Integrated care is an approach to healthcare that combines, often into one setting, behavioral health, substance abuse, and physical health services, sometimes along with supplemental services such as housing and employment support. Integrated care is important to a recovery-oriented approach because it addresses the whole health of an individual, with the understanding that coordination and collaboration between the many services an individual may use can lead to better outcomes.

This issue of Practicing Recovery explores what integrated care is, how it works, and why it matters for the people you serve. The following resources can help you learn more about how the principles of integrated care apply to your practice.

Agency for Healthcare Research and Quality (AHRQ)
AHRQ’s online Academy for Integrating Behavioral Health and Primary Care offers an “Integration Playbook” as an interactive guide to integrating behavioral health in primary care and other ambulatory care settings. The Playbook is intended for primary care practices working to integrate behavioral health into their settings, but has useful resources for any type of provider interested in learning more about how to integrate care.

Integrated Care Resource Center (ICRC)
The ICRC works with the U.S. Centers for Medicare and Medicaid Services (CMS) Medicare-Medicaid Coordination Office to help states share and learn about best practices for delivering coordinated health care to individuals dually eligible for Medicare and Medicaid. The ICRC helps to design and implement programs that better serve beneficiaries, improve quality, and reduce costs. The website is a great resource for information on understanding how your state and others are implementing and funding integrated care programs.

SAMHSA-HRSA Center for Integrated Health Solutions (CIHS)
The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS)—a collaboration between SAMHSA and the U.S. Department of Health and Human Services Health Resources and Services Administration—is a national training and technical assistance (TA) center that promotes the development of integrated health services. CIHS provides TA and support to SAMHSA Primary and Behavioral Health Care Integration (PBHCI) program grantees, SAMHSA Minority AIDS Initiative-Continuum of Care (MAI-CoC) grantees, HRSA-supported safety-net providers (in particular the Behavioral Health Integration and Substance Abuse Services Expansion awardees) and others with an interest in integrated care. CIHS’s website is rich with information on implementing and financing integrated care programs.
One of the keys to successful integrated care is a coordinated and collaborative team that treats each member and the people it serves with respect and openness. **Hopewell Health Centers**, with 16 locations across southeastern Ohio, has developed such a team and offers a wide range of integrated services, including behavioral health care, dental health care, and primary health care to its communities.

Hopewell was established when a federally qualified health center (FQHC) merged with a community health center to begin offering a more robust constellation of services to the people they served. The co-located services that Hopewell offers to individuals with major mental illnesses include primary care, dental care, and wellness programs such as nutrition, tobacco cessation, and physical fitness. People who receive services at a Hopewell location have the benefit of a shared medical record and shared worksite for providers. Supported by an onsite nurse case manager, people using the services experience a seamless integration of providers to meet their needs.

For example, imagine an individual—Bob—arrives for a routine appointment with a psychiatrist. At the start of the appointment, a nurse takes his vital signs, similar to a typical “medical” appointment. Upon discovering that Bob has elevated blood pressure, the nurse goes down the hall to consult with the primary care staff while Bob meets with his psychiatrist. When Bob leaves the psychiatrist, the nurse takes him to the primary care office to immediately address his high blood pressure. The primary care doctor has full access to Bob’s psychiatric medication record through a shared electronic health record (EHR) and can work with other providers within the integrated care team to address possible causes of the high blood pressure, such as medication side effects, stress, or factors. This internal linkage creates a warm transfer and greatly reduces issues related to missed appointments or poor follow-through on referrals.

This coordination is facilitated by a dedicated team of practitioners that includes physicians, nurses, counselors, and peer support specialists. The key, say Hopewell’s leaders, is hiring doctors who are flexible, engaging, and willing and eager to work with colleagues from all levels of care. The pace in these locations is slower than the standard model of 15-minute medication visits, and scheduling is structured to allow for longer appointments and time for collaboration and consultation among team members.

Hopewell’s integrated care approach is based on their “see a need, fill a need” philosophy. For example, when staff realized individuals needed extra help engaging in physical fitness programs, they worked with a local recreation center to obtain free passes to the gym, organized transportation, and stationed a support person onsite at the center to familiarize people with the gym equipment and environment. When they see that another group in the community is meeting an identified need, Hopewell works to develop or strengthen the relationship and formalize partnerships, such as with a local peer run organization.

Hopewell has begun collecting some outcomes data, and it has found that the integrated care model is improving follow-through on referrals to specialists and, anecdotally, has seen great appreciation for the warm and collaborative team.

**Hopewell is a SAMHSA Primary and Behavioral Health Care Integration (PBHCI) Program** grantee. This program provides support to communities to coordinate and integrate primary care services into publicly funded, community-based behavioral health settings to improve the physical health status of people with mental illnesses and addictions.

*Special thanks to Chief Clinical Officer David Schenkelberg and Chief of Behavioral Health Care Operations Sherry Shamblin for providing information for this article.*

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**LEARN MORE:**

- [SBIRT as a Vital Sign for Behavioral Health Identification, Diagnosis, and Referral in Community Health Care](#)
- [Collaborative care for comorbid depression and diabetes: a systematic review and meta-analysis](#)
- [Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with SMI](#)
- [Understanding the Context of Health for Persons with Multiple Chronic Conditions: Moving From What Is the Matter to What Matters](#)
- [The effect of context in rural mental health care: Understanding integrated services in a small town](#)
Dr. Sue Pickett has spent more than 30 years studying the effectiveness of health services for diverse and underserved populations, including adults with serious mental illness (SMI), at-risk youth, and persons experiencing chronic homelessness. As the associate director for systems transformation and strategic planning at the Illinois Department of Human Services Division of Mental Health, Dr. Pickett worked with state and local agencies to develop data-driven policies to better equip the current system to provide high-quality, community-based primary and behavioral health care to indigent adults and children. In each of these roles—both researcher and policymaker—she has seen first-hand how the advancement of integrated systems of care improves both clinical outcomes and quality of life for individuals with major mental illnesses.

Adults with SMI and substance abuse disorders have higher rates of chronic physical illnesses and die earlier than the general population. They are also at increased risk of many physical illnesses, such as obesity, metabolic syndrome, and HIV/AIDS. And, of course, many psychotropic medications cause physical side effects, such as the higher risk of sudden death from cardiac arrhythmias and other cardiac problems for people who take atypical antipsychotics.

Likewise, having a medical condition is a risk factor for developing a mental health or substance abuse disorder. The same holds true for young people: Recent data from the National Surveys on Drug Use and Health show that asthma, bronchitis, pneumonia, obesity (in females only), and diabetes are associated with past-year major depressive episode (MDE) among adolescents.

While research shows that primary care settings provide about half of all mental health care for common psychiatric disorders, people with SMI may not receive sufficient physical care services. Reasons can range from individual, cultural, logistic, and systemic barriers to care.

What is the solution? Integrated care, according to Dr. Pickett. Integrated care settings consider the whole health and wellness of individuals, taking a “no wrong door” approach to the individuals using services—no matter how someone enters the system of care, a full range of services is available to them. Putting primary, mental health, and substance abuse services all in one convenient location helps address many of the issues an individual may be experiencing, while cutting down on problems related to access, follow-through, and other barriers to care.

Why Integrated Care Matters

- **It can reduce health disparities.** Individuals from racial and ethnic minorities are more likely to seek and receive behavioral health care in primary care settings. Integrating behavioral health and primary care can help close the gap on access to services and treatment for this underserved population.

- **It can improve outcomes.** Recent research found significant reductions in measures of depression among individuals treated in community-based integrated care settings. Study participants also reported “positive experiences with behavioral health clinicians and acquiring new skills to cope with adverse situations at work and home.”

- **It may reduce costs.** Some studies have found that integration of primary and behavioral healthcare can reduce hospital admissions and emergency room visits, thereby reducing overall healthcare costs.

- **People prefer it.** Some research shows that individuals want their primary care settings to also be able to address their concerns around mental health and substance abuse. A pilot project conducted by the Patient Centered Outcomes Research Institute (PCORI) found that community health center patients want mental health services to be available at their own health center, rather than traveling to a different location to receive these services.

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For more information, visit www.integration.samhsa.gov

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**THOUGHT LEADER**

Susan Pickett, PhD, Deputy Director of Research and Evaluation, Advocates for Human Potential
Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

This framework helps provider organizations improve outcomes by helping them understand where they are on the integration continuum.

COORDINATED

KEY ELEMENT: COMMUNICATION

LEVEL 1 Minimal Collaboration

LEVEL 2 Basic Collaboration at a Distance

CO-LOCATED

KEY ELEMENT: PHYSICAL PROXIMITY

LEVEL 3 Basic Collaboration Onsite

LEVEL 4 Close Collaboration Onsite with Some System Integration

INTEGRATED

KEY ELEMENT: PRACTICE CHANGE

LEVEL 5 Close Collaboration Approaching an Integrated Practice

LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice

WHAT YOU CAN DO

START SMALL, BUT THINK BIG

Perhaps you cannot put a primary care office in your community mental health center immediately, but consider the small changes you can make now. Reach out, make connections, and see how you can formalize relationships with primary care providers. One small step could be to make sure you have the correct forms and paperwork to allow sharing of medical records. There are myriad resources that can help.

TALK ABOUT PHYSICAL HEALTH

While some certifying bodies such as Commission on Accreditation of Rehabilitation Facilities (CARF) require full bio-psycho-social assessments, some practitioners can be intimidated by conversations about physical health. Simply regularly checking in on physical health, through the use of checklists or other tools, can help you address the whole health of the individuals you serve. Tools such as motivational interviewing may help the people you serve take steps to address their physical health conditions.

SHIFT YOUR PERSPECTIVE

The team at Hopewell noted that long before they formalized their integrated care model they began focusing on reconnecting “the head to the body.” That means, the entire behavioral health team began changing their thought process from singularly addressing an individual’s mental health needs to considering the whole person—thinking about how someone’s physical, social, and environmental situation is related to their behavioral health issues. This approach is closely aligned with SAMHSA’s principles of recovery.

CONFERENCES & EVENTS

Alternatives Annual Conference 2017

Building Healing Communities Together
August 18-21, 2017, Boston, Massachusetts

The National Empowerment Center, a National Consumer Technical Assistance Center, holds the conference each year to present in-depth technical assistance on peer-delivered services and self-help/recovery methods. Learn more...

SAMHSA Voice Awards 2017

August 16, 2017

University of California, Los Angeles

The SAMHSA Voice Awards are held each year to honor consumer/peer/family leaders and television and film professionals who educate the public about behavioral health. Learn more...

NAADAC, The Association for Addiction Professionals Annual Conference

Elevate your Practice
September 22 – 26, 2017

Denver, Colorado

Learn from researchers, clinicians, educators, and students who share their expertise on the latest innovations, best practices, trends, and issues that impact all addiction professionals. Learn more...