; and

• Conduct of benchmarking and literature review on integration initiatives and experience, especially that of our nearby Divisional affiliate, Group Health Cooperative of Puget Sound.

These key elements have provided leverage for several more recent integration initiatives. The first of these is the "Mind Phone," a consultation line staffed by a psychiatrist to answer mental-health-related questions from staff and community network medical clinicians during clinic hours on a "real-time" basis, often while patients are still in the Primary Care Office. Primary care clinicians have expressed high satisfaction with this service during its three years of operation. In addition, modifying the Primary Care Integration Model of GHC, KPNW initiated at the end of 1995 a pilot program fully integrating mental health clinicians into two Primary Care Modules at one clinic. These behavioral health clinicians devote approximately a third of their time to primary care consultation and liaison activity (including brief patient consultation appointments booked by Primary Care Services); the remainder of their time is used for more traditional specialty Mental Health Services. Evaluation of this pilot is currently underway. Based on the model used by GHC, mental health clinicians at other sites also work in Primary Care Modules for several hours per week to provide consultant services and then return to Mental Health Clinic sites to provide specialty services. External grant funding is being sought for a pilot study of what is hoped to be a "best practices" collaborative protocol for treating depression in the primary care setting.

Looking to the future, we expect that these activities will continue to converge and that they will continue to facilitate identification and implementation of the best models for integrating Behavioral Health Services into Primary Care Services at our delivery system sites during the next two years. This accomplishment clearly will involve integration of Mental Health Services clinicians into nearly all staff-based Primary Care Services sites. Reaching this goal will require more clearly delineated scope of practice agreements and more extensive training of staff as well as some difficult resource allocation determinations based on decisions to shift costs between traditional, department-based "silos" and decisions to provide truly new services (including treatment of previously underserved populations). Finally, because only 5% of chemical dependency treatment referrals currently originate from Primary Care Services, this area has been targeted for research to clarify whether it represents another opportunity for improving health care via greater collaboration and integration.

A review of the literature in this area is not appropriate for this brief report. However, the reader needing greater background is referred to the recent reviews listed in the bibliography.

"Looking to the future, we expect that these activities will continue to converge and that they will continue to facilitate identification and implementation of the best models for integrating Behavioral Health Services into Primary Care Services at our delivery system sites during the next two years."

Group Health Cooperative of Puget Sound

Neil Baker, MD
A Stanford Medical School graduate, Dr. Baker was a tenured faculty member and the chief of inpatient psychiatry at the University of Colorado before going to GHC six years ago.

In the past three years, GHC has begun developing an organizationwide program of care for depression. The first stage of the process was to identify and characterize patients receiving depression care and to evaluate the outcomes of this care. Drawing data from GHC's research group, The Center for Health Studies, we found that 12% of enrolled adults annually sought depression care for major and minor disorders and that the patients with major depression used health care resources two to three times more frequently than most enrollees. Our detection levels for patients seen in primary care for major depression were very high; however, in ran-

domized controlled trials using antidepressants in primary care at GHC, clinically significant improvement was seen in only 40% of patients receiving usual care, whereas this degree of improvement was seen in 70% of patients who participated in a guideline-based treatment program.

The second phase of the process was to review the medical literature to collect the best scientifically grounded data to guide us in developing a uniform approach to depression care. To evaluate the strength of published conclusions and to minimize bias in forming our own conclusions, we used GHC's systematic approach for grading the scientific literature (which, for our review, consisted of >7,000 references). As a result of our review of the literature, we determined the following requirements for diagnosis and treatment of depressed patients: formal diagnosis of depression using DSM-IV criteria; shared decisions on treatment selection; serial measurement of severity to assist in determining outcomes; patient education; careful follow-up to assure patient compliance; assessment of the success of initial treatment; continuation of treatment after stabilization; evaluation of patients after six to eight months for maintenance treatment or discontinuation of treatment. The guideline also provides recommendations for medication selection, dosing, and management of side effects.

In the third (current) phase, the guideline is being implemented throughout the Primary Care and Behavioral Health Care delivery systems through a series of steps. The first step consists of systemwide training in use of tools for establishing disease diagnosis and severity. Targets have been set for use of these tools before and during treatment. Simultaneously, the National Committee for Quality Assurance (NCQA) has decided to use Health Plan Employer Data and Information Set (HEDIS) indicators concerning the treatment of depression. This third phase of the Program's development complements use of the HEDIS indicators.

Implementation of the Program for Depression Care will continue later this year with establishment of a depression registry to assist clinicians in tracking care; provision of additional clinical support for follow-up visits; use of strategies to prevent relapse; and enhancement of Behavioral Health consultation services onsite in Primary Care clinics to assist Primary Care teams with their tasks. ❖

References

1. Van den Boss GR, Cummings NA. The twenty-years' Kaiser Permanente experience with psychotherapy of the Hawaii Medicaid population and medical utilization: Implications for national health policy and national health insurance. Health Policy Q 1981;1(2):159-75.
2. Borus JF, Olendzki MC, Kessler L, Burns BJ, Brandt UC, Broverman CA, et al. The 'offset effect' of mental health treatment on ambulatory medical care utilization and charges: month-by-month and grouped-month analyses of a five-year study. Arch Gen Psychiatry 1985;42:573-80.
3. Sobel D. Improving health outcome through collaborative care: (Out of the box) health care strategies [Opening Keynote Address], Third National Primary Care Behavioral Health Care Summit, Chicago, IL; Nov 10-12, 1997.
4. Strosahl K, Sobel D. Behavioral health and the medical cost offset effect: current status, key concepts and future applications. HMO Pract 1996 Dec; 10(4):156-62.
5. Strosahl K. Building primary care behavioral health systems that work: a compass and a horizon. In: Cummings NA, Cummings JL, Johnson JN, editors. Behavioral health in primary care: a guide for clinical integration. Madison, CT: Psychosocial Press; 1997. p. 37-60.
6. Strosahl K, Baker N, Braddick MB, Stuart M, Handley M. Integration of behavioral health and primary care services: the Group Health Cooperative Model. In: Cummings NA, Cummings JL, Johnson JN, editors. Behavioral health in primary care: a guide for clinical integration. Madison, CT: Psychosocial Press; 1997. p. 61-86.
7. Burnes H. Personal Health Improvement Program. HMO Pract 1995 Jun;9(2):59-60.

Bibliography

Simon GE. Can depression be managed appropriately in primary care. J Clin Psychiatry 1998;59 Suppl 2:3-8.

Kim K, Flaherty J. Integrating psychiatric services into primary care settings: a systems approach. Psychiatr Ann 1997;27:430-5.

Harber JD, Mitchell GE, editors. Primary care meets mental health. Tiburon, CA: CentraLink Publications; 1997.

Be a part of future health systems management discussions

If you would like to be a participant in future discussions covering topics of health care management, contact Lee Jacobs, MD, at 404-364-4781, or via e-mail at lee.jacobs@kp.org.

Upcoming topics:
Winter 1998 issue: Public Image—Kaiser Permanente's Response. A Roundtable Discussion.
Spring 1999 issue: Primary Care Redesign—Sharing of Lessons Learned.