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The Experience of Primary Care Providers With an Integrated Mental Health Care Program in Safety-Net Clinics

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Primary care providers participating in a statewide implementation of an integrated mental health care program for "safety-net" patients in primary care clinics were surveyed to elicit their experiences and level of satisfaction. Quantitative analyses were performed to identify respondent characteristics and satisfaction with the program. Qualitative analyses were done to identify common themes in response to the question "How could psychiatric consultation [in the program] be improved?" Primary care providers were generally satisfied with the integrated mental health care program and raised several concerns that suggest important principles for successful future implementations of these types of programs. **Key words:** *care manager, integrated care, primary care, safety net*

THE MAJORITY of mental health care in the United States is delivered in primary care settings.[1] Primary care providers (PCPs) who serve safety-net populations increasingly provide mental health care for patients with a wide range of mental health presentations and diagnoses,[2,3] particularly in community health clinics (CHCs).[2] Access to specialty mental health care is limited for this population, especially in rural and urban underserved areas and many safety net patients prefer treatment for common mental health problems such as depression and anxiety in primary care where they seek help for their other health related problems. The reimbursement, regulatory, administrative, and clinical structures of CHCs and community mental health centers (CMHCs) can be significant barriers to effective integration of care for safety-net

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patients with both physical and mental health needs.[4,5] One answer to this problem is effective "integration" of evidence-based services for patients with common mental health disorders in CHCs.[3,6,7]

Collaborative care is a particular form of integrated behavioral health care that has been demonstrated in more than 70 randomized controlled trials as more effective than usual care for patients with depression.[8,9] This approach has also been established as an effective way to treat primary care patients with a range of anxiety disorders.[10-12] Collaborative care includes integration of a designated mental health care coordinator (CC) in primary care settings to support PCPs treating patients with common mental disorders such as depression and anxiety and to systematically track outcomes of mental health interventions. This team of PCP and CC in primary care is supported by a designated consulting psychiatrist (CP) who provides regular, systematic caseload review to CCs and clinical decision support to PCPs, focusing on patients who are not improving.[4,8,13-17] Results of a survey with more than 450 PCPs who participated in the largest trial of collaborative care to date suggest high levels of PCP satisfaction with this type of care.[18]

The Washington State Mental Health Integration Program (MHIP), funded by the state of Washington with additional funding support by Public Health Seattle and King County, integrates mental health screening and treatment into primary care settings serving safety-net populations in CHCs across the state of Washington,[19] and utilizes the described model of collaborative care to integrate mental health. Started in 2008, the MHIP is now active in more than 140 CHCs throughout the state of Washington. Care is provided through a collaborative team approach including a PCP who refers patients to the program and retains primary responsibility for the medical and mental health care for patients, a designated CC at each CHC location, and a CP (Figure 1).

Each CC has regular phone consultation with his or her assigned CP to review a caseload of patients and develop treatment recommendations including medication management, psychosocial support, and brief psychotherapeutic interventions. All MHIP patients and recommendations are tracked in a Web-based registry tool, the Mental Health Integrated Tracking System, which was adapted from an earlier multisite research study of collaborative care.[20] The CC is responsible

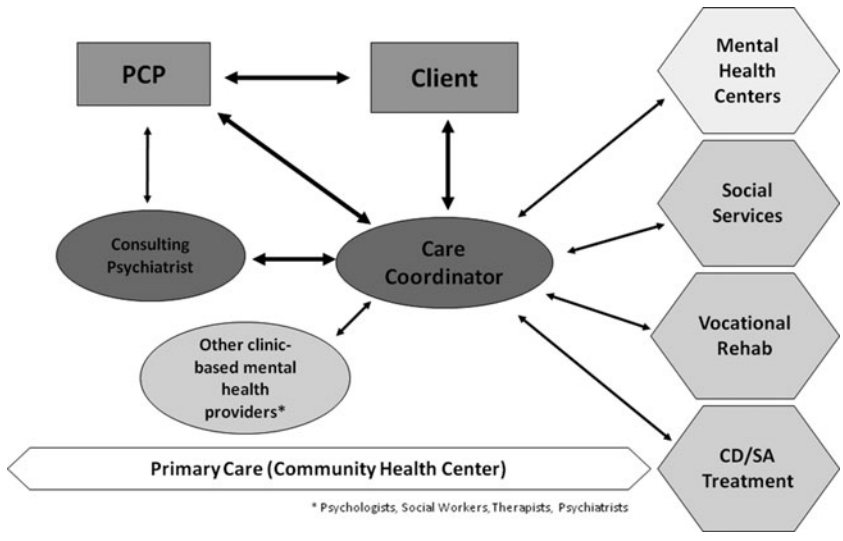

Figure 1. Collaborative care team. PCP indicates primary care provider; CD/SA.

for placing a copy of these recommendations in the patient's medical record and discussing these recommendations directly with the PCP when appropriate. The PCP may access additional clinical advice/decision support directly with the CP by telephone, by e-mail, or if available, in person. The PCP is responsible for prescribing and monitoring all psychotropic medications. Patients who are too challenging to be managed in primary care are referred a partnering CMHC for additional care. Since implementation in 2008, more than 35,000 individuals have received mental health services through the MHIP.

In this study, we report the experience of more than 80 PCPs who participated in MIPH implementation for at least 6 months. We examined PCPs' perceptions of and satisfaction with (*a*) access to and quality of psychiatric support for their patients via the MHIP, (*b*) treating patients with a range of psychiatric diagnoses, and (*c*) access to and quality of resources available to support PCPs via the MHIP. We present the results of quantitative analyses of respondent satisfaction and qualitative analyses of perspectives provided by response to the open-ended question: "How could psychiatric consultation in the MHIP be improved?" To our knowledge, this is the first study to examine and report PCP experiences with an integrated mental health care program designed to address a broad range of psychiatric illnesses in primary care clinics working with safety-net patients.

METHODS

Survey instrument development and dissemination

The survey used in the study was based on a previous survey to assess PCP satisfaction with collaborative care in the largest randomized controlled trial of collaborative for depression which was performed in 18 primary care clinics in 5 states.[18] This survey was modified via consensus by the physician investigators to elicit information about the MHIP, to identify specific quality improvement targets, and to learn more about the training needs of PCPs. The components assessed included engagement with CPs, feedback about CP notes/communication, and satisfaction with the resources provided by the program relative to resources available in the community. Survey responses were assessed using a 5-point Likert scale. For example, survey questions about provider satisfaction with the MHP program ranged from 1 (very satisfied) to 5 (very dissatisfied).

The survey was distributed electronically to the clinic managers of all CHCs that had implemented the MHIP for at least 6 months; managers were responsible for distributing the survey to their eligible PCPs. Each survey was anonymous, but the name of the clinic was recorded. Responses were collected from August 2010 to January 2011. Responses were obtained from a total of 87 primary care providers in 25 clinics throughout the state of Washington.

Quantitative analysis

Providers were grouped into independent practitioners (MD/DO) and mid-level providers (NP/PA/Other) as these groups have different levels of training and may express different perspectives working in an integrated mental health care program. Sample characteristics and responses to survey items were summarized, using χ^2 analysis for categorical measures and analysis of variance for continuous measures for subgroup comparisons. The significance level for these comparisons was set at $P < .05$.

Qualitative analysis

Participants answered an open-ended question: "How could the psychiatric consultation in the MHIP be improved?" The research team analyzed the compiled written responses. First, team members individually open-coded the written texts for the respondents. The team subsequently met as a group and reviewed, refined, and synthesized the codes into themes.

RESULTS

Quantitative analysis

Eighty-seven providers completed the survey. Thirty-four percent identified themselves as either a primary care nurse practitioner, physician assistant, or other type of PCP (NP/PA/Oth); 66% identified themselves as medical or osteopathic physicians (MD/DO). There were significantly ($P = .005$) more females (71%) in the overall sample, with the greatest proportion of female providers among the NP/PA/Oth group (90%). There were no significant differences in age groups between MD/DO and NP/PA/Oth providers. A greater proportion of MD/DO providers (67%) graduated from training before 2001 than NP/PA/Oth providers (50%).

The majority of PCPs surveyed (62%) were either "very satisfied" or "somewhat satisfied" with the resources currently available in their practices to treat patients with mental health concerns who are enrolled in the MHIP. This is in contrast to patients who were not enrolled in the MHIP (care as usual). For those patients, the majority of PCPs surveyed (57%) were either "somewhat dissatisfied" or "very dissatisfied" with the resources currently available to treat patients with mental health concerns (Figure 2). MD/DO and NP/PA/Other providers answered these survey questions similarly.

The majority of PCPs surveyed (82%) found psychiatric consultation provided by MHIP CPs and care managers for their patients with mental health concerns to be "very helpful" or "somewhat helpful," and there was no significant difference in this assessment between MD/DOs and NP/PA/Oth providers ($P = .788$).

Most providers (91%) reported having some form of direct communication with their MHIP psychiatric consultants; a greater proportion of MD/DO providers (95%) reported having had communication with their MHIP psychiatric consultant than the proportion of NP/PA/Oth providers (83%). The majority of providers (84%) also reported receiving psychiatric consultation recommendations, and most providers (82%) reported receiving psychiatric notes in time to facilitate patient care.

The largest proportion of PCPs surveyed (46%; $P = .043$) reported preference for consultation notes to communicate recommendations from CPs. Only 5% of providers reporting preference for direct telephone contact with the psychiatric consultant (Figure 3).

Also, the majority of PCPs (86%) surveyed expressed a preference for having medication recommendations, located within consultation notes, and to include recommendations for alternative medication regimens, with details on titration, side effects, and monitoring parameters. There was no significant difference in this preference between MD/DO and NP/PA/Oth providers ($P = .314$).

Qualitative analysis of survey comments revealed 5 themes related to the challenging

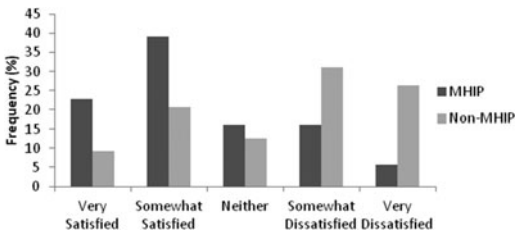

Figure 2. Respondent satisfaction. MHIP indicates Mental Health Integration Program.

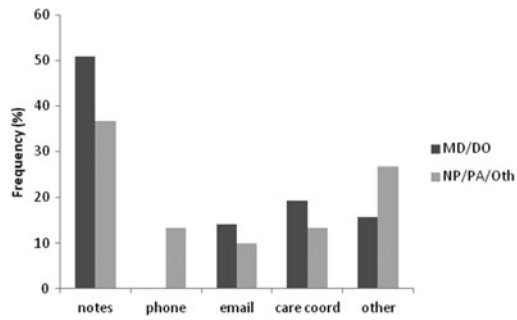

Figure 3. Respondent preferences for communication of recommendations. MD/DO indicates medical or osteopathic physicians; NP/PA/Oth, primary care nurse practitioner, physician assistant, or other type of primary care provider; care coord, care coordinator.

aspects of managing patients with psychiatric problems in the primary care setting (Table 1). Themes 1 to 3 relate to PCP experience of psychiatric complexity of this population, and themes 4 and 5 relate to specific process and workflow in the MHIP.

Provider comments focused on concerns and needs of PCPs caring for patients with complex mental health problems and specific suggestions for how to improve the program.

Theme 1: Desire for increased mental health resources for some patients

Much of the literature that exists regarding effectiveness of collaborative care programs is based on studies of patients with major depressive disorder and anxiety disorders.[22] The MHIP was designed to manage a broader range of psychiatric illnesses in CHCs to include patients with more severe mental disorders such as bipolar disorder, patients with histories of severe trauma and related posttraumatic

Table 1. Themes Identified From Qualitative Analyses of PCP Responses

Theme	Quote
Theme 1. Desire for increased mental health resources for some patients	"I would like there to be the availability of in-office consultation and some ongoing med. management for the most complex cases."
Theme 2. Desire for more direct patient access to specialty psychiatric care	"Many of our patients need psychiatric care that is outside of the scope of Family Medicine . . . . There is concern amongst my peers that we resent having to be responsible from a liability standpoint of prescribing meds suggested by the psychiatrist for conditions and medications we do not feel that comfortable prescribing."
Theme 3. Concern that management of psychiatric care in primary care is "out of scope" of practice of PCPs in the CHC setting	"Our patients are complex: usually multiple Axis I and II at same time; these patients should not be managed in primary care; in the future I recommend an office based psychiatrist once per week at all the clinics to see these complicated pts and co-manage them on site; many of the pts cannot get into the level II clinics . . . for months."
Theme 4. Desire for more PCP education and training in this model of mental health care	"Provide more teaching to clinicians, especially new ones in the program." "It's a great program and very useful. Could be associated with more provider education."
Theme 5. Suggestions for improving the workflow, specifically communication of providers in the integrated care program	"Communication between myself and [care] coordinators at another site is not good. Often I don't receive the recommendations at all and only find out that they exist when I call psychiatrist for assistance." "Patients need to be seen/staffed much sooner after being seen by the medical PCP (not weeks out) and we need increased capacity for diagnosing and medication management."

Abbreviations: CHC, community health clinic; PCP, primary care provider.

stress disorder, patients with mental health and comorbid alcohol and substance abuse problems, and patients with histories of traumatic brain injury. In addition to these behavioral health problems, clients served in the MHIP have significant life stressors, social problems, and a range of medical problems. Management of this level of psychiatric complexity can be challenging even for experienced mental health specialists and so it is not surprising that PCPs in this program felt that they need additional access to specialty mental health care for some of their more challenging clients.

Recognizing this complexity at the time of implementation, the MHIP was designed with 2 levels of care: level 1, management in primary care setting with a collaborative care team composed of CC, CP, and PCP; and level 2, CC support of care in a CMHC, with access to direct care and services with a prescribing psychiatric specialist. In the more rural or remote areas of Washington State, access to CMHCs and specialty mental health services can be limited. Even in urban areas where there are CMHCs to refer patients to, it is not always easy to refer patients to such programs, in part because patients prefer to receive their care in a CHC and in part because effective communication between specialty providers in a CMHC and PCPs in a CHC can be a challenge.

Theme 2: Desire for more direct patient access to specialty psychiatric care

The typical primary care setting is not designed for the longer-term management of complex psychiatric illnesses, and PCPs have historically relied on a traditional consultation model to get the specialty needs of their patients met. At the same time, access to psychiatric specialists, particularly in outlying areas of the state, is extremely limited, if not nonexistent. Across the country, significantly more patients with diagnosable mental health problems receive care from PCPs than from mental health specialists.[1] Most prescriptions for psychotropic medications are written by PCPs, and there simply are not enough prescribing mental health specialists to meet the demand for care, especially in underserved areas. This is a clear source of frustration for PCPs and has been summarized effectively in a recent survey of PCPs in which two-thirds of the respondents expressed poor satisfaction with the availability of specialty mental services for their clients.[23]

The goal of integrated care programs such as MHIP is to bridge this access gap by effectively leveraging and amplifying limited psychiatric specialty resources through use of behavioral health CCs and through CPs systematically reviewing panels of patients treated in primary care and focusing their consultation on patients who are particularly challenging or not improving as expected. This aspect of integrated care is inherently different than a traditional consultation and referral model, where many psychiatric aspects can happen out of the immediate awareness of the referring PCP. So, for those PCPs used to the traditional consultation model, this approach where a specialist consultant supports them in prescribing psychotropic medications can be initially unsettling. There is no doubt that some CHC MHIP patients require treatment in specialty mental health settings, and up to 20% of the patients identified in primary care are eventually referred and treated in a CMHC. On the contrary, the experience with the MHIP has taught us that with close tracking of clinical outcomes and weekly support from a CP, PCPs can over time improve their capacity to manage even moderately complex patients with comorbid medical and mental health problems. When this is successful, it results in patient-centered care that can improve both patient and provider satisfaction.

As opposed to a traditional consultation model where the PCP sends the patient to a mental health specialist for a consultation and recommendations for care come back to the PCP, the MHIP offers the PCP the advantage of having a trained CC in the office. This CC can follow-up on and support changes in treatment and regularly update treatment

recommendations during weekly caseload review session with the CP who is available to discuss a patient with the treating PCP if there are concerns or questions.

A few surveyed PCPs raised concerns about their "liability risk" associated with treating patients with mental health disorders. If well implemented, an effective collaborative care program should reduce this risk compared with care as usual, because the patient is closely tracked by a CC who has ready access to a CP if patients are not improving as expected, a level of care that is well above the most common scenario in which PCPs are treating patients without such structured and systematic support. Also, it is worth reiterating that physicians/care teams that actively address mental health issues (particularly suicide risk) and document risk assessments/treatment are far less likely to be named in lawsuits.[24]

Theme 3: Concern that management of psychiatric care in primary care is "out of scope" of practice of PCPs in the CHC setting

Originally designed and tested for primary care patients with depression and other common mental disorders, the MHIP program was implemented in primary care clinics that also encounter patients with more severe and persistent mental disorders. This raised concerns among some of the providers surveyed about the adequacy of the program to address the needs of such complex patients.

Recognizing the complexity and severity of illness for many of the patients seen in the MHIP and these concerns raised by providers, MHIP CPs who are reviewing patients with a CC may recommend direct examination of a patient by the CP either in person or using videoconference technology. In such cases, the CP has the advantage of approaching these consultations with a significant amount of information already gathered by and discussed with the CC. This provides important collateral information that is often not available in a traditional psychiatric consultation, and it can also improve the efficiency and effectiveness of these consultations. In programs that care for a patient population with complex mental health problems such as MHIP, this blended collaborative care model is probably ideal. After an in-person consultation, CPs may identify that some patients have needs for care that cannot be safely met in a primary care setting even with a collaborative care team and that should be referred for such additional services to a CMHC (level 2 care in the MHIP).

Theme 4: Desire for more PCP education and training in this model of mental health care

Respondents expressed a desire for more training and education, suggesting that the PCPs generally liked the MHIP (Figure 3), and expressed more interest in the MHIP, once they understood how it works. This is supported by several respondent comments requesting increased education and training related to the MHIP itself (Table 1). This is in line with previous studies indicating that PCP "buy-in" and support of integrated mental health care programs increased once they recognized positive outcomes in their patients.[18]

In the MHIP, PCPs are encouraged to use CPs as a resource for any questions or concerns regarding care of their patients in the program. Consulting psychiatrist also include contact information (pager number, e-mail) at the end of all written recommendations forwarded to PCPs. Both CCs and PCPs have direct access to CPs (telephone, pager, e-mail), and while CCs discuss patients with CPs on a regular basis (weekly case reviews), PCPs rarely contact CPs directly, even when they are reminded with every note that they have such access to their consultant. The exception is in situations where the PCP is confronted with an urgent or emergent patient situation in the office; this is where PCPs are most likely to contact CP directly for recommendations/advice, particularly regarding psychiatric triage or urgent medication decision making. It is the authors' experience that successful management and PCP support in

these situations quickly build PCP trust and endorsement of the program.

This qualitative analysis also highlights the expanded role of the CP in this model. As compared with the traditional consultation model, in the collaborative care model, CPs can have a significant amount of contact with PCPs, allowing for broadening and deepening of liaison role. Consulting psychiatrists in the MHIP are responsible for the management of a population of patients, while also being responsible for the support of a group of CCs and their associated PCPs, which presents several opportunities for expanding CP role as an educator, not only about the program but also by way of didactic education about the nature and management of psychiatric disorders. As a result, it has been the authors' experience in the MHIP that, over time, the knowledge and skill levels for managing common psychiatric illnesses of participating PCPs are substantially increased.

Theme 5: Concerns about process and workflow of communication in integrated care

In daily practice, PCPs are pressed for time, especially in CHCs and other safety-net settings.[25] Because of this, PCPs want useful information that is practical and directly relevant to care of their patients. This may be a reason that PCPs in general in this survey expressed preference for clinical notes for communication of recommendations in the MHIP and why MD/DOs, in particular, expressed no interest in phone communication with consultants in this model (Figure 3).

Effective and timely communication among providers is critically important to make a collaborative care program work well. It is crucial for timely implementation of care recommendations. As shown in Figure 1, CCs based in primary care have an important role in coordinating and facilitating communication between providers for a substantial caseload of patients followed in primary care. Care coordinators must develop skills in screening, diagnostic, and intervention skills, how to effectively use electronic medical record/registry systems, and develop methods for communicating effectively and efficiently with CPs and PCPs.

The integrated mental health care team approach to psychiatric management has been said to dissolve barriers to effective and efficient communication between physician and nonphysician providers.[26] Successful CC navigation of local barriers to communication is critical to the success of a program such as MHIP. It is not unusual for CCs to be confronted with PCPs who present a communication challenge, particularly if those same PCPs are initially resistant to participation in an integrated care model and holding to preference for a traditional consultation/referral model to access psychiatric care for their patients. Effective training of CCs, PCPs, and CPs in collaborative care should anticipate such communication challenges and offer (*a*) specific skills building by CCs in identifying communication preferences of the PCPs they support, (*b*) support to assist CCs in advertising and promoting their role to PCPs in their assigned CHCs, and (*c*) program administrative support to help troubleshoot and resolve persisting challenges.

DISCUSSION

Quantitative analysis

Compared with mental health services for their patients not enrolled in the MHIP, PCPs surveyed were more satisfied with the integrated services in the MHIP than with the usual referral services available for patients not in the program. Primary care providers found the recommendations generated by CC and CP case reviews for patients enrolled in the MHIP helpful and timely.

In their survey of 4720 physicians, O'Malley and Reschovsky[21] found that physicians who report using health information technology to support patient care, having adequate time for patient care encounters, and making use of a nurse care manager to help treat chronic medical conditions also reported higher

interspecialty communication with their consultants, particularly in the receipt of consultant reports. The MHIP contains all 3 of these elements, including increased time from clinic-based care coordinators who can provided additional assessment, patient education, and treatment.

Implications for future implementations

On the basis of the themes identified from this survey, 3 areas emerged to address in future implementations (Table 2). First, providers need clear orientation about the program including information about patients who should be treated in primary acre and those who need specialty mental health treatment. Second, developing a defined workflow can facilitate integrated care. Third, education using both informal and formal approaches is an appreciated benefit of integrated care. These concepts could be applied in any future implementation of integrated care programs.

Limitations

This study was conducted in the context of the MHIP, a statewide quality improvement effort. There are some limitations. First, not all of the PCPs who participated in the MHIP completed the survey, so the perspectives offered are not necessarily generalizable to the entire population of PCPs participating in the program. Second, there was no control group representing PCPs who were not participating in the MHIP, so there is no way of knowing if some of the perspectives offered are particular to participation in the MHIP or represent general attitudes about management of mental health needs in primary care. Third, while the survey sought to identify challenges with the MHIP by specifically asking how the program could be improved, it would have been helpful to specifically ask what aspects of the program are working well for PCPs. Not asking this is a missed opportunity, for highlighting and reinforcing aspects of the program are working for participating PCPs. Despite this oversight, however, PCPs were able to report overall satisfaction with the program compared with other available programs in their clinics.

CONCLUSIONS

Using a mixed-methods approach, this study demonstrates that PCPs were generally

Table 2. Guidelines to Improve PCP Experience of Collaborative Care

Orientation	Clear orientation to strengths and limitations of resources available in collaborative care program
	Guidance on which patients would be eligible for and how to access more intensive treatment (eg, direct assessment, referral to community mental health centers)
	Foster the concept that the psychiatric consultant will be available to support the primary care team
Defined workflow	Clear protocols for timely communication between team members
	Consider using the formal team-building process, such as the tools available at http://uwaims.org
Education	Leverage the consulting psychiatrist as a resource for both formal teaching sessions (in clinic sessions) and informal education through notes and support calls
	Make sure all PCPs have easy access to consulting psychiatrist contact information

Abbreviation: PCP, primary care provider.

more satisfied with services offered through the integrated care program than with resources available to them under care as usual. Several of the themes identified by the qualitative analysis highlight the challenges PCPs face when dealing with patients who have complex mental health, substance abuse, and psychosocial problems. They also provide useful suggestions to those hoping to implement effective integrated care programs (Table 2). Proactively addressing these concerns of PCPs could help facilitate PCP comfort with the program and support successful implementation of integrated mental health care programs in primary care settings in the future.

REFERENCES

1. Wang PS, Demler O, Olfson M, Pincus HA, Wells KB, Kessler RC. Changing profiles of service sectors used for mental health care in the United States. *Am J Psychiatry.* 2006;163:1187-1198.
2. Druss BG, Bornemann T, Fry-Johnson YW, McCombs HG, Politzer RM, Rust G. Trends in mental health and substance abuse services at the nation's community health centers: 1998-2003. *Am J Public Health*. 2006;96:1779-1784.
3. Vannoy SD, Mauer B, Girn K, Ingoglia C, et al. CHCs to support integration of behavioral health and general medical care. *Psychiatr Serv*. 2011;62:753-758.
4. Thielke S, Vannoy S, Unutzer J. Integrating mental health and primary care. *Prim Care Clin Office Pract.* 2007;34:571-592.
5. Kilbourne AM, Irmiter C, Capobianco J, et al. Improving integrated general medical and mental health services in community-based practices. *Adm Policy Ment Health.* 2008;35:337-345.
6. Zeiss AM, Karlin BE. Integrating mental health and primary care services in the Department of Veterans Affairs health care system. *J Clin Psychol Med Settings*. 2008;15:73-78.
7. Kates N, McPherson-Doe C, George L. Integrating mental health services within primary care settings: the Hamilton Family Health Team. *J Ambul Care Manag*. 2011;34(2):174-182.
8. Gilbody S, Bower P, Fletcher J, et al. Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. *Arch Intern Med.* 2006;166:2314-2321.
9. Thota AB, Sipe TA, Byard GJ, et al. Collaborative care to improve the management of depressive disorders: a community guide systematic review and meta-analysis. *Am J Prev Med*. 2012;42(5):525-538.
10. Roy-Byrne P, Craske MG, Sullivan G, et al. Delivery of evidence-based treatment for multiple anxiety disorders in primary care: a randomized controlled trial. *JAMA.* 2010;303(19):1921-1928.
11. Katon WJ, Lin EHB, Von Korff M, et al. Collaborative care for patients with depression and chronic illnesses. *N Engl J Med.* 2011;363(27):2611-2620.
12. Bauer AM, Azzone V, Goldman HH, et al. Implementation of collaborative depression management at community-based primary care clinics: an evaluation. *Psychiatr Serv.* 2011;62:1047-1053.
13. Unutzer J, Katon W, Callahan CM, et al. Collaborative care management for late-life depression in the primary care setting: a randomized controlled trial. *JAMA*. 2002;288(22):2836-2845.
14. Neumeyer-Gromen A, Lampert T, Stark K, Kallischnigg G. Disease management programs for depression: a systematic review and meta-analysis of randomized controlled trials. *Med Care*. 2004;42:1211-1221.
15. Alexopoulos GS, Katz IR, Bruce ML, et al. Remission in depressed geriatric primary care patients; a report from the PROSPECT study. *Am J Psychiatry*. 2005;162:718-724.
16. Bower P, Gilbody S, Richards D, et al. Collaborative care for depression in primary care: making sense of complex intervention: systematic review and meta-regression. *Br J Psychiatry.* 2006;189:484-493.
17. Katon W, Unutzer J. Collaborative care models for depression: time to move from evidence to practice. *Arch Intern Med*. 2006;166:2304-2306.
18. Levine S, Unutzer J, Yip JY. Physician's satisfaction with collaborative disease management program for late-life depression in primary care. *Gen Hosp Psychiatry*. 2005;27:383-391.
19. Unutzer J, Chan Y-F, Hafer E, et al. Quality improvement with pay-for-performance incentives in integrated behavioral health care [published online ahead of print April 19, 2012]. *Am J Pub Health*. 2012;102:e41-e45. doi:10.2105/AJPH.2011.300555.
20. Unutzer J, Choi Y, Cook IA, Oishi S. A Web-based data management system to improve care for depression in a multicenter clinical trial. *Psychiatr Serv*. 2002;53(6):671-678.
21. O'Malley AS, Reschovsky JD. Referral and consultation communication between primary care and specialist physicians: finding common ground. *Arch Intern Med*. 2011;171(1):56-65.
22. Woltman E, Grogan-Kaylor A, Georges H, Perron B, Kilbourne AM, Bauer MS. Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: Systematic

review and meta-analysis. *Am J Psychiatry*. 2012; 169:790-804.
23. Cunningham PJ. Beyond Parity: Primary Care Physicians' perspectives on access to mental health care. *Health Aff*. 2009;28(3):w490-w501.
24. Roberts AR, Monferrari I, Yeager KR. Avoiding malpractice lawsuits by following risk assessment and suicide prevention guidelines. *Brief Treat Crisis Interv*. 2008;8(1):6-14.
25. Fiscella K, Epstein RM. So much to do, so little time: care for the socially disadvantaged and the 15-minute visit. *Arch Intern Med*. 2008;168(17): 1843-1852.
26. Bentham W, Vannoy SD, Badger K, Wennerstrom A, Springgate BF. Opportunities and challenges of implementing collaborative mental health care in post-Katrina New Orleans. *Ethn Dis*. 2011;18(suppl): S30-S37.