Annotated bibliography, 4/09- to be updated and searchable version on our website summer 09. All resources available through OCCIC. Please contact Jonas Thom 513-458-6733 jthom@healthfoundation.org

Model Programs Training & Education	Wulsin, L. R. (1996). An agenda for primary care psychiatry. *Psychosomatics, 37*:2, 93-99. Overview This article defines a new niche in the psychiatry: primary care psychiatry. The author also reviews existing clinical and academic projects to identify the elements of primary care psychiatry and discusses training models in the field.
Model Programs Policy	Brazelon Center for Mental Health Law. (2004). *Get it Together: How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders.* Available online at: http://www.bazelon.org/issues/mentalhealth/publications/getittogether/ Overview This paper summarizes the findings from existing research regarding primary care & mental health integration. It examines model programs for integrating care, and offers recommendations for future programs.
Business Case Policy	Ohio Department of Mental Health. (2005). *Mental Health: The Business Case. Treatment Works . . . People Recover.* Available online at: http://www.dmahealth.com/Reports/Business%20Case%20MH%20fin%209%201%2005.pdf Overview This paper outlines the benefits of increasing support for mental health services in Ohio. It defines and describes the areas of need for mental health treatment and presents public cost of metal illness. The paper also calculates the potential financial savings from improving access to mental health care
Model Programs Policy	Health Policy Institute of Ohio, The. (2007). *Directions in Mental Health and Primary Care Integration in Ohio*, Columbus, OH: Author. Available online at: http://www.healthpolicyohio.org/publications/mentalhealthintegration.html Overview Uses a literature review and interviews with key stakeholders to examine the integration of mental health and primary care in Ohio. The paper also identifies barriers/opportunities at the state, regional and county levels, characteristics shared by successful projects and policy issues related to integrated models in Ohio.
Policy	Health Policy Institute of Ohio, The. (2009). *Ohio Medicaid Basics 2009,* Columbus, OH: Author. Available online at: http://www.healthpolicyreview.org/daily_review/2009/02/hpio-releases-ohio-medicaid-basics-2009.html Overview This article describes Medicaid programs in Ohio, and presents a review of current issues in 2009.

Business Case	Partnership to Fight Chronic Disease. An Unhealthy Truth (Presentation). <u>Overview</u> Provides statistics to dispel myths about health and chronic disease
Child: Trauma & Health	Ohio Childhood Trauma Task Force. (2006). Letting the Light Sine Through: Shining the Light on Childhood Trauma in Ohio. Published by the Ohio Department of Mental Health. <u>Overview</u> Reviews the work of the Childhood Trauma Task Force and presents a strategic plan to address chidhood trauma in Ohio. Contains information on the long-term implications of childhood trauma, which include higher incidence of health problems and mental illness.
Children: Policy Issues Health: Oral health	Grantmakers in Health. (2008). Critical Services for Our Children: Integrating Mental and Oral Health into Primary Care. Issue Brief 30. Available online at: http://www.gih.org/info-url2678/info-url_show.htm?doc_id=670339 <u>Overview</u> Discusses barriers in the current model for the delivery of mental and oral health services to children. This article also reviews possible program and policy solutions to allow for more integrated care.
Children: Policy Issues	Schwartz, S. & Glascock, M. (2008). Improving Access to Health Coverage for Transitional Youth. Published by the National Academy for State Health Policy. Available online at: http://www.nashp.org/_docdisp_page.cfm?LID=238837C8-EE54-4919-B5CEB02BFC0F9D20 <u>Overview</u> This paper focuses on young adults who are transitioning out of foster care and the juvenile justice system. It provides demographic information about transitional youth, describes the barriers that they face in accessing healthcare. The paper then identifies "key transition points" in the foster care and juvenile justice systems, which can present challenges and opportunities to connect youth to health services. Finally, the paper suggests improvements and policy changes to Medicaid that may promote the enrollment and retention of youth.
Children: Trauma & Health	Teplin, L., McClelland, G. M., Abram, K. M. & Weiner, D. A. (2005). Crime victimization in adults with severe mental illness: Comparison with the national crime victimization study. *Archives of General Psychiatry, 62*:8, 911-921. <u>Overview</u> This article compares the responses of 936 clients of 16 mental health agencies to those of the general population on the National Crime Victimization Survey. This is the first known wide-scale study of the prevalence, incidence and patterns of victimization among individuals with severe mental illnesses. The study found that, when compared to the general population, individuals with severe mental illnesses were significantly more likely to report being victim to violent crime, personal theft, and rape.

Children: Trauma & Health	Norris, F. H. (1992). Epidemiology of trauma: Frequency and impact of different potentially traumatic events on different demographic groups. *Journal of Consulting and Clinical Psychology, 60*:3, 409-418. <u>Overview</u> Examined the frequency and perceived impact of 10 potentially traumatic events in a sample of 1,000 adults. The authors found that 69% of the sample had experienced at least one of the events, with 21% experiencing one in the past year. The authors found that sexual assault yielded the highest rate of post-traumatic stress disorder. Responses also indicated that people become less susceptible to PTSD as they get older.
Children: Trauma & Health	Anda, R. F., Felitti, V. J., Bremner, D., Walker, J. D., Whitfeld, C. Perry, B. D., Eube, S. R., & Giles, W. H. (2005). The endiring effects of abuse and related adverse experience in childhood: A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience, 256*, 174-186. <u>Overview</u> This study used the Adverce Childhood Experiences Study to evaluate the relationship between childhood trauma and 18 outcomes in the affective, somatic, substance abuse, memory, sexual and aggression domains. Researchers found that difficulties in the outcomes increased with the number of adverse childhood experiences reported.
Health: Obesity	Parks, J., Radke, A. Q. & Ruter, T. (2008). Obesity reduction & prevention strategies for individuals with serious mental illness. Published by the National Association of State Mental Health Program Directors (NASMHPD) Medical directors Council. Available online at: http://www.nasmhpd.org/publicationsmeddir.cfm <u>Overview</u> This report was developed by NASMHPD to explore and address issues related to obesity among individuals with severe mental illnesses. The report explores the rates and causes of obesity among individuals with SMI, and describes programs and intervention that prevent obesity or decrease weight in this population. The program also makes policy recommendations to improve the systems of care for the SMI population at the national, state and local levels.
Health: Diabetes	Frayne, S. M., Halanych, J. H., Miller, D. R., Wang, F., Lin, H., Pogach, L., Sharkansky, E. J., Keane, T. M., Skinner, K. M., Rosen, C. S., Berlowitz, D. R. (2005). Disparities in diabetes care: Impact of mental illness. *Archives of Internal Medicine, 165*, 2631 – 2638. <u>Overview</u> This study used the medical records of more than 300,000 Veterans Health Administration patients to explore the quality of diabetes care. Researchers found that patients who were diagnosed with mental health disorders were less likely to meet diabetes performance measures than those with no mental health diagnosis.

Health: Diabetes Health: Hypertension	Nasrallan, H. A., Meyer, J. M., Goff, D. C., McEvoy, J. P., Davis, S. M., Stroup, T. S., & Lieberman, J. A. (2006). Low rates of treatment for hypertension, dyslipidemia and diabetes in schizophrenia: Data from the CATIE schizophrenia trial sample at baseline. *Schizophrenia Research, 86*, 15-22. Overview This study used the baseline data of patients admitted into a separate study to examine the prevalence of diabetes, hyperlipidemia and hypertension, and the percentage of those individuals receiving appropriate treatment at the time of enrollment. Rates of non-treatment among those diagnosed with medical problems were high: 62.4% were not being treated for hypertension and 88% were not being treated for hyperlipidemia. While rates of non-treatment in those with diabetes were also quite high (approximately 30%), this is not significantly different from rates in community samples. The authors concluded that this research provides "further evidence that improvements in health screening and monitoring of this population are necessary."
Health: Diabetes	Cohen, M. (2007). Medicaid and the uninsured: An overview of Medicaid enrollees with diabetes in 2003. Published by the Kaiser Family Foundaiton. Available online at: www.kff.org/medicaid/7700.cfm Overview This report uses data reported to the federal government through the Medicaid Statistical Information System (MSIS) to examine how individuals with diabetes use Medicaid coverage. The results indicate that Medicaid enrollees use significantly more acute care services than those without diabetes, and that nearly 1/3 of Medicaid enrollees with diabetes were also diagnosed with a mental illness. The report draws conclusions and makes policy recommendations based on its findings.
Business Case Policy	Garske, G. G. (1999). The financial costs of severe mental illness. *The Journal of Rehabilitation, 65*. Overview Reviews the costs related to severe mental illness in the U.S. and outlines clinical and policy implications.
Health: Diabetes	American Diabetes Association. (2008). Direct and indirect costs of diabetes in the United States. Accessed online at: http://www.diabetes.org/diabetes-statistics/cost-of-diabetes-in-us.jsp Overview Provides information regarding the cost of diabetes in the U.S., including the cost of medical expenditures and indirect costs.
Health: Diabetes	HealthDay News. (2004). Mentally ill susceptible to diabetes: Report recommends close monitoring to manage risk. Accessed online at: http://www.14wfie.com/Global/story.asp?S=1624212 Overview: News article discussing a research report that indicates that individuals with severe mental illnesses are nearly four times more likely to develop diabetes than members of the general population. The report was published as a supplement in the December 2003

	volume of *Postgraduate Medicine*
Health: Oral Health	Knapp, L. S. (2008). Medication, devastation, tooth preservation: A call to action. *NAMI Voice, 15* (October 2008), p 4. Accessed online at: http://www.nami.org/Template.cfm?Section=Annual_Report_Ratings&Template=/ContentManagement/ContentDisplay.cfm&ContentID=42535 Overview: This article discusses the importance of oral health in patients with SMI, as well as the relationship between medications for SMI and tooth decay.
Health: Cardiovascular	Hennekens, C. H. (2007). Increasing global burden of cardiovascular disease in general populations and patients with schiziophrenia. *Journal of Clinical Psychiatry, 68*, suppl. 4. Overview Describes the incidence and risk factors for coronary heart disease among patients with schizophrenia.
Health: Cardiovascular	Kaplowitz, R. A., Scranton, R. E., Gagnon, D. R., Cantillion, C, Levenson, J. W., Sesso, H. D., Fiore, L. D., & Gaziano, J. M. (2006). Health care utilization and receipt of cholesterol testing by veterans with and those without mental illness. *General Hospital Psychiatry, 28*, 137-144. Overview This study utilized Veterans Affairs administrative data to determine the likelihood of receiving a cholesterol test for those individuals diagnosed with mental illnesses and those without. For those who used fewer outpatient services, individuals with mental health diagnoses were less likely to have received cholesterol testing. There were fewer discrepancies among those individuals with higher levels of service utilization.
Health: Cardiovascular	Druss, B. G., Bradford, D. W., Rosenheck, R. A., Radford, M. J., Krumholz, H. M. (2000). Mental disorders and use of cardiovascular procedures after myocardial infarction. *Journal of the American Medical Association, 283:*4, 506-511. Overview This study examined a national sample of 113,653 patients who were hospitalized for an acute myocardial infarction to determine if individuals with severe mental illnesses are more or less likely to receive surgical intervention than those without mental illnesses. The result indicated that individuals with SMI are significantly less likely to undergo surgical procedures than those without mental disorders.
Health: Cardiovascular Health: Diabetes	Newcomer, J. W. (2007). Antipsychotic medications: Metabolic and cardiovascular risk. *Journal of Clinical Psychiatry, 68*, suppl 4. Overview: Discusses cardiovascular and metabolic risk factors among individuals with SMI, and discusses the role that antipsychotic medications play in health problems such as diabetes and cardiovascular disease. The article also outlines monitoring strategies and approaches to impact modifiable risk factors for health problems in individuals with SMI.

Mortality Rates Medical Co-morbidity	Nasrallah, H. A. (2007). Dying too young: cardiovascular neglect of the mentally ill. *Current Psychiatry, 6*: 1. Overview This is a Letter from the Editor of *Current Psychiatry*. In it, the author identifies research with discusses the shortened life expectancies of people with SMI, along with research that identifies high rates of diabetes, heart disease and obesity in this population. The author makes suggestions to improve the screening and monitoring of health conditions in psychiatric patients.
Health: Risk Behaviors	Strine, T. W., Mokdad, A. H., Dube, S. R., Balluz, L. S., Gonzalez, O., Berry, J. T., Manderscheid, R. & Kroenke, K. (2008). The association of depression and anxiety with obesity and unhealthy behaviors among community-dwelling US adults. *General Hospital Psychiatry, 30*:2, 127-137. Overview: This study uses BRFSS data to examine the relationship between common mental health problems (depression & anxiety) and a number of unhealthy behaviors (smoking, obesity, physical inactivity, alcohol consumption). The results indicate that adults with current depression or a lifetime diagnosis of depression or anxiety were significantly more likely than others to engage in all of the risk factors.
Medical Co-Morbidity	Sokal, J., Messias, E. Dickerson, F. B., Kreyenbuhl, J., Brown, C. H., Goldberg, R. W. & Dixon, L. B. (2004). Comorbidity of medical illnesses among adults with serious mental illness who are receiving community psychiatric services. *The Journal of Nervous and Mental Disease, 192*:6, 421-427. Overview: This study examined medical comorbidity in a sample of 200 psychiatric outpatients diagnosed with schizophrenia and affective disorders as compared to match samples from the general population. Both patient groups had higher odds of medical conditions, including respiratory infections, diabetes, and liver problems.
Model Programs	Ohlsen, R. I., Peacock, G., Smith, S. (2005). Developing a service to monitor and improve physical health in people with serious mental illness. *Journal of Psychiatric and Mental Health Nursin, 12*:5, 614-619. Overview: This article describes the development and implementation of the Well-Being Support Program (WSP), an intervention designed to provide treatment and monitoring of physical health problems among mentally ill patients.
Model Programs Policy Funding Barriers to Integration	Mauer, B. J. (2007). Clinical models, policy and financing: The view from 20,000 feet with a few stops on the ground. *Presented at Colloquium of National Leaders in Collaborative Behavioral Health and Primary Care, June 15, 2007*. Overview: This presentation provides information and statistics to support the integration of behavioral health and primary care, discusses models of integration and collaborative care, and discusses policy and funding barriers to integrated care.

Model Programs Policy Funding Barriers to Integration	Mauer, B. J. & Druss, B. G. (2007). Mind and body reunited: Improving care at the behavioral and primary healthcare interface. *Paper prepared for the American College of Mental Health Administration*. Available online at: http://www.acmha.org/summit/Pre_Summit_Paper_021907.pdf Overview This paper explores the interface between primary care and behavioral health in the public sector. The authors describe models of collaboration and coordination of care and discuss cross-system research efforts. The article then describes challenges and opportunities to integrating primary care and mental health, and discusses future research, policy and funding needs.
Policy Barriers to Integration	Horvitz-Lennon, M., Kilborne, A. M., Pincus, H. A. (2006). From silos to bridges: The general health care needs of adults with severe mental illnesses. *Health Affairs, 25:*3, 659-669. Overview: In this article, the authors discuss the need for integrated mental health and primary care services. They also discuss barriers to this integration and propose strategies to eliminate (or reduce) barriers.
Policy Barriers to Integration	Druss, B. G., Marcus, S. C., Campbell, J., Cuffel, B., Harnett, J., Ingoglia, C., Mauer, B. (2008). Medical services for clients in community mental health centers: Results from a national survey. *Psychiatric Services, 59*:8, 917 – 920. Overview: This article presents the results of a survey of community mental health centers (CMHC). The results indicate that while more than two-thirds of CMHCs screen for common medical problems, only half can provide treatment for those problems. Less than one third of CMHCs currently offer medical services on site. Survey respondents indicated that barriers to providing mental health care in CMHCs include reimbursement issues, workforce limitations and lack of space. Respondents also reported experiencing a lack of options for referrals to medical providers in the community.
Health: General Health Business Case	Druss, B. G., Rohrbaugh, R. M., Levinson, C. M., Rosenheck, R. A. (2001). Integrated medical care for patients with serious psychiatric illness: A randomized trial. *Archives of General Psychiatry, 58*, 861-868. Overview: This study compared health utilization and outcomes between individuals enrolled in an integrated care clinic and those who received care through a general medicine clinic. The results indicate that individuals enrolled in the integrated care clinic were more likely to receive primary care and preventative measures outlined in clinical guidelines. They also experienced greater improvement in health. There were not differences among the two groups in total health care costs, or in mental health symptoms.

Model Programs Business Case	Druss, B. G. & von Esenwein, S. A. (2006). Improving general medical care for persons with mental and addictive disorders: Systematic review. *General Hospital Psychiatry, 28*, 145-153. Overview: This article presents review of outcome evaluations of programs designed to improve the physical health of people with SMI/SUD. The studies presented represent a variety of intervention approaches. Overall the results of the evaluations indicate that programs have a positive impact on access to medical care and quality of medical care. Only three studies reviewed cost of interventions; however, all three found programs to be cost-neutral.
Model Programs Policy Mortality Rates Medical Co-morbidity	Goff, D. C. (2007). Integrating general health in private community psychiatry practice. *Journal of Clinical Psychiatry, 68*, [suppl 4], 49-54. Overview This article discusses the causes of mortality and morbidity among SMI patients, and makes recommendations for monitoring and addressing medical risk factors in psychiatric patients. The article also discusses the importance of the psychiatrist as patient advocate.
Policy Model Programs Barriers to Integration	Pincus, H. A. (2003). The future of behavioral health and primary care: Drowning in the mainstream or left on the bank? *Psychosomatics, 44*:1, 1-11. Overview: This article discusses barriers that often prevent effective integration of primary care and mental health services. The author then describes trends and assumptions that may direct the future of care, and presents a framework to provide integrated care.
Policy	Druss, B. G. (2002). The mental health/primary care interface in the United States: History, structure and context. *General Hospital Psychiatry, 24*, 197-202. Overview The goal of this article is to provide an historical, systemic perspective on the integration of mental health and primary care. It discusses the history and core features of primary care and their implications for the interface between primary care and mental health.
Business Case	Hackman, A. L., Goldberg, R. W., Brown, C. H., Fang, L. J., Dickerson, F. B., Wohlheiter, K., Medoff, D. R., Kreyenbuhl, J. A., Dixon, L. (2006). Use of emergency department services for somatic reasons by people with severe mental illness. *Psychiatric Services, 57*:4, 563-566. Overview: This study reviewed a randomly selected sample of individuals receiving community-based psychiatric care to identify factors associated with use of the emergency department (ED) for medical reasons. ED use among the sample was relatively high as compared to the general population. ED use was negatively associated with older age, and positively associated with the number of co-occurring medical conditions, smoking, recent injury, and a recent change in health provider.

Model Programs	M. Wynia, & J. Matiasek (2006). Promising Practices for Patient-Centered Communication with Vulnerable Populations: Examples from Eight Hospitals. *Report published by The Commonwealth Fund*. Accessed online at: http://www.cmwf.org/Content/Publications/Fund-Reports/2006/Aug/Promising-Practices-for-Patient-Centered-Communication-with-Vulnerable-Populations--Examples-from-Ei.aspx Overview: This report presents promising practices that were gleaned from a series of site visits and focus groups investigating methods of patient-centered communication.
Depression Training & Education	The Macarthur Initiative on Depression & Primary Care. www.depression-primarycare.org Overview The mission of the MacArthur Initiative on Depression and Primary Care is to enhance the ability of primary care providers to identify and manage depression. The website includes resources for clinician and staff education (including a practice suggestions, screening tools, and training information) resources for organizations seeking to improve the treatment of depression, and a publications/links section that directs readers to other resources.
Depression	Unutzer, J., Katon, W., Callahan, C. M., et al. (2002). Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. *Journal of the American Medical Association: 288*, 2836-2845. Overview: A multicenter study was used to compare the effectiveness of the IMPACT (Improving Mood-Promoting Access to Collaborative Treatment) intervention or care as usual in depressed patients over the age of 60. Results indicate that patients who received the IMPACT intervention were more likely to report a reduction in symptoms, and that patients receiving the intervention reported a greater reduction in depression than those receiving care as usual.
Depression	Unutzer, J., Katon, W., Williams, J. W., et al. (2001). Improving primary care for depression in late life: The design of a multicenter randomized trial. *Medical Care, 39*: 785-799. Overview: This article describes IMPACT, a primary care treatment strategy that uses a team of clinicians (psychologist/nurse, psychiatrist and primary care physician) to treat late life depression. Treatment is provided for 12 months, and consists of three steps, relapse prevention and a maintenance plan.

Depression	Solberg L.I., Fischer L.R., Rush W.A. & Wei F. (2003). When depression is the diagnosis, what happens to patients and are they satisfied? *American Journal of Managed Care, 9*:2, 131-140. <u>Overview:</u> This article presents the results from a follow up survey of individuals who were diagnosed with depression at primary care clinics. Patients were surveyed approximately one week after their initial visit, and then re-surveyed three months later. The results indicate that, while 75% reported receiving a prescription for antidepressant medication, only half received a recommendation to visit a mental health therapist or to use stress reduction techniques. The results indicate that ¾ of patients were still symptomatic three months later. Patients reported a low level of satisfaction with their care.
Depression	DiMatteo, M. R., Lepper, H. S., Croghan, T. W. (2000). Depression is a risk factor for noncompliance with medical treatment: Meta-analysis of the effects of anxiety and depression on patient adherence. *Archives of Internal Medicine, 160*, 2101-2107. <u>Overview</u> The authors present a review of research correlating medical patients' treatment noncompliance with their anxiety and depression. Research indicates depressed patients are three times more likely to be noncompliant when compared to nondepressed patients. Anxiety was not found to be consistently related to noncompliance.
Depression	Wells, K. B., Sherborne, C., Shoenbaum, M, et al. (2000). Impact of disseminating quality improvement programs for depression in managed care. *Journal of the American Medical Association, 283*:2, 212-220. <u>Overview:</u> This study found that depressed patients whose primary care physicians who used QI interventions that provided patient education, medication follow up and access to therapy experienced better outcomes and reported receiving more appropriate care than those receiving usual care. In patients receiving QI interventions, 30 percent more received counseling, and 40 percent more received appropriate antidepressants. Patients receiving QI were approximately 10 percent less likely to have depression at follow-up than those who did not receive QI.
Depression Business Case	Frank, R., McGuire, T. G., Normand, S. T., Goldman, H. H. (1999). The value of mental health care at the system level: The case of treating depression. *Health Affairs, 18*:5, 71-88. <u>Overview</u> The authors present Systems Cost-Effectiveness (SCE), a method for assessing the cost/effectiveness of mental health care using administrative data. They then apply this method to the acute-phase treatment of depression in a large population of insured adults.

Depression Model Programs	Rubenstein, L. V., Jackson-Triche, M., Unutzer, J, Miranda, J., Minnium, K, Pearson, M. L., Wells, K. B. (1999). Evidence-based care for depression in managed primary care practices. *Health Affairs, 18*: 5, 89-105. Overview: This paper presents the results of an attempt to implement externally designed, evidence-based practices for depression care in managed care organizations. The authors found that local practice leaders were able to implement interventions with acceptable fidelity (above 70%).
Depression Heart Disease	National Institute of Mental Health. (2002). Depression and heart disease: A fact sheet that summarizes what heart disease patients need to know about depression. Accessed online at: http://www.mentalhelp.net/poc/view_doc.php?type=doc&id=8664&cn=5 Overview This brochure, published by the NIMH, provides information on depression and heart disease.
Depression Business Case	Campbell, T. L., Franks, D., Fiscella, K, et al. (2000). Do physicians who diagnose more mental health disorders generate lower health care costs? *Journal of Family Practice, 49*:4, 305-310. Overview: This article presents research investigating the relationship between the number of mental health conditions diagnosed by primary care physicians (PCPs) and health care costs. The researchers found that patients of PCPs who diagnosed more mental health conditions had 9% lower health care costs overall. Inpatient expenses were 20% lower when compared to patients whose PCPs diagnosed the smallest number of mental health conditions.
Depression Model Programs	Schulber, H. C., Katon, W., Simon, G. E. & Rush, A. J. (1998). Treating major depression in primary care practice: An update of the agency for health care policy and research practice guidelines. *Archives of General Psychiarty, 55*, 1121-1127. Overview: This article reviewed studies published between 1992 and 1998 on treatment of depression in primary care settings in order to update the depression guidelines sponsored by the Agency for health Care Policy and Research. The authors conclude that psychopharmacological intervention and psychotherapy are both effective ways of managing depression in the context of primary care. However, the authors note that this approach requires organized treatment programs and a mental health specialist to serve as a primary provider for more serious mental illnesses.
Depression Model Programs Policy	Pincus, H. A., Pechura, C. M., Elinson, L., Pettit, A. R. (2001). Depression in primary care: Linking clinical and systems strategies. *General Hospital Psychiatry, 23*, 311-318. Overview This article discusses the importance of identifying and treating depression in primary care settings. It describes treatment models for depression, and discusses the barriers and facilitators to executing these models in a primary care setting. Finally, the article discusses a framework for the treatment of depression in the primary care setting.

Policy	Phillips, B. & Bazemore, A. (2007). An access deprivation index and HealthLandscape. Presentation available online at: http://www.graham-center.org/online/graham/home/publications/presentations/2007/bphilps-adi.html Overview This presentation discusses Access Deprivation Index, a measure of risk for experiencing barriers to accessing healthcare. It also presents the rationale, data requirements and methods for mapping the Access Deprivation Index.
Model Programs Funding	Health Management Associates. (2007). Integrating publicly funded physical and behavioral health services: A description of selected initiatives. Report prepared for the Robert Wood Johnson Foundation, available online at: http://www.oregon.gov/DHS/ph/hsp/docs/rwjfreport.pdf Overview: This report identifies and describes models of integrated service programs, and discusses the conceptual framework for these programs. It also highlights communication tools, screening tools and funding mechanisms that can be useful to integrated program. Finally, the report discusses the need for collaboration and sustainability planning in developing and implementing a successful integrated program.
Business Case Model Programs Policy	National Association of Community Mental Health Centers & the Robert Graham Center. (2007). Access denied: A look at America's medically disenfranchised. Report available online at: http://www.graham-center.org/online/graham/home/publications/monographs-books/2007/rgcmo-access-denied.html Overview: This report focuses on the "medically disenfranchised" in the United States, a group defined as "the number of people with no or inadequate access to a primary care physician due to local shortage of such physicians." The report presents statistics to describe the medically disenfranchised (demographics, rates of insurance, etc.) and discusses the long-term consequences of not having a medical home. The report makes recommendations to address the problem of access to medical care, and discusses opportunities and challenges to policy work.
Business Case Model Programs Policy	National Association of Community Health Centers, the Robert Graham Center & George Washington University. (2008). Access transformed: Building a primary care workforce for the 21st century. Report available online at: http://www.graham-center.org/online/graham/home/publications/monographs-books/2008/rgcmo-access-transformed.html Overview: This report provides statistics to describe the current primary care shortage, as well as reasons for the shortage. It also presents the ACCESS for All American plan, an initiative by health centers to increase their capacity.

Business Case Model Programs Policy	National Association of Community Health Centers, the Robert Graham Center & Capital Link. (2007). Access granted: The primary care payoff. Report available online at: http://www.graham-center.org/online/graham/home/publications/monographs-books/2007/rgcmo-access-granted.html Overview: This report builds an economic/cost-savings case for investing in primary care and community health programs. It presents data re: cost expenditures and health care savings, as well as the economic impact of community health centers.
Business Case Model Programs Policy Barriers to Integration	Brazelon Center for Mental Health Law. (2004). Get it together: How to integrate physical and mental health care for people with serious mental disorders. Report available online at: http://www.bazelon.org/issues/mentalhealth/publications/getittogether/ Overview: This report reviews research findings and model programs for improving the coordination and integration of physical and mental health services. The report also discusses barriers to integration, and presents policy recommendations.
Policy Barriers to Integration	Brazelon Center for Mental Health Law. (2005). Integration of primary care and behavioral health: Report on a roundtable discussion of strategies for private health insurance. Report available online at: http://www.bazelon.org/issues/general/publications/RoundtableReport.pdf Overview: This report is the work product of a two day Roundtable that the Brazelon Center hosted to discuss strategies for integration of mental health and primary care within the private health insurance system. The report discusses the barriers to integration identified by Roundtable participants, and their recommendations.
Policy	Brazelon Center for Mental Health Law. (2009). A healthcare reform issue brief: Integrating mental health in healthcare overview. Document available online at: http://www.bazelon.org/issues/healthreform/issuepapers/Overview.pdf Overview: This is one of a series of issue briefs produced by the Brazelon Center. It discusses the integration of mental health and primary care in the context of the current health reform discussion, and offers policy recommendations to improve mental health care.
Policy	Brazelon Center for Mental Health Law. (2009). A healthcare reform issue brief: Primary care providers' role in mental health. Document available online at: http://www.bazelon.org/issues/healthreform/issuepapers/PrimaryCare.pdf Overview This is one of a series of issue briefs produced by the Brazelon Center. It discusses the role of primary care providers in mental health, and the importance of supporting the collaboration and integration of care. The report also offers policy recommendations to promote integrated care.

Policy	Brazelon Center for Mental Health Law. (2009). A healthcare reform issue brief: Improving care for people with severe mental illness. Document available online at: http://www.bazelon.org/issues/healthreform/issuepapers/Severe.pdf Overview This is one of a series of issue briefs produced by the Brazelon Center. It identifies components of effective treatment programs for people with severe mental illnesses and offers policy recommendations to promote the long-term management of severe mental illnesses.
Smoking Model Programs	Ohio SAMI CCOE. (2008). Annual medical professionals training: Advancing tobacco recovery in Integrated Dual Disorder Treatment (IDDT) programs. Overview: Training materials from the 2008 SAMI medical professionals training. Includes information about IDDT (including principles, fidelity scale, information about successful implementation, and the role of medical professionals in IDDT), smoking cessation in mental health settings, and pharmacological and psychosocial interventions in smoking cessation.
Business Case Model Programs Funding	US Department of Health & Human Services. (2008) Medicaid reimbursement for behavioral health services in primary care settings. Overview: This presentation focuses on funding for mental health services in primary care settings. The presentation identifies barriers to funding, components of care models, steps to access funding streams, and suggestions for improving funding options.
Policy Business Case Reimbursement for Services Barriers to Integration	Mauch, D., Kautz, C., Smith, S. A. (2008). Reimbursement of mental health services in primary care settings [HHS Pub. No. SMA-08-4324]. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Report available online at: http://download.ncadi.samhsa.gov/ken/pdf/SMA08-4324/SMA08-4324.pdf Overview This is the final report of a study that identified the barriers to and solutions for reimbursement of mental health services in primary care settings. This report describes the purpose for the project, reviews findings from a White Paper that identified barriers, summarizes the recommendations of a panel of experts, and presents suggestions on steps to overcome barriers.

Policy Business Case Funding	Department of Health and Human Services, Office of Inspector General. (2004). Applying the national correct coding initiative to Medicaid services [OEI-03-02-00790]. Report available online at: http://oig.hhs.gov/oei/reports/oei-03-02-00790.pdf Overview: The Office of Inspector General conducted a survey "to determine the extent to which State Medicaid agencies use the National Correct Coding Initiative (CCI) edits" and to determine "the extent to which the Medicaid program paid for services that would have been denied if State Medicaid agencies implemented the CCI." They found that most state Medicaid agencies do not use the CCI, resulting in $54 million in inappropriate payments. The report makes recommendations to prevent inappropriate payments.
Funding	Smith, S. & Charneco, E. (2007). Examples of states' billing codes for mental health services, publicly funded. Report available online at: http://hipaa.samhsa.gov/pdf/Ex_States_Billing_Codes_public_MH_Services.pdf Overview This is a collection of successful codes that states use to bill for mental health services. It provides an orientation to Level I and Level II HCPCS Codes. The report also presents a chart of the most frequently used codes organized by service and state, descriptions of services that might go under each code, and individual contacts re: billing and successful codes.
Policy Model Programs Funding Barriers to Integration	Butler, M. Kane. R. L., McAlpine, D., Kathol, R. G., Fu S. S., Hagedorn, H., & Wilt, T. J. (2008). Integration of mental health/substance abuse and primary care No. 173 (Prepared by the Minnesota Evidence-Based Practice Center under Contract No. 290-02-0009.) AHRQ Publication No. 09-E003. Rockville, MD. Agency for Healthcare Research and Quality. Report available online at: http://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf Overview: This is a "comprehensive systematic review" of the interface of general medicine and mental health care. The article presents describes successful models of integration, discusses program outcomes and reviews differences in outcomes for illness type and patient age. The article then discusses the documented barriers to integrated care (with a specific focus on HIT and reimbursement structures), presents case studies, and discusses policy implications and areas of future research.
Mortality Rates Medical Co-morbidity	Miller, B. J., Paschall, C. B. & Svendsen, D. P. (2006). Mortality and medical comorbidity among patients with serious mental illness. *Psychiatric Services, 57*:10, 1482-1487. Overview: This study used Data from a public mental health hospital in Ohio to examine mortality and medical comorbidity among patients with SMI. The study revealed excess mortality among patients with SMI, with heart disease and suicide being leading causes of death. The authors found that obesity and hypertension were the most common comorbid medical conditions among the sample. The authors conclude that integrated medical and physical health services could help improve quality of life for this population.

Medical co-morbidity Mortality Rates	Roshanaei-Moghaddam, B. & Katon, W. (2009). Premature mortality from general medical illnesses among persons with bipolar disorder: A review. *Psychiatric Services, 60*:2, 147-156. Overview: This article presents a systematic review of publish research examining the mortality from general medical causes among individuals with Bipolar Disorder. The authors identified seventeen studies involving 331,000 patients with bipolar spectrum disorder. Mortality rates from general medical conditions and specific problems (i.e., cardiovascular, respiratory, cerebrovascular & endocrine disorders) were significantly higher in individuals with bipolar disorders than in controlled samples without SMI, with cardiovascular disease appearing to be the most consistent cause of excess mortality.
Mortality Rates	Dembling, B. P., Chen, D. T. & Vachon, L. (1999). Life expectancy and causes of death in a population treated for serious mental illness. *Psychiatric Services, 50*, 1036-1042. Overview: This study describes the prevalence of specific fatal disease and injury conditions in a sample a population of adults who received services from the Massachusetts Department of Mental Health, as compared to individuals in the general population. Researchers found that individuals served by the department of mental health had a significantly higher frequency of deaths from accidental and intentional injuries (particularly poisoning by psychotropic medications). Deaths from cancer, diabetes and circulatory disorders were less frequent in those served by the department of mental health than in the general population. Those who were served by the department of mental health lost, on average, 8.8 more years of potential life than members of the general population.
Barriers to Care Policy	Bradford, D. W., Kim, M. M., Braxton, L. E., Marx, C. E., Butterfield, M. & Elbogen, E. B. (2008). Access to medical care among persons with psychotic and major affective disorder. *Psychiatric Services, 59*:8, 847-852. Overview: This study compares a sample of individuals with SMI (psychotic disorders bipolar disorder or major depressive disorder) with a sample of individuals with out mental illnesses on several outcomes: having a primary care physician, being unable to get needed medical care, being unable to get a needed prescription medication, delaying medical care because of cost. The results indicate all individuals in the SMI population experience barriers to care than the general population. Those with psychotic disorders and bipolar disorder were more likely to report difficulty establishing a relationship with a primary care physician.

Mortality Rates Medical co-morbidity	Svendsen, D. P., Paschall, C. B. & Miller, B. (2005). Medical Director's corner: Mortality and medical co-morbidity in patients with serious mental illness. *ODMH Quality Matters Newsletter, May 2005 Edition*. Article available online at: http://dmhext01.mh.state.oh.us/dmh/newsletter/qualitymatters.nsf/onlinecontentprinterfriendly/7C803B3C9FBD9AD485256FD6004C6E43?OpenDocument#1.%20Medical%20Director's%20Corner Overview: This study used state records to examine mortality and rates of medical co-morbidity in individuals who experienced at least one hospitalization in Ohio's public mental health system over a five-year period. Age-adjusted mortality was higher among hospitalized individuals than for either the US or Ohio general populations. The overall risk of death in the hospitalized sample was over three times greater than in the general population. The article contains tables identifying the 10 the leading causes of death, mean years of potential life lost for each cause, and rates of medical co-morbidity.
Medical co-morbidity Business Case	Jones, D. R., Macias, C., Barriera, P. J., Fisher, W. H., Hargreaves, W. A., Harding, C. M. (2004). Prevalence, severity, and co-occurrence of chronic physical health problems of persons with serious mental illness. *Psychiatric Services, 55*:11, 1250-1257. Overview: The authors of this article used Medicaid claims forms to examine the prevalence, severity and co-occurrence of physical illness in a sample of individuals with SMIs. Approximately 75% of the sample had a documented chronic health condition, and half had two or more chronic health conditions. Data from this study suggests that chronic pulmonary illness is the most prevalent and co-morbid condition in the SMI sample, with an average annual cost of treatment of $8,277. Age, obesity and substance use were found to be significant predictors of individual health problem severity.
Policy Risk Factor Rates Model Programs	National Council, The. An Avoidable Tragedy: The Relationship of Premature Death and Serious Mental Illness. Factsheet available online at: http://www.thenationalcouncil.org/galleries/policy-file/AnAvoidableTragedy.pdf Overview: This is a two-page fact sheet published by the National Council for Community Behavioral Healthcare (NCCBH) that discusses the integration of primary care and mental health services. The fact sheet includes prevalence rates of modifiable risk factors (i.e., smoking, obesity, diabetes, etc.), outlines NCCBH's vision of what an improved primary care/mental health delivery system will look like, and provides examples of how states have improved their delivery systems.
Medical Co-morbidity	Chwastiak, L. A., Rosenheck, R. A., McEvoy, J. P., Keefe, R. S., Swartz, M. S., Lieberman, J. A. (2006). Interrelationshps of psychiatric symptom severity, medical comorbidity, and functioning in schizophrenia. *Psychiatric Services, 57*:8, 1102-1109. Overview: This article examines the relationship between psychiatric symptom severity, medical co-morbidity and psychosocial functioning in individuals with schizophrenia. More than half (58%) of the sample had at least one medical condition, and 9% had four or more medical conditions. Hypertension (20%) and diabetes (11%) were the most prevalent medical conditions in the sample. The results suggest that medical co-morbidity is related to

	decreased neurocognitive functioning and increased depressive symptoms, medical co-morbidity is not related to more severe symptoms of schiziophrenia or psychosocial functioning.
Mortality Rates Medical Co-Morbidity	Torgovnick, K. (2008). Why do the mentally ill die younger? *Time*. Article available online at: http://www.time.com/time/health/article/0,8599,1863220,00.html Overview: This news article, published online by Time, describes the high medical co-morbidity and mortality risk of individuals with SMIs. The article includes statistics from the National Association of State Mental Health Program Directors research on co-morbidity and mortality, and describes the response of organizations such as the National Alliance on Mental Illness (NAMI).
Policy Barriers to Care	Abelson, R. (2008). Uninsured put a strain on hospitals. *The New York Times*. Article available online at: http://www.nytimes.com/2008/12/09/business/09emergency.html Overview: This news article, published by the New York Times, discusses the increasing strain on emergency departments as the numbers of uninsured increase and access to health care becomes more limited.
Medical Co-Morbidity	Kiraly, B., Gunning, K., & Leiser, J. (2008). Primary care issues in patients with mental illness. *American Family Physician, 78*:3, 355-362. Overview: This article was written for primary care providers, and discusses important considerations treating patients with SMI. The article discusses the high rates of medical co-morbidity, and the causes of poor health in individuals with SMI. It also provides information about medications that are commonly used to treat SMI, as well as common drug interactions and side effects
Barriers to Care	Druss, B. G., Rosenheck, R. A., Desai, M. M., Perlin, J. B. (2002). Quality of preventive medical care for patients with mental disorders. *Medical Care, 40*:2, 129-136. Overview: This study compares the quality of preventative services in individuals SMIs and/or SUDs, and members of the general population. The results indicate that individuals with co-morbid SMI/SUD diagnoses are least likely to receive preventative services. On average, individuals in the sample received 64% of the available preventative care procedures. Individuals with co-morbid SMI/SUD diagnoses received 58% of preventative services, those with SUD received 65% and individuals with SMIs received 60% of preventative services.
Medical Co-Morbidity Mortality Rates	Bender, E. (2006). Death data have researchers searching for answers. *Psychiatric News, 41*:22, 26. Article available online at: http://pn.psychiatryonline.org/cgi/content/full/41/22/26 Overview: This article provides a brief overview of research conducted in Ohio that reveals the high rates of medical co-morbidity and mortality among individuals with SMI.

Medical Co-Morbidity Mortality Rates	Colton, C. W., Manderscheid, R. W. (2006). Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Preventing Chronic Disease: Public Health Research, Practice and Policy ,3*:2, 1-10. Article available online at: http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm Overview: This article compares rates of mortality and medical co-morbidity among public mental health clients in eight states (Arizona, Missouri, Oklahoma, Rhode Island, Texas, Utah, Vermont and Virginia). Public mental health clients in all eight states experienced a higher risk of death than the general population. Public mental health clients died younger than a comparative sample, and most died of natural causes.
Medical Co-Morbidity	Dickerson, F. B., Brown, C. H., Daumit, G. L., LiJuan, F., Goldberg, R. W., Wohlheiter, K. & Dixon, L. B. (2006). Health status of individuals with serious mental illness. *Schizophrenia Bulletin, 32*:3, 584-589. Overview: This study examined the health indices of 200 adults with SMIs, as compared to a sample of the general population. Individuals with SMIs were found to have significantly fewer indicators of good health. Only 1% of the SMI population met criteria for all five health indicators, as compared to 10% of the general population.
Mortality Rates Medical Co-Morbidity Risk Factor Rates	Elias, M. (2007). Mental illness linked to short life. *USA Today.* Article available online at: http://www.tucsoncitizen.com/ss/byauthor/50473 Overview: This is a news article published by USA Today and affiliates that discusses the high rates of morbidity and medical co-morbidity among adults with SMIs. The article includes mortality and co-morbidity statistics, and discusses the impact of behavioral risk factors (i.e., smoking and obesity) on the health of people with SMIs.
Medical Co-Morbidity	Kennedy, C., Salsberry, P., Nikel, J., Hunt, C., Chipps, E. (2005). The burden of disease in those with serious mental and physical illnesses. *Journal of the American Psychiatric Nurses Association, 11*:1, 45-51. Overview: This study looked at the overall health impact of chronic disease among a sample of individuals with severe mental illnesses. The sample of individuals with SMI scored consistently lower on measures of physical and mental health than did members of the general population. When comparing individuals with chronic illnesses, individuals with SMIs experienced higher incidence of negative health consequences than their counterparts without SMIs. The authors of the study conclude that chronic disease has a higher burden among the mentally ill.

Mortality Rates Medical Co-Morbidity	Connolly, M. & Kelly, C. (2005). Lifestyle and physical health in schizophrenia. *Advances in Psychiatric Treatment, 11*, 125-132. <u>Overview:</u> This article reviews factors that contribute to the high mortality rate among individuals with schizophrenia The article discusses lifestyle factors (diet, exercise, smoking, obesity), and common side-effects of long-term antipsychotic use (diabetes, obesity, elevated triglycerides, metabolic syndrome and prolactin elevation). The authors then make suggestions to improve the treatment and health of individuals with schizophrenia.
Research Methodology	Richards, J., Davies, P. D., Winston, M. Davies, M. & Moseley, L. (2001). An all-Wales study of the physical health of people with a severe mental illness (SMI). Pilot Study Summary Report for the Wales Office for Research and Development in Health and Social Care. <u>Overview:</u> This document presents the methods and objectives of a pilot study conducted by the Wales Office for Research and Development. The pilot was developed to assess potential sample size, determine potential response rates, address ethical considerations and test and refine methodology. The authors concluded that the study protocol is appropriate, and reported plans to conduct the study.
Mortality Rates Policy	Flory, C. B. & Friedrich, R. M. Why do individuals with severe mental illness die before their time? Article published by NAMI Massachusetts, available online at: http://www.namimass.org/articles/time.htm <u>Overview:</u> This article presents the results of a survey of 220 NAMI families in 23 states. Survey results indicated high incidence of factors associated with premature morbidity, including suicide attempts (47%), high risk for accidents (20%), substance abuse problems (21%), and medical co-morbidity (48%). The article then gives recommendations of ways family members can advocate for quality care for individuals with SMI.
Business Case Policy Barriers to Integration Funding	Blount, A., Schoenbaum, M., Kathol, R., Rollman, B. L., Thomas, M., O'Donohue, W., Peek, C. J. (2007). The economics of behavioral health services in medical settings: A summary of the evidence. *Professional Psychology: Research and Practice, 38*:3, 290-297. <u>Overview:</u> This article presents a review of findings from research on behavioral health and primary care, including cost-effectiveness and cost-savings research. It then discusses barriers to the integration of care, including funding and reimbursement issues, and presents suggestions to address those barriers.

Business Case Policy	Peppe, E. M., Mays, J. W., Chang, H. C., Becker, E., DiJulio, B. (2007). Characteristics of Frequent Emergency Department Users. Issue brief paper prepared for the Kaiser Family Foundation, and available online at: http://www.kff.org/insurance/7696.cfm Overview: This issue brief presents a number of statistics describing high frequency and low frequency ED users. Figure 10 is particularly of note, as individuals who are diagnosed with both physical and mental chronic conditions are the most likely to be high ED users.
Tobacco Use	Rx for Change. (2008). Information available online at: http://rxforchange.ucsf.edu/ Overview: Rx for Change is a comprehensive tobacco cessation training program that trains health professional students and licensed clinicians to assist patients with quitting. The program is based on principles set forth in the U.S. Public Health Service Clinical Practice Guideline for Treating Tobacco Use and Dependence. The materials include: • Presentations to inform clinicians and mental health peer counselors • Information about the epidemiology of tobacco use, principals of addiction, health benefits of quitting • Behavioral and pharmacological interventions to assist smoking cessation • Information sheets • Patient worksheets and self-report measures of tobacco use and dependence • A faculty coordinator's guide
Tobacco Use	Smoking Cessation Leadership Center (2009). Catalogue of Tools. Available online at: http://smokingcessationleadership.ucsf.edu/Resources.html Overview: This is a collection of tools and resources that can be useful to clinicians hoping to assist patients with smoking cessation. The catalogue includes interventions models, curricula, information for speakers' bureaus, provider resources, patient resources, and behavioral health resources.
Tobacco Use	Colorado Department of Public Health and Environment (2009). Smoking Cessation for Persons with Mental Illnesses: A Toolkit for Mental Health Providers. Available online at: http://smokingcessationleadership.ucsf.edu/Downloads/MH/Toolkit/Quit_MHToolkit.pdf Overview: This toolkit presents information for mental health providers assisting individuals with SMIs in quitting tobacco use. The toolkit provides information about assessing readiness to quit, treatments to assist in smoking cessation, strategies for reducing relapse, and community resources. The toolkit also includes a review of relevant literature and references.

Mortality Rates Medical Co-Morbidity Policy Model Programs	National Wellness Summitt. (2007). Documents from the National Wellness Summit for People with Mental Illness. Documents available online at: http://www.bu.edu/cpr/resources/wellness-summit/papers-and-presentations.html Overview: These documents include papers and presentations from a summit convened to address the crisis of early mortality for people with SMIs. The website also includes background information about the early mortality issues, and will include a strategic plan once it is developed. Documents and presentations include: • Effective Policy and Practice. (Draft Paper & Presentation) • Health and Wellness in the Future for People with Mental Illness. (Presentation) • Federal Initiatives. (Presentation) • Promoting Wellness – Saving Lives. (Presentation) • Promoting Wellness at Academic and Research Settings. (Presentation) • Promoting Wellness for Mental Health Consumers: The Role of Primary Care. (Presentation) • Morbidity and Mortality in People with Severe Mental Illness. (Presentation) • The quest for optimal health: Can education and training cure what ails us? (Draft Paper & Presentation) • Welcoming remarks, National Wellness Summit for people with mental illnesses. (Presentation).
Policy Mortality Medical Co-morbidity	SAMHSA. (2008) "10 by 10." The pledge to reduce early mortality in people with mental illnesses. Presentation available online at: http://thenationalcouncil.net/Handouts08/handouts/B05-Boardman-1.pdf Overview: This presentation provides statistics about mortality among individuals with severe mental illnesses. It also discusses risk factors and outlines the CMHS/SAMHSA National Wellness Action Plan.
Model Programs Policy Barriers to Integration	Ng, A., Druss, B. G. & Sanchez, D. (2008). Addressing the challenges of providers in treating persons with mental health issues. Teleconference documents available online at: http://www.stopstigma.samhsa.gov/teleconferences/archive/training/teleconference09082008.aspx Overview: This is a training that discusses the challenges in integrating primary care and mental health treatment. The presentation describes research involving barriers to care for individuals with SMIs, including first hand accounts from individuals about their health care experiences. The training then presents an overview of strategies that can help providers to more effectively treat and manage individuals with SMIs.
Policy Mortality Rates Medical Co-morbidity	National Council for Community Behavioral Healthcare. (2006). National Council News. November 2006. Available online at: http://www.thenationalcouncil.org/cs/november_2006 Overview: This document, one in a series of monthly newsletters, discusses the findings of the 2006 NASMHPD report on mortality in individuals with serve mental illness. It discusses steps that the National Council is taking to address mortality and medical co-morbidity.

Policy Model Programs Barriers to Integration Funding	Maurer, B. J. (2006). Behavioral health/primary care integration: Finance, policy and integration of services, July 2006. Paper developed for the National Council of Community Behavioral Healthcare and available online at: http://www.thenationalcouncil.org/galleries/business-practice%20files/Finance-Policy-Integration.pdf Overview: This paper reviews the status of financing and policy support for the integration of mental health and primary care services. It reviews barriers, funding streams and presents model and pilot programs.
Policy Model Programs Mortality Rates Medical Co-Morbidity	Rosenberg, L. (2006). Addressing a national tragedy. Behavioral Healthcare, December 2006. Available online at: http://archives.behavioral.net/ME2/dirmod.asp?sid=&nm=&type=Publishing&mod=Publications%3A%3AArticle&mid=&id=83096FD6B6BA45EE90D67E9BAD352336&tier=4 Overview: This article discusses the results of the 2006 NASMHPD report on mortality and medical co-morbidity among individuals with SMI. It also briefly reviews initiatives to address these issues.
Model Programs	National Council's Primary Care – Mental Health Collaborative Care Project Site Application. Overview: Application for participation in the National Council's Primary Care Mental Health Collaborative Project, which helps organizations "create a mutually beneficial relationship with a primary care organization" in their communities.
Policy	Reynolds, K. (2008). A concept paper regarding the creation of a public/private National Resource Center for Integrated Healthcare. Overview: This paper outlines the need for and possible functions of a National Resource Center for Integrated Healthcare. It also discusses sustainability of a National Resource Center
Policy Business Case Funding	National Council for Community Behavioral Healthcare. Mental Illness & Substance Use Disorders and State Healthcare Reform. Factsheet available online at: http://www.thenationalcouncil.org/galleries/policy-file/State%20Healthcare%20Reform.pdf Overview: This is a fact sheet that presents information from *Coverage for All: Inclusion of Mental Illness and Substance Use Disorders in State Healthcare Reform Initiatives*. It discusses the numbers of individuals with mental illnesses or substance use disorders who lack medical coverage, as well as the economic and human costs of lack of coverage for these individuals. The fact sheet then presents major findings from the study, and makes recommendations for state policy.

Policy Model Programs	Maurer, B. J. (2006). Behavioral health/primary care integration: The four quadrant model and evidence-based practices, revised February 2006. Report developed for the National Council and available online at: http://www.thenationalcouncil.org/galleries/business-practice%20files/4%20Quadrant.pdf Overview: This is a conceptual paper that is intended to give policymakers a framework to discuss integrated healthcare. It presents the four quadrant model, as well as a discussion of using EBPs to integrate care.
Policy Funding	Maurer, B. J. (2004). Behavioral health/primary care integration: Environmental assessment tool state level policy and financing, Spring 2004. Report developed for the National Council and available online at: http://www.thenationalcouncil.org/galleries/business-practice%20files/PC-BH%20Environment-State%20Policy.pdf Overview: This tool was developed to help state level agencies and provider organizations assess state level policy and financing in terms of supporting collaboration among behavioral health and primary care providers.
Policy Model Programs Business Case Barriers to Integration	Maurer, B. J. (2003). Background paper: Behavioral health/primary care integration models, competencies and infrastructure, May 2003. Paper developed for the National Council and available online at: http://www.machc.com/Documents/Reports/Intergrative%20Behavioral%20Health%20Care/Supplemental%20Tools/SectionI%20Intergrative%20Care.pdf Overview: This paper provides an overview of the discussion of integration and proposes a conceptual model for how behavioral health and physical health services can be integrated. The authors discuss reasons for focusing on integration, and identify barriers. They then go on to define integration, and discuss principles and models of integrated care.
Policy Model Programs Business Case Evaluation	American College of Mental Health Administration (2007). Mind and body reunited: Improving care at the behavioral and primary healthcare interface. Materials from the 2007 Santa Fe Summit, available online at: http://www.acmha.org/summit/summit_2007.cfm Overview: The materials from the 2007 Santa Fe Summit include presentations and papers that focus on issues related to the integration of mental health and primary care. Topics include: • Making a case for integration • Funding/reimbursement for integrated services • Model Programs • Measuring outcomes from integrated programs • Leadership/Policy issues

Policy Funding	Baucus, M. (2009). Call to action: Health reform 2009. www.finance.senate.gov Overview: This white paper includes Max Baucus' (Chairman, US Senate Committee on Finance) thoughts on healthcare policy and the process of healthcare reform.
Mortality Rates Medical Co-Morbidity Policy	Carmel, H. (2008). Medical co-morbidities and reduce lifespan of persons with severe mental illness: Implications for clinicians and policymakers. Prescriptions for progress, *2*:4. June 2008. Available online at: http://www.behavioral.net/Media/DocumentLibrary/PFP_Volume2_Issue4.pdf Overview: This article discusses mortality and rates of medical co-morbidity among individuals with severe mental illness. The article also outlines clinical and policy implications of health disparities.
Barriers to Care Policy	Cunningham, P. J. (2009). Beyond parity: Primary care physicians' perspectives on access to mental health care. *Health Affairs*. Article available online at: http://content.healthaffairs.org/cgi/content/full/hlthaff.28.3.w490/DC1 Overview: This article reports the results of a 2004-2005 survey of primary care physicians. About two thirds of the physicians surveyed reported having difficulty obtaining mental health services for their patients. This is almost twice as high as the rates of physicians reporting problems referring to other services. Physicians cited provider shortages, health plan barriers and lack of coverage as the most significant barriers to mental health care access.

Physical and Mental Health Integration

The Ohio Coordinating Center for Integrating Care

DRAFT Webography

Federal

CMHS/ NIDRR/SAMHSA: Wellness Summit
<http://www.bu.edu/cpr/resources/wellness-summit>
The website, hosted by Boston University's Center for Psychiatric Services in conjunction with an NIDRR/SAMHSA-funded Rehabilitation Research and Training Center, is
Designed to provide information on promoting wellness for people with
mental illnesses. The "Pledge for Wellness" also appears there.

HHS <http://www.healthypeople.gov/hp2020/default.asp>
Healy People 2020: provides science-based, 10-year national objectives for promoting health and preventing disease and will reflect assessments of major risks to health
and wellness, changing public health priorities, and emerging issues
related to our nation's health preparedness and prevention. The
initiative led by the Dept. of Health and Human Services (HHS) leverages
scientific insights and lessons learned from the past decade, along with
new knowledge of current data, trends, and innovations.

AHRQ : http://www.ahrq.gov/populations/chroniccaremodel>
Also within HHS, the Agency for Healthcare Research and Quality (AHRQ)
has introduced a Toolkit for Implementing the Chronic Care Model in an
Academic Environment . This toolkit aims to help improve care for consumers who need chronic care, and it presents a range of materials for implementing the Chronic
Care Model in academic healthcare settings. Designed to transform
service delivery, the Chronic Care Model creates a unique,
multi-disciplinary team approach that empowers consumers to become
active participants in their own care.

National

IMAPCT : University of Washington: http://impact-uw.org/
Depression screeing and treatment in primary care. In one of the largest treatment trials for depression to date, a team of researchers led by Dr. Jürgen Unützer followed 1,801 depressed, older adults from 18 diverse primary care clinics across the United States for two years. The 18 participating clinics were associated with eight health care organizations in Washington, California, Texas, Indiana and North Carolina. The clinics included several Health Maintenance Organizations (HMOs), traditional fee-for-service clinics, an Independent Provider Association (IPA), an inner-city public health clinic and two Veteran's Administration clinics.

National Council : Business & Practice Areas: Integrated Healthcare
http://www.thenationalcouncil.org/cs/integrated_healthcare Overall well-being is a function of both mental and physical health. Just as screening and evaluation for mental illnesses and addictions is increasingly available in primary care settings, screening and evaluation for general health problems must be available in behavioral health settings. Despite funding and staffing barriers and confusing liability and confidentiality issues, many community behavioral healthcare organizations have implemented innovative clinical and financing models to address the comprehensive healthcare needs of those they serve. The National Council offers the resources to support the replication and adaptation of models that are effectively providing comprehensive care.

Bazelon: http://www.bazelon.org/issues/general/publications/RoundtableReport.pdf

This publication presents major points from a 2004 roundtable convened to discuss strategies for integration of primary care and behavioral health in the context of private health insurance. Roundtable participants included health care leaders with expertise in primary care, mental health and substance abuse services, and public and private-sector health plan policy, purchasing and administration. [Item IN-3 $4, shipping and handling included] (Feb. 2005)

Health Management Associates: http://www.healthmanagement.com/files/rwjfreport.pdf

Several state and local health policymakers, managed care organizations and providers have recently implemented programs designed to address both the behavioral (mental and substance abuse disorder) and physical health needs of individuals. As the topic of integrated physical and behavioral health garners increasing attention, The Robert Wood Johnson Foundation sought assistance in understanding the facets of existing integrated services initiatives in order to have knowledge of the approaches, treatment models and services used to achieve integration. The aim of the *Integrating Publicly Funded Physical and Behavioral Services: A Description of Selected Initiatives* report is to identify and describe existing models of publicly funded integrated service programs.

NASHPD: http://www.nasmhpd.org/

National resources, inclusing NASMHPD Medical Directors Council Technical Report - Measurement of Health Status for People with Serious Mental Illnesses., and NASMHPD Medical Directors Council Technical Report - Obesity Reduction & Prevention Strategies for Individuals with Serious Mental Illness, October 2008

Ohio

- Interface Network: https://interfacenetwork.grouphub.com/login
- OCCIC: http://www.ohioactcenter.org/occic.html#OCCIC
- WMR : http://www.wmrohio.org/wmrovw.html
  Tobacco and Recovery : http://www.ohiotobaccorecovery.case.edu/
- Health Policy Insititue of Ohio:
  http://www.healthpolicyohio.org/publications/mentalhealthintegration.html