Table comparing key components of the Primary and Behavioral Health Care Integration (PBHCI) grants and Commissioning for Quality and Innovation (CQUIN) program

	PBHCI (US)	**CQUIN (Eng.)**
Target Population	Adults with serious mental illness – about 15,000 between 2009 and 2015	Adults with psychotic illness (affective or schizophreniform) – about 25,000 annually
Site	Outpatient behavioral health clinics throughout America	Inpatient mental health units or community Early Intervention Services (EIS) in England
Financing authority	SAMHSA	Funding provided by NHS England to 211 Clinical Commissioning Groups (CCGs – consortia of clinical and lay stakeholders, led by a GP, that commissions services for local area). CCGs then disseminate funds.
Payment mechanisms	Direct grant funding: $400,000 per year for four years, tied in to providing certain physical health and wellness services and in meeting certain quality outcomes.	P4P mechanism used in conjunction with a provider budget: 1.0-2.5% of a provider organization's (Trust) budget is withheld unless quality indicators are met.
Spend	$40 million in 2015	Estimated $165 million annually
Expected/Required services	Core requirements (for 2015): - Comprehensive care management - Care coordination and health promotion - Comprehensive transitional care Other areas of emphasis: - Health Information Technology – grantees must achieve meaningful use standards - Prevention and health promotion – preventive screening and assessment tools;	Patients must be screened during admission for: - smoking status - lifestyle factors (including diet, exercise, alcohol and drugs), - Body Mass Index, - Blood pressure, - Glucose regulation (HbA1c or fasting glucose or random glucose as appropriate) - Blood lipids; and where clinically indicated, directly provided with, or referred onwards to other services for interventions for each identified problem (with

	incorporating recovery principles; peer leadership and support; must provide one of tobacco cessation, nutrition consultation, health education, self-help/management - Sustainability – grantees must submit a sustainability plan in Year 2 Data collection requirements includes: quarterly BP, BMI, waist circumference, Breath CO; annual plasma glucose (fasting) and/or HbA1c, and lipid profile; six-monthly national outcome measures	thresholds for intervention being as set out in NICE guidelines).
Integration structures	Need to have on-site primary care services* and formal written agreements with at least 3 other primary care providers delivering services to the local patient population. Referrals must be made to external providers for specialist physical care. These are core requirements of the grant.	Monitoring must be conducted on-site but external referral (to primary care* or specialist physical care) is the norm if intervention is required.
Accountability mechanisms	Grantees must provide quarterly progress reports to demonstrate that they are meeting program requirements to receive the next year's funding.	The CQUIN operates on a sliding scale. It is fully met if 90 out of a random sample of 100 inpatients with a psychotic illness or 80 out of a random 100 community EIS patients (as audited by the Royal College of Psychiatrists) treated by the Trust in the last year (denominator) show that they were screened for all six measures listed in the CQUIN guidance and where appropriate referred.

Impact (outcomes)	From early RAND report:[1] - Large variation in extent of integration achieved - Greater improvement in control of diabetes, dyslipidemia and hypertension compared to non-integrated clinics (no improvement in obesity or smoking cessation rates) - Better access to care Subsequent analyses have shown improvement in lipid control (but not other parameters of physical care) and reduced hospitalizations in those grantees in whom integration had been already established for a period of time.[2, 3]	Figures on achievement are not yet publically available but are intended to be from the next financial year. Anecdotal evidence suggests improved interface working between primary and secondary care, increased focus in the physical healthcare of individuals with serious mental illnesses and improved access to physical health checks for individuals with serious mental illness, both in primary care and in secondary mental health services.[4]

*Note: primary care services in the UK and the US are defined differently, not just in the types of services provided (e.g. ob/gyn in the US is considered primary care whereas in the UK it is a specialism provided only in hospitals) but also profession (so a referral to primary care in the UK would in the majority of cases involve review by a primary care physician whereas in the US primary care services are more likely to be delivered by nursing or allied health professionals).

Abbreviations: BP = blood pressure; BMI = body mass index; CO = carbon monoxide; HbA1c = glycated hemoglobin; P4P = pay for performance; Q4 = fourth quarter; SAMHSA = Substance Abuse and Mental Health Administration

References:

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