

Advancing Clinical Information Systems to Support Care Coordination and Improved Outcomes for Individuals with Mental Health and Substance Use Disorders

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California Institute for Mental Health
CaIMHSA Integrated Behavioral Health Project



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Introduction

The Patient Protection and Affordable Care Act (ACA) of 2010 is driving a new era in how we think about health, how health care is delivered, how quality is defined, and how technology is used to facilitate the efficiency and effectiveness of the health care delivery system as well as individuals' ability to achieve optimal health. Conversations about health are no longer limited to one's physical health, but also include behavioral health and the social determinants of health. "Whole-person" and "person-centered" care are emerging as expectations for what the reformed health system should be accountable for and deliver. **Integrated care** is defined as services in which providers consider all of an individual's health conditions in the course of treatment, including physical illness, mental disorders, or substance abuse, and where providers coordinate care for the patient or client.¹ An integrated, collaborative care model is included in the language of the ACA, and care coordination stands out as one of the most important means of achieving that integration.

No single system of care can fully meet the needs of individuals with complex and co-occurring health, mental health or substance use disorders. Providers across the safety net need to work collaboratively to assure each individual's care is person-centered, focused on the whole person, and proactive. A critical tool to manage this coordinated, person-centered care is a **clinical information system**, or **CIS**. The MacColl Institute for Healthcare Innovation offers the following description of a CIS:

*"Integrated care brings together the different groups involved in patient care so that, from the patient's perspective, the services delivered are consistent and coordinated."*²

"Effective chronic illness care is virtually impossible without information systems that assure ready access to key data on individual patients as well as populations of patients. A comprehensive clinical information system can enhance the care of individual patients by providing timely reminders for needed services, with the summarized data helping to track and plan care. At the practice population level, an information system can identify groups of patients needing additional care as well as facilitate performance monitoring and quality improvement efforts."³

Historically, CIS have been designed for use in single provider settings, not to support collaborative, multi-agency care processes. Nevertheless, the premise of this paper and associated recommendations is that much of the core architecture and functionality of CIS can be leveraged to support the added complexity of integrating and coordinating services provided by separate entities, including primary care and behavioral health providers.

¹ SAMHSA. Understanding Health Reform: Integrated care and why you should care.

² http://www.mckinsey.com/insights/health_systems/what_does_it_take_to_make_integrated_care_work

³ http://www.improvingchroniccare.org/index.php?p=Clinical_Information_Systems&s=25

CIS are products (such as registries⁴ and other population health management tools) that provide greater clinical functionality compared to most electronic health records (EHR) or electronic medical records (EMR).⁵ A well-designed CIS enables provider organizations to improve outcomes and processes for individual patients, populations or groups of patients, and whole systems of care by providing real-time information that enables identification of changes that improve future performance and outcomes. As such, they are quality improvement tools that provide the infrastructure necessary to document and track improvements in population health and patient experience, while reducing the system fragmentation that leads to poor care quality and higher costs.

Although CIS are becoming more widely used in medical settings and clinics, the application for behavioral health is typically limited to the identification of some mental health and/or substance use disorders and prescribed medications, along with limited tracking of symptoms (e.g., depression levels).

Supporting improved outcomes for individuals with mental health (MH) and/or substance use disorders (SUD) calls for an expansion of the functionality and content of CIS so behavioral health providers can use them to support their services - and all involved providers can use them to work together to coordinate care.

While providers may achieve some improved coordination through the use of their local CIS, developing systems that coordinate across providers and organizations will require a broader commitment and investment by the range of stakeholders potentially involved, including health plans, primary care, mental health, and substance use clinics and providers. This commitment requires investing in a range of services – from prevention to shared care planning and care coordination – to support data integration among providers.

The goal of this paper is three-fold:

- 1) Engage leaders of provider and payer organizations to look beyond the capability of health records and transaction systems, and envision the benefits of a well-designed CIS for their organizations;

*RECOMMENDATIONS FOR CIS
TO SUPPORT MH/SUD INTEGRATION
AND WHOLE PERSON CARE*

- *Increased Functionality*
 - *Expanded Data and Clinical Content*
 - *Supports for Successful Implementation*
-

⁴ “A registry — an information system that can track individual patients as well as populations of patients — is a necessity when managing chronic illness or preventive care. The registry is the foundation for successful integration of all the elements of the **Chronic Care Model**. The entire care team uses the registry to guide the course of treatment, anticipate problems, and track progress.”

<http://www.ihf.org/knowledge/Pages/Changes/ClinicalInformationSystems.aspx>

⁵ Electronic Health Records versus Chronic Disease Management Systems: A Quick Comparison, March 2008, California Health Care Foundation, <http://www.chcf.org/publications/2008/03/electronic-health-records-versus-chronic-disease-management-systems-a-quick-comparison#ixzz2aSbJw484>
<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/E/PDF%20EHRvsCDMSFactSheet.pdf>

- 2) Enlist thought-leaders and innovators to advance the use of CIS for care coordination and support improved outcomes for individuals with serious MH/SUD; and
- 3) Heighten the field's awareness of the practical role a CIS can play in supporting the integrated care of complex clients.

We offer recommendations for critical CIS functionality and core data elements to be collected and tracked, as well as key factors for successful implementation. Our recommendations can be used to modify existing CIS applications or in the development of new products. These recommendations are based on the work of the Integrated Behavioral Health Project (IBHP) and California Institute of Mental Health (CiMH) over the past eight years. Since 2008, IBHP and CiMH have collaborated on projects to advance integrated behavioral health and primary care and improve health outcomes for people with mental illness and co-occurring MH/SUD by focusing on the development of new service delivery models in numerous sites throughout the State of California. The recommendations also reflect the views and experiences of twenty experts from California and Washington State who were interviewed over a four-month period from February to May 2013 (See Appendix A). In addition, this paper was reviewed and informed by an advisory group made up of leaders from mental health, substance use, primary care and payer organizations (see Appendix B).

Recommendations for Clinical Information Systems to Support Coordinated Care

Meaningful coordination between behavioral health and primary care organizations requires tracking individual patients within and across systems, sharing and exchanging information in real-time, accessing information in clinically informative and usable ways, and creating and sustaining awareness in both sectors of the importance of addressing behavioral health and primary care needs of patients in all settings. The following provides a summary of recommendations for CIS in three areas: functionality, data and clinical content, and implementation considerations. These recommendations are based on input from experts in the field and our advisory panel as well as learning from recent integration projects.

I. Recommended Functionality

To promote services that address both the mental health/substance use disorder (MH/SUD) and physical health (PH) needs of patients, and support coordination across service providers, a well-functioning CIS should address the following 10 areas:

1. **Shared Care Planning:** Fundamental to care coordination is shared care planning.⁶ A CIS must support collaborative planning, routine use of key cross provider client objectives and, ultimately, a shared care plan. Examples of how a CIS can be leveraged to do this include:
 - Make it accessible to providers in both behavioral health and primary care settings.
 - Allow providers across systems to develop a shared care plan that is dynamic and not static (i.e., can be used to inform an individual provider's services and supports, and then updated to help inform others involved in each patient's care).

RECOMMENDED CIS FUNCTIONALITY

- 1) Shared Care Planning
- 2) Clinical Prompts and Flags
- 3) Treatment Reconciliation
- 4) Treatment Progress and Measurement
- 5) Broad Range of Information
- 6) Patient Engagement
- 7) Ease of Adaptability, Access and Use
- 8) Communication and Information Exchange
- 9) Proactive Care and Prevention
- 10) Security

⁶ Shared problem lists and shared care plans are becoming the standard of care for persons with multiple/complex health conditions and to support client self-management. For example, there are shared problem lists and care plan requirements recommended in Meaningful Use Stage 3 Work Group Recommendations 2012. (http://www.healthit.gov/sites/default/files/muwg_02_oct_12.pdf): The Agency for Healthcare Research and Quality in collaboration with The Institute for Healthcare Improvement have sponsored the development of an on-line shared Care plan, <http://www.innovations.ahrq.gov/content.aspx?id=2191>

- Include names of care team members and names of caregiver and family support persons who are involved the patient’s care.
 - Include patients’ goals in their own words as well as any advance directives that are in place.
2. Clinical Prompts and Flags: A CIS should provide prompts or flags to facilitate effective, timely treatment and coordination of care. These prompts should be designed to allow for quick prioritization of immediate needs while keeping the whole person’s needs clear. In a well-designed CIS, prompts enable providers to differentiate immediate and long-term needs, and improve the efficiency of the encounter. Examples of prompts that support coordinated care include:
- Alert the primary care provider and team regarding a patient’s behavioral health needs.
 - Remind the primary care provider and team to explore behavioral health reasons for why a patient’s chronic illness is not well-controlled.
 - Remind both primary care and behavioral health providers to attend to preventive care.
 - Prompt behavioral health providers to monitor basic physical health care vital signs and labs such as blood pressure, body mass index (BMI), fasting glucose, and, for those on psychotropic medications, kidney and liver functioning.
 - Flag high-risk patient and/or follow-up needs.
 - Prompt to guide clinical decisions and medication selection consistent with evidence-based care guidelines.
-
- “The patient is an integrated person with multiple needs. We separate it out because it’s easier for us, not because it makes sense.”*
-
- Lisa Golden, San Francisco
Department of Public Health*
3. Treatment Reconciliation: Providers who care for complex clients need access to comprehensive information to assure their treatment supports complement and do not conflict with the treatment recommendations of other providers and vice versa. A common example of this is medication reconciliation, a process that is facilitated by a CIS. Given the interactive nature of physical, mental and substance use disorders, this reconciliation process applies to all types of treatment, regardless of its modality or provider.
4. Treatment Progress and Measurement: Providers need a means to facilitate treatment decisions and track over time the status of clients’ conditions and progress towards goals or targets. This functionality helps link individual treatments and supports to the shared plan, and assures that encounters promote wellness and whole health. Ideally, this functionality also enables the provider to “treat to wellness” as well as “treat to target.” While CIS are commonly designed to measure and track physical conditions and outcomes, they often lack comparable capability for tracking mental health or substance use outcomes. Expanding measurement functionality to include these categories is critical. Examples of potential categories include:

- Mental health and/or substance use recovery.
- Patient engagement, patient activation, or stage of change.
- Symptom severity, e.g., level of depression, anxiety, or pain.
- Functional status.
- Patient’s wellness and health goals.

5. Broad Range of Information: To effectively support the coordinated care of complex clients, a CIS needs the capacity to capture a broad range of data elements based on the complexity of client needs. To generate informative, tailored, client-specific data displays, a CIS needs to consider additional information such as:

- A profile that promotes a comprehensive understanding of the individual, including health and wellness (e.g., nutrition, exercise, and stressors).
- Psychosocial and social determinants of health, and risk factors associated with family history, environment, and behaviors.
- Person-centered goals.
- Care management encounters including enabling services like transportation, connection to housing, and food stamps.

6. Patient Engagement: A CIS needs to support the engagement of clients in their care processes, including self-care. Examples of CIS functionality for patient engagement include:

- Supporting meaningful patient and provider interaction and promoting behavior change by providing a view over time of clients’ vital signs, lab results, and other measures (e.g., weight loss, smoking cessation, and chronic illness management).
- Allowing patients to communicate with their providers, to schedule appointments, etc.
- Allowing patients access to their health records (e.g., lab tests, medications prescribed), self-management and self-care information, and Frequently Asked Questions.

“Currently, IT systems are developed for providers, agencies and payers to track outcomes, but not designed for data to be given back to the consumer. It needs to be more sophisticated.”

-Brenda Goldstein, Lifelong Medical

7. Ease of Adaptability, Access and Use: To support real-time, clinical use of data by individual providers, a CIS must be easy to use. Capabilities particularly important for integration include:

- A single visual display of a patient’s profile that *includes* behavioral health.
- Simple provider generated queries and data sorting.
- Accessibility to anyone on the multidisciplinary team whether on-site or virtually.
- Analytic and reporting capabilities to measure both the costs and savings associated with integration with MH/SUD.

- Creation of clinical and operational performance dashboards which clinic staff/organizations can use to track measures and improvements.
8. Communication and Information Exchange: A CIS should promote and support cross system communication and information exchange to support clients. Population-based analytic software or registries need to pull data from multiple EMRs to analyze and present data in a meaningful way to provider teams that span multiple sectors. In addition, CIS need to support communication and exchange of information among individual providers, hospitals, and health plans as well as communication with patients regarding changes in condition, questions about treatments or side effects, care coordination needs, and other issues.
 9. Proactive Care and Prevention: A CIS needs the capacity to support proactive care and prevention at both the individual patient and population levels. Examples include:
 - Providing standard reports as well as user queries and filters to monitor different subpopulations and clinical conditions and compare a particular patient to the population in general.
 - Enabling the identification of patients that need outreach to schedule age or gender-specific preventative services.
 - Analytical capacity to synthesize data to risk stratify patient populations, which in turn supports proactive, population based, cost-effective, targeted care management.
 10. Security: Exchange of information can only be successful when appropriate controls are in place for protecting the privacy of individuals' personal health information. A CIS must have highly flexible and specific privacy controls to support both individual preferences of security and relevant laws and regulations. For example, to address confidentiality policies such as HIPAA⁷ and 42 CFR Part 2⁸, a CIS should track release of information and client consents, and open or close access according to individual patients' preferences.

Finally, regulatory compliance and reimbursement are not considered core functions for a CIS since Practice Management Systems and EMR/EHRs typically address these. However, a well-designed, routinely used CIS can contribute important information to substantially reduce the risk for fraud and abuse, especially patient harm.

II. Recommended Data and Clinical Content

CIS core functionalities will only be useful if relevant information for integration of MH/SUD is routinely and systematically captured. Given the diversity and complexity of patients with MH/SUD and other

⁷ Health Insurance Portability and Accountability Act (HIPAA) requires the protection and confidential handling of protected health information.

<http://www.dhcs.ca.gov/formsandpubs/laws/hipaa/Pages/1.00%20WhatIsHIPAA.aspx>

⁸ Code of Federal Regulations, Title 42: Public Health. Part 2 of the CFR refers to the confidentiality of alcohol and drug abuse patient records.

chronic conditions, a CIS must be able to capture and track a wide array of data. Supporting improvement of populations or groups of clients adds breadth and depth to the data needed.

Common Existing CIS Data Categories	New Data Categories Recommended
Demographics Vitals Conditions/Diagnoses Medicines Lab and Other Diagnostic Tests Risk Factors Consults, Education and Referrals Vaccinations Notes	Care Team Wellness Levels of Functioning Patient Goals and Directives

Over the last two decades, patient registries, a common CIS used in primary care settings, have evolved from individual disease focused to supporting the whole patient, regardless of condition(s). These more whole health focused registries generally support the categories of data listed below. To effectively support care coordination and MH/SUD integration, the following *additional data elements* are recommended for these established categories:

1. **Demographics:** While patients’ demographics are routinely captured in CIS tools like registries, they are often missing information related to the social determinants to health. It is recommended this category be altered and expanded to include information such as:
 - Socioeconomic status
 - Employment status
 - Housing status
 - Food security
 - Neighborhood safety
2. **Vitals:** The vitals category of patient data needs to include mental health as well as physical vitals. Examples of this include general distress measures (e.g., depression, anxiety, thoughts of suicide) and quality of life indicators.
3. **Diagnoses/Conditions:** As is the case with most patient registries, a CIS should contain all possible diagnoses and conditions. To support MH/SUD integration, a CIS should include all diagnoses in the DSM⁹ (ideally aligned with ICD codes). However, key to this change in the CIS is increasing awareness and provider knowledge of the interconnectedness across physical, mental health and substance use disorders.
4. **Medicines:** To support the integration of MH/SUD concerns, the medication lists in CIS should include all psychotropics by specific medication as well as drug class. In addition, to support

⁹ Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association

shared care planning and coordination, the name and contact information of prescribers should also be included.

5. Lab and Other Diagnostic Tests: The category of labs and other diagnostic tests should be expanded and used to keep track of the results of tests ordered by all providers in the care team, including dates tests were ordered and completed to facilitate follow up. The availability of these data is vital to enabling routine treatment reconciliation and whole person care.
6. Risk Factors: Risk factors are a category that needs to be expanded considerably, given their impact on treatment effectiveness, client engagement and overall care coordination concerns. Additional factors to be included are:
 - Family risk factors like family medical history, structure and dynamics, history of suicide, domestic violence, and child abuse; and
 - Legal and other health risks like criminal/legal history, involvement with any social service or correctional agency (e.g., Probation, Children and Family Services, etc.), and gun ownership/access.
7. Consults, Education and Referrals: In terms of care coordination and whole person care, this category of data is one of the most important and must be expanded to include all types of services, including medical, behavioral, social, self-help, educational, and benefits advocacy. An invaluable category for the care coordinator, this area must include dates of referred services, roles and responsibilities for scheduling and follow-up, status of referrals and findings, among others.

In addition to expansion of these existing categories, we recommend the CIS evolve to capture several additional data categories:

1. Care Team: The names, contact information, and roles of all care team members need to be available in a CIS. As such, we recommend adding this new category of data and making it easy to use and keep current. Team members include other providers, the care coordinator or navigator, and key family member or other supports. For example, for known providers who are care team members, these data can be pre-populated and available in pull-down menus. This approach would allow reporting and querying by team member names. Other individual members of the care team (e.g., family members) can be captured as free text.
1. Wellness: Exercise, eating and sleep habits are examples of wellness related factors that are very important to supporting whole health. We recommend the creation of a new data category to capture and track wellness and wellness behaviors to expand their relevance to all populations, not just individuals with specific chronic conditions, such as diabetes or cardiovascular issues. Given the wide-ranging and individual nature of wellness issues and activities, this information is likely best captured as free text. While this eliminates searchability of this content, it maintains important individual level information for providing person-centered care.

2. Levels of Functioning: Individual functional status is another area that is highly relevant to achieving whole health. A patient’s level of functioning is critical to treatment and self-care and so should inform all care planning and treatment. Additional elements to consider include:
 - Activities of daily living
 - Social support system
 - Coping skills
 - Self-esteem
 - Interaction with peers
 - Learning disorders
 - School attendance and performance (in children)
 - Other life stressors (e.g., living with a family member who is dying, has a family member who is incarcerated, etc.)

Some categories of functioning have standardized measures (e.g., Activities of Daily Living), while others will be more tailored to the practice setting and care team needs. Ideally, these data would be captured via both pre-populated pull-down menus and free-text.

3. Patient Goals and Directives: To be person centered, it is important to capture the treatment goals and preferences in the words of the patient. This area can also include advanced directives. As with the Wellness category, patient goals and directives are highly individualized. Capturing this information in a CIS is recommended via free text.

“If we cannot get clarity or the green light to share data across portals, we are not going to advance on integration.”

- *Dianna Daly, Cal Optima*

III. Recommended Implementation Considerations

Increased functionality and expanded data and clinical content do not ensure that a CIS will be used effectively to support the integration and coordination of MH/SUD with primary care services. Since CIS implementation can be challenging, we asked experts and our advisors to identify key factors to support positive adoption of a CIS.¹⁰ These can be grouped into four areas: leadership and oversight, clinical and operational processes, technical structure and interface, and health plan involvement.

1. Leadership and Oversight: Strong leadership is essential to help behavioral health and primary care practices make the cultural shift to understanding the use of CIS systems for managing and improving patient care and sharing data across organizations to improve care coordination. Factors that facilitate this include:
 - Clear guidance on how and what data can be shared across systems (including State interpretation on HIPAA regulations to create data sharing standards across counties), and then development of appropriate data sharing policies and agreements.

¹⁰ Integrated Policy Initiative: Behavioral Health Measurement Project, January 2011
<http://ibhp.org/uploads/file/Measurement%20report%20Linkins.pdf>

- Consensus between primary care and behavioral health about a set of core data elements to be captured and shared.
 - Organizational leaders or change “champions” to be the “go to” persons within their respective departments/units who have the comfort level and fluency with the technology to support the learning among others.
 - Strong IT management leadership and skills to help bridge the “generation gap” with regard to use of technology.
2. Clinical and Operational Processes: Implementing a CIS requires attention to how the system will be incorporated into everyday clinical practices and operations within the context of clinics, including:
- Work flows designed to ease the burden on data entry by staff.
 - Workforce retraining to help clinicians to use data for improvement, including supporting conversations with patients, case conferences and care coordination.
 - Supervisor training in the use of data for supervision.
 - Easy to use tools for data collection.
 - Online assessments available for patients.
3. Technical Structure and Interface: To allow effective and efficient use of a CIS and the array of information that is relevant to each patient, there are key factors related to its technical structure and user interface that should be thoughtfully addressed:
- Report writing and querying that staff can do on their own.
 - Technology to achieve interface across different systems to maximize the downloading of data from other systems and minimize the manual entry of data.
4. Health Plan Involvement: As provider organizations endeavor to develop and use CIS to integrate MH/SUD services and provide whole-person and person-centered care, health plans also have an important role. Recommendations to engage and expand the role of health plans include:
- Provide reimbursement for preventive services.
 - Require shared care planning paid for and incentivized by the health plan.
 - Support shared care plans by creating a place for them to live outside of individual agencies.
 - Address issues of health literacy.
 - Inform patients about the benefits of their providers sharing about their health information to promote more universal consents.
 - Play a strong role in helping counties and organizations to share information, collect and house data, and use the data for improving population health.

Summary

As care organizations plan and revamp their service systems to integrate MH/SUD and primary care services, and routinely coordinate care, it is critical to leverage new and existing technology to support and enhance the effectiveness of these new care delivery approaches. No single system can meet the range of issues that need to be addressed in caring for complex patients or clients, which is why coordination and collaboration across the safety net is so important. The use of CIS for this complex work may also be leveraged to inform the emerging Federal requirements for meaningful use, as well as adhere to them as they take effect.

To ensure that clinical information systems are designed to support the administration and delivery of integrated, coordinated care, leaders and clinicians from primary care and behavioral health need to work collaboratively with software vendors to ensure and improve the functionality and flexibility of CIS to support person-centered care. In addition, to strengthen connections and integration between primary care and behavioral health providers, it is essential that health plans take a leadership role to provide accountability and incentives to align goals around measurement, data-sharing and care management to facilitate shared care planning and proactive care.

About CiMH

The California Institute for Mental Health (CiMH) was established in 1993 to promote excellence in mental health services through training, technical assistance, research and policy development. CiMH strives to promote wellness and positive mental health and substance use disorder outcomes through improvements in California's health systems.

Please visit us at www.cimh.org

In collaboration with a range of partners from government, academia and the service delivery sectors amongst others, CiMH is working on several initiatives that address the pressing need for improved linkage and access between primary and behavioral healthcare in our state.

About IBHP

Launched in 2006, the Integrated Behavioral Health Project (IBHP) is an initiative to accelerate the integration of behavioral health services and primary care in California. Our goal is to identify and elevate program elements, strategies, and treatment approaches leading to successful integration of mental and physical care. IBHP is a team of consultants working for the California Mental Health Services Authority (CalMHSA) as part of its Statewide Stigma and Discrimination Reduction Initiative.

Please visit us at www.ibhp.org

Support for this project was provided by IBHP with funding from a CalMHSA contract.

Appendix A – Key Informants

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