



**California Primary Care, Mental Health, and
Substance Use Services
Integration Policy Initiative**
September 14, 2009

Volume II: Working Papers

The Integration Policy Initiative is a project of CiMH and funded by The California Endowment with additional financial support provided by IBHP

About the IPI Report

California's county mental health directors, other state mental health leaders and leaders from the Integrated Behavioral Health Project and Community Health Centers met together February 2008 in a Policy Forum to discuss issues related to integrated care and the healthcare needs of people with serious mental illnesses. The conclusions of the Forum were clear: The failure to address the need for primary and behavioral health care coordination and integration has resulted in grave consequences for individuals and families including chronic medical conditions and early mortality in individuals with serious mental illnesses. The other side of the primary care/behavioral health interface is the significant number of people in primary care that need behavioral health services. Primary care is usually the first community-based health care contact for individuals and is intended to provide comprehensive care, responding to most health care needs. The Forum and the dialogues that were initiated there led to the development of the Integration Policy Initiative.

The Integration Policy Initiative (IPI) builds on the significant work already underway in California, incorporating models developed in California and nationally that are intended to improve general healthcare, primary care, the integration of mental health (MH) and substance use (SU) services with primary care and the integration of primary healthcare with MH and SU services. There are tensions among these systems in California, as there are in other parts of the country—the legacy of many years of working in silos as well as a chronic lack of funding. While policy and financing barriers must be addressed at the state and national levels, collaboration to achieve the IPI Vision must be addressed at the local level, in each community. The IPI Report is intended to support primary care and MH/SU providers in their future work to improve the integration of these services.

The Volume I: Report is accompanied by two volumes of additional materials, Volume II: Working Papers and Volume III: Examples for Dissemination. Not every reader will want all the information, but many will want something more than the *Executive Summary* in the Report. Here is a quick tour:

1. To **keep the Vision in sight**, look at the top of each page
2. To **review specific examples of the substantial integration work** and thinking in California, see:
 - *Volume II, Map of Selected California Integration Initiatives*
 - *Volume III: Examples For Dissemination*
3. To **understand the values** that must always inform implementation, refer to:
 - *Volume I, IPI Principles*
 - *Volume II, Quality Chasm Aims/Rules*
 - *Volume II, National Consensus Statements on Recovery*
4. To **learn about clinical models**, services to be provided and measurement strategies, review:
 - *Volume I, IPI Continuum*
 - *Volume II, Delivery System Design*
 - *Volume II, Measurement*
 - *Volume II, Resource List*
 - *Volume I and Volume II, Endnotes*
5. To **become aware of the issues that impact implementation** of these clinical models, see:
 - *Volume I, Appendix A: Brainstormed Barriers/Opportunities*
 - *Volume II, Delivery System Design*
 - *Volume II, Financing and Regulation*
 - *Volume II, Workforce Development*
 - *Volume II, Healthcare Information Technology.*
6. To **focus on future actions** to move the Vision forward, read:
 - *Volume I, IPI Recommendations*
 - *Volume II, Recommendations Timeline*
 - *Volume II, IPI Continuum Worksheet for Community Dialogue*
 - *Volume III, Examples For Dissemination*
7. For **background on the IPI process** and those who participated, see:
 - *Volume I, Appendix B: IPI Process and Participants*

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Recommendations Timeline

The following table summarizes the IPI Recommendations in a five-year time horizon in which activities are sequenced to reflect optimal phasing assumptions and real timeframes (e.g., the deadlines for renewal of federal waivers).

Timeline	2009	2010	2011	2012	2013	2014
Recommended Actions, in Collaboration With Other Organizations						
Delivery System Design						
Advocate for clear policy direction that designates the IPI Vision/Principles/Continuum and stepped model of care as the framework for a reformed healthcare system in California	X					
Develop strategic approaches to change organizational culture, ensure person-centered care and reduce stigma regarding MH/SU among providers, the community and consumers/family members (see Volume II: Delivery System Design)	X	X				
Develop detailed clinical guidance for person-centered collaborative care and disseminate through multiple channels (e.g., CalMEND, CPCA, IBHP, CMHDA committees)		X				
Develop training and technical assistance that supports the IPI Vision /Principles/Continuum and the varying levels of readiness in implementing these ideas	X	X	X			
Dissemination Part I: Promote a phased implementation of the strategic and clinical approaches, supporting communities as they develop their local approaches to implementing the IPI Continuum, and map the spread of implementation—this activity is already underway thru CALMEND, IBHP and others		X	X	X		
Dissemination Part II: Continue to support implementation of the strategic and clinical approaches and development of the local IPI Continuum throughout the state as financing and regulatory changes provide better supports (see below)			X	X	X	
Link to statewide healthcare information technology	X	X	X	X	X	X

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Timeline	2009	2010	2011	2012	2013	2014
Recommended Actions, in Collaboration With Other Organizations						
initiatives (see Volume II: Healthcare Information Technology) to assure they support the IPI Vision/Principles/ Continuum (e.g., making information sharing seamless as a part of collaborative care)						
Link to statewide workforce development initiatives (see Volume II: Workforce Development) to assure they support the IPI Vision/Principles/ Continuum (e.g., develop core competencies in co-occurring disorders and integration approaches)	X	X	X	X	X	X
Complete statewide development of the IPI Continuum in each community and implement strategic approaches, clinical guidance, training/technical assistance for current workforce, and aligned finance and regulation						X
Conduct evaluation of new components at agreed upon intervals (see Measurement below)			X	X	X	X
Financing						
Obtain approval to pay for same day MH/SU and PC services <ul style="list-style-type: none"> Requires legislative action (see AB 1445) to address specific CA FQHC regulations For broader application, would require additional legislation 	X					
Obtain approval to pay for expanded definition of qualified staff (e.g., MFTs, Licensed Professional Counselors) or sign-off by PhD or LCSW for other licensed disciplines <ul style="list-style-type: none"> Currently a federal initiative, which if passed, would require CA changes in regulations 	X	X				
Participate in planning for the 1115 Medicaid Waiver (e.g., Hospital Financing Waiver) <ul style="list-style-type: none"> Expand coverage statewide for Medically Indigent Adults Add MH/SU services to benefit package and encourage integrated service models as part of the 	X	X				

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Timeline	2009	2010	2011	2012	2013	2014
Recommended Actions, in Collaboration With Other Organizations						
Medical Home/Care Management initiatives						
Develop the business case for integration (with an emphasis on the safety net system)		X				
Address barriers to financing integrated services and seek to leverage/align what each system (MH/SU/PC) currently has in resources and incentives (see Volume II: Financing and Regulation), preparatory to renewal of 1915(b) Waiver		X				
Examine Drug Medi-Cal benefit and current programmatic/geographic silos of Alcohol and Drug Programs to assess potential for benefit redesign to support collaborative care		X				
Analyze Certified Public Expense (CPE) and develop policy recommendations that would maximize federal match (see Volume II: Financing and Regulation), preparatory to upcoming renewal of 1915(b) Waiver (e.g., Medi-Cal codes for early intervention services)		X				
Convene stakeholders to make recommendations regarding a revised 1915(b) Medi-Cal MH Managed Care Waiver to support the IPI Vision/Principles/Continuum and address: <ul style="list-style-type: none"> • Definition of who is served (clarifications for age group cohorts) • Definition of where services are offered • Definition of what services are available • Definition of financing methods 		X	X			
Submit revised 1915(b) Medi-Cal MH Managed Care Waiver			X			
Regulation						
Assess Title 9 regulations guiding the carve-out Medi-Cal Mental Health Plans administered by the counties and determine potential revisions that would not require revisions to the underlying 1915 (b) waiver		X				
Develop revised regulations based upon revised 1915B			X	X		

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Timeline	2009	2010	2011	2012	2013	2014
Recommended Actions, in Collaboration With Other Organizations						
waiver						
Implement revised regulations and waiver				X	X	X
Measurement						
Identify, document and assess data currently collected across funding sources and systems (MH/SU/PC) to determine data elements that are useful, not useful and/or missing and make recommendations regarding elimination of mandatory data elements that are not useful and/or redundantly reported		X				
Identify and pilot tools for clinical outcomes assessment across MH/SU/PC settings	X	X				
Develop a Statewide Uniform Data Set (MH/SU/PC) that can be analyzed to inform policy and practice regarding integrated care outcomes (see Volume II: Measurement)		X				
<ul style="list-style-type: none"> Select indicators/measures/outcomes being used nationally and by integration projects currently underway in California (e.g., CalMend, IBHP, CMSP, MHSA, HRSA/BPHC, IHI) 			X			
<ul style="list-style-type: none"> Agree on core current data collection requirements and processes 			X			
<ul style="list-style-type: none"> Initially gather Uniform Data Set through existing reporting methods 			X			
Conduct “baseline” Uniform Data Set data gathering and analysis			X			
Implement Statewide Uniform Data Set						
<ul style="list-style-type: none"> Through existing reporting methods 				X	X	
<ul style="list-style-type: none"> Through fully integrated data set 				X	X	X
<ul style="list-style-type: none"> Ongoing analysis, including business case elements 						X
Establish and implement a research agenda to support knowledge development, identification of evidence-informed practices, and cost offset analysis		X	X	X	X	X

IPI Continuum Worksheet for Community Dialogue

<p>Who Provides Which Services? Worksheet for Community Agreements/Collaborative Planning by the Physical, Mental and Substance Use Healthcare Providers Serving the Safety Net Population Setting for Each Level—It is anticipated that:</p> <ul style="list-style-type: none"> • Providers of MH/SU services will differ among communities (while services for mild MH/SU complexity may be located in primary care, this might not always be the case; while services for severe MH/SU complexity [including the continuum of treatment and community support services defined in the W & I Code] are generally located in specialty MH/SU agencies, there may be some components of MH/SU specialty services that could be offered within primary care) • It is important to reach community agreement on which organizations will provide which levels of MH/SU services • It is important to decide how these organizations will work together for a <i>seamless system</i> that supports access to appropriate MH/SU services, based on individual needs and preferences, and also supports transitions—stepped care up and recovery planning step-down • In addition to developing agreements on which organizations will provide which levels of MH/SU services, collaborative planning is required to determine where the healthcare needs of individuals with serious/severe mental and/or substance use disorders will be met, to assure access to healthcare homes that meet the needs and preferences of these consumers 				
<p>Name of Community:</p>		<p>Names of Participating Organizations:</p>		
<p>Establish agreements on where the healthcare needs of individuals with serious/severe mental and/or substance use disorders will be met, to assure access to healthcare homes that meet the needs and preferences of these consumers.</p>				
<p>Setting for Each MH/SU Level: Describe how collaboration will be achieved across levels and specify below the setting(s)/agency(ies) in your community for each level of MH/SU services for the safety net population, to provide choice and meet the needs and preferences of consumers.</p>				
	<p>Mild MH/SU Complexity</p>	<p>Moderate MH/SU Complexity</p>	<p>Serious MH/SU Complexity</p>	<p>Severe and Persistent MH/SU Complexity</p>
<p>Primary Care</p>				
<p>Specialty MH</p>				

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Specialty SU				
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Key Roles (describe for each level). This listing is intended to generate discussion during the collaborative planning process regarding the relative roles of key players and how they will collaborate, and perhaps change roles, in a stepped care model.

Primary care provider				
Psychiatrist				
Care manager				
Case manager				
Other MH clinicians				
MH program				
SU specialist				
SU program				
Peers/families				
Promotora/navigator				
Pharmacist				
Housing Supports				
Emergency Dept.				
Inpatient MH or SU				
Community Resources				
Medical specialists				
Surgical specialists				
Hospitals				
Other (describe)				

Delivery System Design

A great deal has been accomplished in implementing models for integrated care in California, but there are limitations to how much more can be done without addressing the barriers to integration that are identified in this Report. Starting from an initial listing of barriers developed by the Advisory Group, Work Groups were convened to focus on barriers and recommendations; Work Group members added to the listing of barriers. The listings incorporate the issues identified by the individuals participating in the process, and represent a range of perspectives. The groups went on to focus on the key issues to be addressed, as reflected in the Recommendations and these working paper discussions.

Delivery System Design

1. Need to define standards of care, operationalize them and identify and define measures
2. Improved system performance will require systematic communication, handoffs, referral completion and cultural change for organizations and individual staff
3. Narrowed role of psychiatrists to prescribing only, creating problems with retention and quality of care
4. Stigma regarding substance use disorders in MH and PC providers as well as the community at large
5. Lack of shared awareness/understanding of Recovery, with different meanings for MH, SU and PC
6. Medical model vs. recovery, and many other system language differences
7. Fragmentation of communication in the overall health system, pervasive nature of silos
8. Activating consumers and the community to be proactive users of the system
9. Differences in physical health, mental health and substance use cultures, leading to resistance to integration
10. Lack of shared mission/vision and lack of awareness of interdependence
11. Resistance to change, particularly in these hard times
12. Bias toward building more of the same
13. County MH & SU (BH) systems, underfunded and struggling, seen by some as broken
14. Community perception of county BH, stigma/lack of access
15. Development of competing FQHC BH systems that can't communicate with county BH systems
 - Lack of planning and partnership at both state and local levels
 - Turf issues/scope of services in BH and PC
16. Leverage what each system currently has in resources and incentives, to align MH/SU/CHC financing to achieve synergy for the best possible outcomes
17. Weak state structures for leadership and policy development
 - County-centric
 - No mechanisms for dealing with lack of access/disparities across counties
18. MHSAs have created tensions with CHCs and other systems in some communities

Delivery System Design Recommendations

1. Advocate for clear policy direction that designates the IPI Vision/Principles/Continuum and stepped model of care as the model for a reformed healthcare system in California

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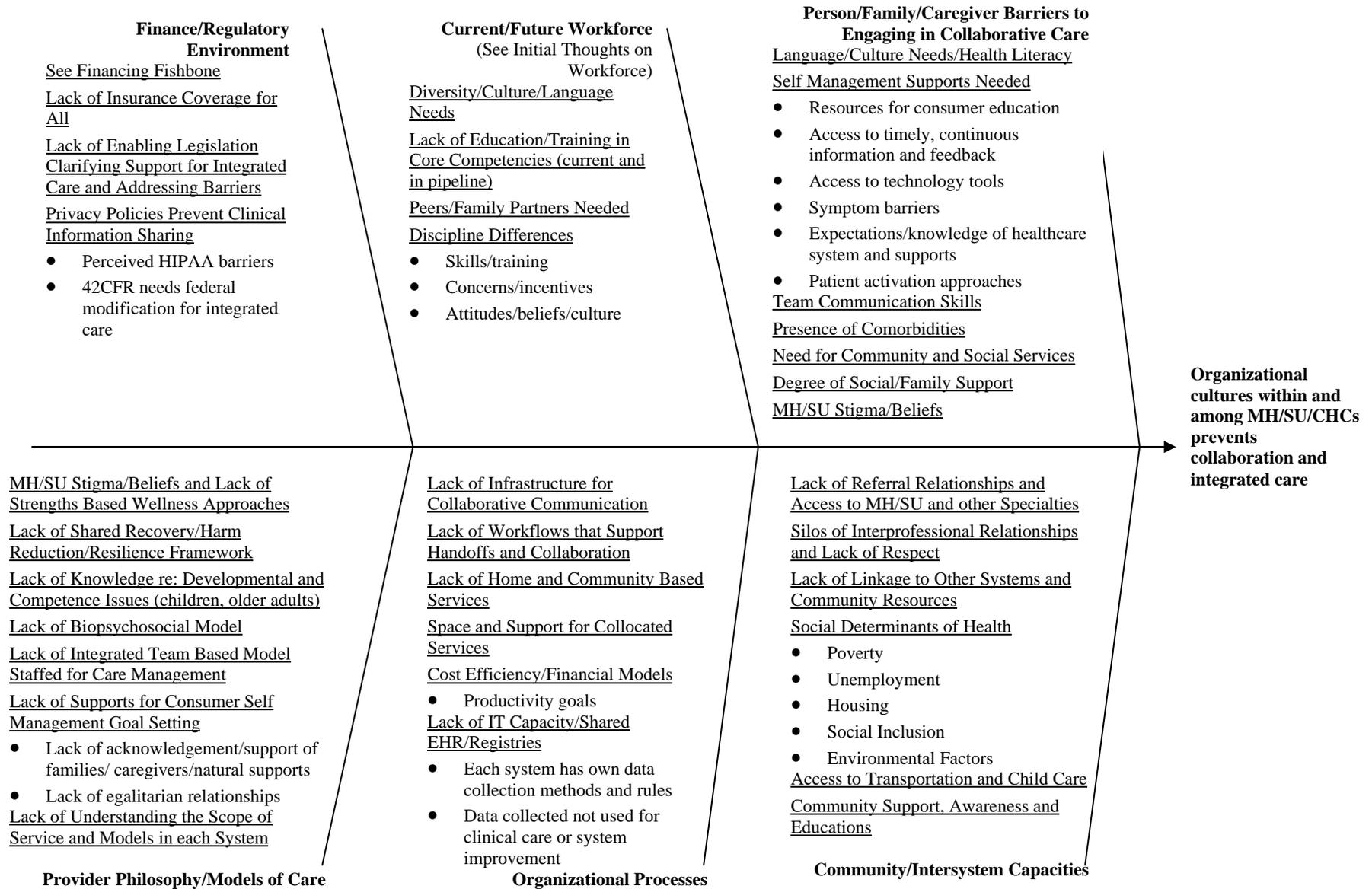
2.	Develop strategic approaches to change organizational culture, ensure person-centered care and reduce stigma regarding MH/SU among providers, the community and consumers/family members (see Volume II: Delivery System Design)
3.	Develop detailed clinical guidance for person-centered collaborative care and disseminate through multiple channels (e.g., CalMEND, CPCA, IBHP, CMHDA committees)
4.	Develop training and technical assistance that supports the IPI Vision /Principles/Continuum and the varying levels of readiness in implementing these ideas
5.	Dissemination Part I: Promote a phased implementation of the strategic and clinical approaches, supporting communities as they develop their local approaches to implementing the IPI Continuum, and map the spread of implementation—this activity is already underway thru CALMEND, IBHP and others
6.	Dissemination Part II: Continue to support implementation of the strategic and clinical approaches and development of the local IPI Continuum throughout the state as financing and regulatory changes provide better supports (see below)
7.	Link to statewide healthcare information technology initiatives (see Volume II: Healthcare Information Technology) to assure they support the IPI Vision/Principles/ Continuum (e.g., making information sharing seamless as a part of collaborative care)
8.	Link to statewide workforce development initiatives (see Volume II: Workforce Development) to assure they support the IPI Vision/Principles/ Continuum (e.g., develop core competencies in co-occurring disorders and integration approaches)
9.	Complete statewide development of the IPI Continuum in each community and implement strategic approaches, clinical guidance, training/technical assistance for current workforce, and aligned finance and regulation
10.	Conduct evaluation of new components at agreed upon intervals (see Measurement below)

“Organizations that have worked on integrating care between primary care and behavioral health practitioners have come to understand the significantly different cultures, languages, and processes that primary care and behavioral health clinicians bring to collaborative efforts. Those who write and lecture on integrated care routinely list these differences as one of the barriers to successful collaboration. Those who train behavioral health practitioners for primary care roles focus a portion of their curriculum on the topic of cultures.¹ This awareness has emerged while trying to promote behavioral health in primary care and there is every reason to expect that, as organizations bring primary care into behavioral health settings, similar issues will emerge. The success of person-centered healthcare homes will depend on bridging these cultural differences. This is a policy and practice leadership challenge, at every level—team, clinic, community, state, and national.”²

As noted in the Report, the IPI work groups used fishbone diagrams to brainstorm the complex barriers to integration. The purpose of a fishbone diagram, as a quality improvement tool, is to identify the contributing factors/issues that affect the problem to be solved. This ensures that planning prioritizes problem solving among contributing factors that have the most leverage.

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Organizational Culture



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There are six main issue areas in the Organizational Culture fishbone developed by the Delivery System Design Work Group. Selected examples of issues on the fishbone and their relationship to state or national activities are discussed below.

- Finance/Regulatory Environment (see full working paper on Finance and Regulatory and Privacy Policies below)
- Current/Future Workforce (see full working paper on Workforce Development)
- Patient/Family/Caregiver Barriers to Engaging in Collaborative Care
- Provider Philosophy/Models of Care
- Organizational Processes
- Community/Intersystem Capacities

Privacy Policies

“HIPAA is perceived as (but isn’t necessarily) a barrier to communication—sharing information for the purposes of care collaboration is a permitted use under HIPAA, with the exceptions of HIV status and receipt of substance abuse treatment.”²

CFR Title 42: Public Health, Chapter I: Public Health Service, Department of Health And Human Services, Part 2: Confidentiality of Alcohol and Drug Abuse Patient Records states that records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance (2.1) of any drug abuse prevention function or (2.2) program or activity relating to alcoholism shall be confidential and be disclosed only for the purposes and under the circumstances expressly authorized (based on patient consent). Whether or not the patient gives his written consent, the content of such record may be disclosed to medical personnel to the extent necessary to meet a bona fide medical emergency. There has been some discussion, in the context of collaborative care, that Title 42 should be amended to allow disclosure for the purposes of care coordination among healthcare providers, beyond the current reference to a medical emergency.

State laws and regulations regarding mental health privacy are frequently more restrictive than HIPAA, in which case they override. Washington State recently passed legislation (HB2025) to amend their state law, adopting the following language: *“Treatment records of a person may be released without informed written consent in the following circumstances [new language follows]: (i) Consistent with the requirements of the health information portability and accountability act, to a licensed mental health professional...or a health care professional...who is providing care to a person, or to whom a person has been referred for evaluation or treatment, to assure coordinated care and treatment of that person. Psychotherapy notes, as defined in 45 CFR Sec 164.501, may not be released without authorization of the person who is the subject of the request for release of information...(j) To administrative and office support staff designated to obtain medical records for those licensed professionals listed in (i) of this subsection.”*

Patient/Family/Caregiver Barriers to Engaging in Collaborative Care

Amidst the issues that get in the way of providing collaborative care is the stigma associated with mental health and substance use disorders. *“Stigma refers to attitudes and beliefs that motivate*

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individuals to fear, reject and avoid those who are labeled, diagnosed or perceived to have a serious mental illness – often anyone who is seen as “different.” Stigma also affects those who work with, advocate for or love people who are perceived as different. Family members are frequently stigmatized, especially by clinicians and the mental health system but also by society at large, judged responsible for a loved one’s mental illness and treated with suspicion or disapproval. These views can be damaging to people who are already struggling under challenging circumstances, leading to isolation and a high risk of developing clinical depression themselves (Gray, 2003)...Finally and most importantly, the shame and blame of society’s discomfort with the differentness of mental illness lands squarely upon those most vulnerable – those struggling to have meaningful lives while coping with the symptoms and effects of mental illness.

Children and adults with experience of mental illness are at high risk of internalizing stigma and suffering diminished self-esteem, feelings of confidence and mastery in their own abilities (Corrigan, 1998, Link, 1987). The low self-esteem that results from internalized stigma is often experienced as shame, and interferes with a person’s life goals and quality of life (Corrigan, 2004). This low self-esteem and demoralization from constant reinforcement that one is shameful and devalued has been associated with failing to pursue work or independent living. In the view of one researcher, “It is undoubtedly threatening and personally disheartening to believe that one has developed an illness that others are afraid of” (Link et al, 2001, p. 1621).

Internalized stigma is also related to willingness to engage in treatment: “Consumer advocates have argued, and research seems to support the idea, that many psycho-social and medical treatments disempower people, and as a result, people in need decide not to fully participate in services” (Corrigan, 2004, p. 620). This research indicates that effective services that are defined useful by persons with mental illness and are also non-shaming can reduce stigma and internalized stigma, increasing the willingness of people to utilize and engage in those services.”³

This means that models of collaborative care and how they are communicated to consumers, family members and/or caregivers must be person-centered and work to eliminate stigma as experienced by those served. To be person-centered, services should be linguistically and culturally competent and provided to a substantial degree by staff from the same ethnic/linguistic groups as those served, incorporating these culturally competent elements:

- A culturally competent service provider or system acknowledges diversity and recognizes its value, is knowledgeable about cultural differences and can provide high quality services adapted to meet unique cultural needs.
- Outreach and engagement strategies are designed to reach diverse communities where the populations identified can be identified and engaged in services.
- Successful service delivery teams engage and empower consumers with plans that are appropriate to their needs, maximize the benefits derived from use of culturally appropriate strategies and supports and thus reduce under-utilization of services that puts the consumers at-risk of placement in more restrictive settings. Focusing on consumer-generated goals that are culturally relevant empowers consumers to engage in services and maintain that engagement.

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- Culturally competent services are sensitive to the client's cultural identity, available in the client's primary language and use the natural supports provided by the client's culture and community.
- Goal setting and planning processes are culturally sensitive and build on an individual's cultural community resources and context. Individual, culturally focused community supports are identified and integrated into planning. Services plans reflect and respect the healing traditions and healers of each individual enrollee.
- Culturally diverse and culturally informed staff incorporate culturally relevant strategies, including alternative therapies and the use of families and extended families to provide natural supports for consumers. The use of these culturally relevant strategies also builds consumer commitment to treatment and their individual service plans.

A related issue is the development of models for successful self-management of co-morbid medical, mental health, and/or substance use disorders. *“This emphasis on self-care resonates with the behavioral health system’s movement towards a Recovery and Resilience orientation, utilizing approaches such as the newly revised Wellness Management and Recovery program or Copeland’s Wellness Recovery Action Plan. With these models, the behavioral health field has developed structured approaches that strengthen the individual’s capacity to set goals for improved self management of specific conditions and to problem solve barriers using the resources of the community and personal support systems in addition to formal services.”*² Recent research on patient activation approaches and the experience in the mental health system of adapting volunteer (peer) group models (for example, Stanford’s Chronic Disease Self-Management Program [CDSMP], Lorig) for wellness support will be resources for training and technical assistance.

The Patient Activation Measure (PAM) appears to be a valid and reliable instrument to measure activation and may be useful for both designing interventions and in evaluating them. *“The measure can be used in a clinical setting to assess individual patients and to develop care plans tailored to that patient and integrated into the processes of their care. Because the measure is developmental, interventions could be tailored to the individual's stage of activation. For example, those at early stages of activation would need interventions designed to increase knowledge about their condition and their treatments. Patients at later stages would need interventions designed to increase their skills and confidence in the different self-management tasks. As patients advance in activation, the type of interventions that will be helpful to them will also change. The approach is economical because it is targeted rather than omnibus...In summary, wide use of a precise, valid, and useful measure is the first step toward the goal of informed and engaged patients and ultimately to more effective and efficient delivery systems.”*⁴

Provider Philosophy/Models of Care

“Studies have shown that many health care professionals harbor unconscious negative feelings about their clients (Tate, 1991). Although under the recovery philosophy the client-physician relationship is more appropriately conceptualized as a partnership, stigmatizing attitudes, including devaluing statements, are sometimes endorsed by mental health professionals (Perlick et al, 2001). Psychiatrists sometimes perpetuate biased and stigmatizing attitudes, and the way that psychiatry is structured tends to reinforce the status quo (Fink and Tasman, 1992). Research

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has shown that the impact of perceived stigma may be even more powerful in non-mental health settings that provide treatment for depression, such as primary care (Sirey et al, 2001).”³

The National Alliance on Mental Illness (NAMI) National is currently surveying leaders, families, and friends (in California and other states) on their experiences and thoughts regarding discussions of mental health concerns about their child (if a mental health illness developed before age 18) with primary care staff and physicians. The intent of the survey is to develop materials that will help primary care staff and physicians understand the key role they play in ensuring families feel respected, comfortable, and listened to when discussing the mental health needs of their child. These and other materials developed under the auspices of the Mental Health Services Oversight and Accountability Commission (MHSOAC) will be useful in addressing provider philosophy and practice.

In order to address the stigma issues outlined above, the models of collaborative care and how they are communicated will require addressing stigmatizing attitudes among healthcare providers regarding both mental health and substance use disorders. Frequently, services to address these disorders are seen as less “science-based” than services in the physical healthcare system (see the Mark Stanford discussion paper in Volume III regarding substance use treatment in the context of the Care Model). However, as the physical healthcare system realigns its work to support people living with chronic health conditions, there is a common ground for philosophies to intersect and develop strengths-based wellness approaches, grounded in a biopsychosocial model that works to support recovery/resilience/harm reduction.

Another challenge is that of selecting, implementing and delivering integration models with fidelity. The Agency for Healthcare Research and Quality (AHRQ) reported last fall on a quantitative and qualitative analysis of 33 trials that examined the impact of integrating MH specialists into primary care. Findings included:

- Studies tended to show positive results for symptom severity, treatment response and remission when compared to usual care
- There were wide variation in levels of provider integration and integrated processes of care
- There were no clear patterns that suggest that outcomes improve as levels of provider integration or integrated process of care increase
- IMPACT has the strongest results for adults and older adults; limited studies exist for children

The study concluded that more work is needed on understanding what elements of integration are vital to producing desired goals, recommending that: *“research aimed at efficiently matching clinical and organizational processes and resources to different levels of care for varying levels of severity, and patients stratified by risk and complexity, would build on the...IMPACT trials and Intermountain Healthcare’s examples.”⁵*

The Hogg Foundation for Mental Health also released a report last fall regarding integrated care. In the chapter on models, they reported on three major approaches:

- Co-location
 - MH providers and primary care providers are housed in the same facility, supporting “warm hand-off”

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- This does not ensure that providers collaborate in treatment; this may vary greatly across clinics
- The research is somewhat limited—*“simply placing a BH specialist in PC is unlikely to improve patients’ outcomes unless care is coordinated and based in evidence-based approaches”*
- Primary Care Behavioral Health Model
 - A behavioral health consultant serves as consultant to PCP, focusing on optimizing the PCP’s quality of care for patients
 - This model targets behavioral issues related to medical diagnoses instead of traditional MH problems like depression and anxiety
 - The model has not yet been systematically evaluated—*“although likely beneficial, the effectiveness of the model is not yet known”*
- Collaborative Care
 - Also known as the IMPACT model, this is an adaptation of the Care Model for psychiatric disorders, using stepped care to treat depression, anxiety disorders, and bipolar disorders
 - It embeds a MH care manager and consulting psychiatrist into primary care team, with a registry to track and monitor response to treatment
 - There have been numerous studies of clinical and cost effectiveness, with adolescents, adults, and older adults, with and without co-morbid medical illnesses and from different ethnic groups—*“significant research evidence demonstrates that collaborative care improves outcomes for a wide range of patients”*
 - This is the model the Hogg Foundation has been implementing in a number of Texas safety net primary care clinics.⁶

The IPI project built on the Intermountain Healthcare MH levels of care to develop the IPI Continuum, and recommends the IMPACT model as an evidence-based practice for integrating MH/SU services into primary care. Key elements of the IMPACT model are:

- Systematic diagnosis and outcomes tracking
- Care manager
- Self management goal setting, use of community resources, and activation
- Psychiatric consultant
- Stepped care

Note that, subsequent to the IMPACT research trials (which focused on depression in older adults), the IMPACT model has been expanded to address additional MH diagnoses commonly found in primary care, in all age groups from adolescents to older adults. The IMPACT implementation team is also integrating SBIRT into their model.⁷

Organizational Processes

Many of the organizational processes in the physical, mental health and substance use delivery systems are the product of history, regulation, financing methods and “work-arounds” developed over time. The Institute for Healthcare Improvement (IHI) has led the way in the physical healthcare system in the application of process improvement to achieve better outcomes. These methods became the foundation for the Bureau of Primary Health Care (BPHC) Health Disparities Collaborative, which has focused on process improvement for such conditions as diabetes, depression and cardiovascular disease in FQHCs.⁸

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NIATx (formerly known as The Network for the Improvement of Addiction Treatment) is working with the community of substance use disorder providers to apply these methodologies. The National Council Collaboratives as well as state and local mental health initiatives have also applied these structured quality improvement methods. This body of learning and current research can be brought to the development of collaborative care workflows and processes at both the community and the provider organization level.

Community/Intersystem Capacities

The IPI Vision establishes the community as the focus for achieving individual and population health and wellness. The participants in the IPI dialogues recognized the varying levels of collaborative development within California counties and their communities, as well as the diversity of the counties in size, structure, available services and existing partnerships. This recognition led to the development of the IPI Continuum, a framework for community dialogue. As summarized in the recommendations, the intent is to support each California community in developing their local IPI Continuum over the next five years.

Engaging community stakeholders in local IPI Continuum planning will necessarily include a process of community education and destigmatizing of MH/SU needs and services. A public health approach that focuses on healthy emotional development and the incorporation of MH/SU services into primary care settings (where MH/SU screening and brief interventions should become as normalized as blood pressure checks) can be meshed with MHSA anti-stigma initiatives for maximum impact on community attitudes and support.

Measurement for Clinical Improvement and Practice-Based/Health Services Research

A great deal has been accomplished in implementing models for integrated care in California, but there are limitations to how much more can be done without addressing the barriers to integration that are identified in this Report. Starting from an initial listing of barriers developed by the Advisory Group, Work Groups were convened to focus on barriers and recommendations; Work Group members added to the listing of barriers. The listings incorporate the issues identified by the individuals participating in the process, and represent a range of perspectives. The groups went on to focus on the key issues to be addressed, as reflected in the Recommendations and these working paper discussions.

<i>Measurement Recommendations</i>	
1.	Identify, document and assess data currently collected across funding sources and systems (MH/SU/PC) to determine data elements that are useful, not useful and/or missing and make recommendations regarding elimination of mandatory data elements that are not useful and/or redundantly reported
2.	Identify and pilot tools for clinical outcomes assessment across MH/SU/PC settings
3.	Develop a Statewide Uniform Data Set (MH/SU/PC) that can be analyzed to inform policy and practice regarding integrated care outcomes (see Volume II: Measurement) <ul style="list-style-type: none"> • Select indicators/measures/outcomes being used nationally and by integration projects currently underway in California (e.g., CalMend, IBHP, CMSP, MHSA, HRSA/BPHC, IHI) • Agree on core current data collection requirements and processes • Initially gather Uniform Data Set through existing reporting methods
4.	Conduct “baseline” Uniform Data Set data gathering and analysis
5.	Implement Statewide Uniform Data Set <ul style="list-style-type: none"> • Through existing reporting methods • Through fully integrated data set • Ongoing analysis, including business case elements
6.	Establish and implement a research agenda to support knowledge development, identification of evidence-informed practices, and cost offset analysis

The Delivery System Design Work Group also focused on measurement and developed these detailed ideas, which are the foundation for the recommendations above.

Assess and Recommend Core Measures for Integrated Care

1. Identify, document, and assess data currently collected across funding sources and systems (health, MH, SU) to determine data elements that are useful, not useful, and missing
 - CalMEND completed an initial overview, but SU data sets are missing, and methods are needed for co-occurring measurement. CalMEND has developed measurements to accompany the Change Package for Cardiovascular Disease (Individuals with Mental Health and Physical Health Needs), and is piloting the Clinically Informed Outcomes Management (CIOM) consumer feedback tool in LA County.
 - MHOAC is looking at measures related to Full Service Partnerships, CiMH is gathering MH related measures being used in California, and CalOMS is working on measurement parameters.

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- The CHCs are using registries, tracking measures identified as part of the Health Disparities Collaborative for cardiovascular disease, diabetes, depression, and other conditions. FQHCs also have a national Uniform Data Set that is a requirement.
 - IBHP used the Duke and PHQ9 for Phase I data collection and has individualized outcome measurements for the different approaches of Phase II sites.
 - The NCQA HEDIS data sets, reported by health plans are another source of data.
2. Use initially available performance measures from sources such as those described above to initiate measurement as phased implementation begins, acknowledging that additional and better data collection will occur over time as the MH/SU/CHC systems become more aligned and a Uniform Data Set is developed.
 3. Develop a Statewide Uniform Data Set that can be analyzed to inform policy regarding integrated care outcomes
 - Leverage current data collection requirements to begin developing a Statewide uniform data set to monitor and improve health and system outcomes
 - In developing a statewide uniform data set, replicate indicators/measures/outcomes being used nationally and in projects currently underway in California (e.g., CalMend, IBHP, CMSP, etc.)
 - Discriminate across age groups for measures that are relevant to the age cohort
 4. Create a consistent feedback loop to the organizations and clinics that are collecting the data to facilitate performance monitoring and improvement; support community-based evaluation of improvement in emotional health of the population
 5. Create data collection frequency to account for both shorter-term organizational performance/quality monitoring, as well as longer-term population health outcomes
 6. Track cost information at the organizational and individual levels, as part of overall outcomes
 - Frame as “affordability” of care at the individual level
 - Analyze cost offsets or cost shifting, which may be more appropriate than cost savings, at the organizational and system level. There should also be an understanding/recognition of the short-term and long-term impacts associated with broad cross-system changes when examining cost implications. (Costs may go up in the short-term)

Domains of Outcome Measures

The following represents an initial effort to identify the general “domains” that are important to track with respect to individual/population health outcomes as well as organizational/system-level outcomes of integration. Overarching across domains, there will need to be Structure, Process and Outcome components.

The following Domains (and sample indicators) at the Individual/Population and Organizational levels were discussed:

1. Individual/Population Level

Physical Health Status: (*Tracked consistently over time, regardless of setting*)

- Morbidity/Mortality rates
- BMI, waist circumference

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- Blood pressure, blood glucose, cholesterol levels
- Prevention program/service participation rates
- Immunizations/Health Screenings

Substance Use Changes:

- Reduction in drug/alcohol use
- Smoking cessation
- Abstinence
- ASI is one possible tool

Mental Health Outcomes

- Emotional, behavioral, cognitive status
- Improvement in depression, anxiety, cognitive status, using standardized tools
- Use of other tools that measure achievement of individual goals such as those listed here as physical health status or functional status

Social Status Outcomes

- Social support network (family, friends, other supports) & their availability/ability to provide support (i.e., assess family/caregiver stress and their need for support)
- Cultural, ethnic, religious/spiritual values (to promote culturally competent care)
- Economic resources
- Physical environment assessment (adequacy and safety of living arrangement, access to transportation and other resources)

Functional Status Outcomes: *(Test possible tools, see Cal MEND CIOM tool)*

- Activities of Daily Living (personal care functions) (ADL Scale)
- Instrumental Activities of Daily Living (housekeeping, laundry, transportation, medication management, money management, shopping, etc.) (IADL Scale)
- ED visits/hospitalizations
- Employment/Productivity
- Homelessness/Independence
- Linkage to natural community supports (perhaps move to Social domain)
- Ability to live as independently as possible in least restrictive environment

Quality of Life

- Defined by the individual
- Measurements of “well being”/self efficacy/social connectedness
- Activities of daily living (move to Functional Status)
- Environmental/social measures (include with Social domain)

Self-management

- Individuals establish and make progress on self-management goals (weight, exercise, smoking, medication adherence, appointment attendance)

Consumer/Family Satisfaction

- MHSIP is an example

2. Organizational Process and Capacity Measures

- Increased screening and assessment (MH, SU, and medical conditions)
- Track disparity between number served vs. number that need services
- Improved access to specialty services (medical, mental health, substance use, and other specialties)
- Engagement/retention in treatment services
- Number of people in case/care management
- Linkage to community supports
- Increase in prevention services
- MOUs
- Referral agreements or referral guidelines established
- Increased and improved communication/coordination across health, mental health and substance use providers
- Clinical guidelines established across provider organizations
- Reduced stigma across provider groups
- Registries, EMR
- Improved data sharing across organizations
- Improved provider awareness and competency of MH/SU/Medical conditions (outside practice domain)
- Develop cross-provider training curricula
- Include patients/family members in care planning and information sharing

Research

“Given the enormous rate of activity on the primary care/behavioral health interface, it is critical that services research be informed by, and help inform, these evolving models. Researchers must be willing to move from the more traditional “top down” models of intervention design to partnerships with administrators and community leaders to develop and evaluate these evolving models. In order to ensure timeliness and relevance, these evaluations will need to use innovative approaches beyond those used in traditional randomized trials, and include careful cost analyses to understand if, and how, these models can be sustained in real world settings.”⁹

There is a newly developing national Collaborative Care Research Network (CCRN) and, within California, a number of academic institutions and health services researchers who are currently engaged in work around collaborative/integrated care. A research agenda that is part of the California IPI implementation process would leverage these resources to add to the knowledge and business case regarding collaborative/integrated care.

Financing and Regulation

A great deal has been accomplished in implementing models for integrated care in California, but there are limitations to how much more can be done without addressing the barriers to integration that are identified in this Report. Starting from an initial listing of barriers developed by the Advisory Group, Work Groups were convened to focus on barriers and recommendations; Work Group members added to the listing of barriers. The listings incorporate the issues identified by the individuals participating in the process, and represent a range of perspectives. The groups went on to focus on the key issues to be addressed, as reflected in the Recommendations and these working paper discussions.

Finance

1. Fiscal policy and regulations, including the Medi-Cal carve-out
 - Siloed cost and reporting systems
 - Explore funding for SU services in PC/SBI codes
 - Staff qualifications for FQHC billing (MFTs or cosigning)
 - Bill for same day MH and PC services
2. Gather together all of the sources of Certified Public Expense (CPE) and look at how to maximize federal match
3. Use the upcoming MH Medicaid waiver to better define the system and how it will serve the population, reduce regulation—rather than revise Title 9, revise the waiver, and then rules will follow that are aligned
 - Look at the current 10 county hospital waiver and consider whether MH could be addressed as part of that initiative
4. Make the case for early intervention of MH/SU in PC, with reductions of long term costs
5. Reimburse care management and psychiatric consultation in PC
6. Support MH teams working in PC settings providing services for those with serious and persistent MH/SU issues
7. Lack of parity for uninsured—indigent care requirements don't extend to BH
8. Scarcity of resources
9. Categorical/fragmented funding and advocacy for continued categorical funding—look in the mirror at ourselves and our commitments to retaining our categories
10. History of turf and competition for resources
11. Resistance to shared funding
12. Fear of loss of funding

Regulatory

1. HIPAA and confidentiality rules or the myths about them as barriers to communication
2. Inconsistent and conflicting mandates at national, state and local level
3. Rules and regulations should support the new clinical model
4. Categorical program requirements and advocacy for their continuation—look in the mirror at ourselves and our commitments to retaining our categories
5. Revisit licensing structures
6. Develop legislation defining medical homes

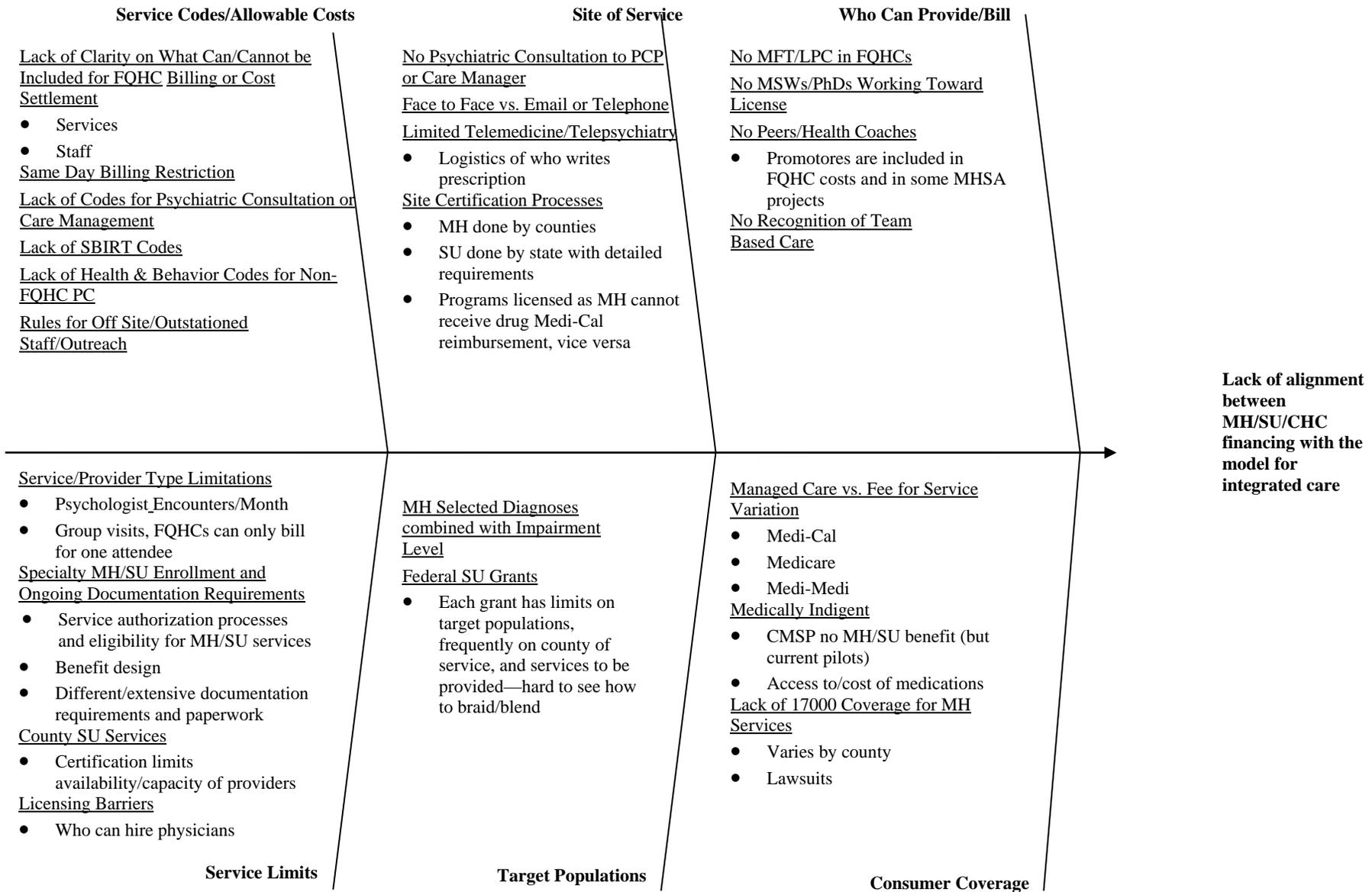
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Financing Recommendations
1. Obtain approval to pay for same day MH/SU and PC services <ul style="list-style-type: none"> • Requires legislative action (see AB 1445) to address specific CA FQHC regulations • For broader application, would require additional legislation
2. Obtain approval to pay for expanded definition of qualified staff (e.g., MFTs, Licensed Professional Counselors) or sign-off by PhD or LCSW for other licensed disciplines <ul style="list-style-type: none"> • Currently a federal initiative, which if passed, would require CA changes in regulations
3. Participate in planning for the 1115 Medicaid Waiver (e.g., Hospital Financing Waiver) <ul style="list-style-type: none"> • Expand coverage statewide for Medically Indigent Adults • Add MH/SU services to benefit package and encourage integrated service models as part of the Medical Home/Care Management initiatives
4. Develop the business case for integration (with an emphasis on the safety net system)
5. Address barriers to financing integrated services and seek to leverage/align what each system (MH/SU/PC) currently has in resources and incentives (see Volume II: Financing and Regulation), preparatory to renewal of 1915(b) Waiver
6. Examine Drug Medi-Cal benefit and current programmatic/geographic silos of Alcohol and Drug Programs to assess potential for benefit redesign to support collaborative care
7. Analyze Certified Public Expense (CPE) and develop policy recommendations that would maximize federal match (see Volume II: Financing and Regulation), preparatory to upcoming renewal of 1915(b) Waiver (e.g., Medi-Cal codes for early intervention services)
8. Convene stakeholders to make recommendations regarding a revised 1915(b) Medi-Cal MH Managed Care Waiver to support the IPI Vision/Principles/ Continuum and address: <ul style="list-style-type: none"> • Definition of who is served (clarifications for age group cohorts) • Definition of where services are offered • Definition of what services are available • Definition of financing methods
9. Submit revised 1915(b) Medi-Cal Managed Care Waiver
Regulatory Recommendations
1. Assess Title 9 regulations guiding the carve-out Medi-Cal Mental Health Plans administered by the counties and determine potential revisions that would not require revisions to the underlying 1915 (b) waiver
2. Develop revised regulations based upon revised 1915B waiver
3. Implement revised regulations and waiver

“There has been a growing dialogue about the barriers to financing behavioral health in primary care.^{10, 11} For example, care managers/behavioral health consultants and psychiatric consultation in primary care have not been reimbursable, despite their prominence in the researched models. A recent exception to this is the DIAMOND Project in Minnesota, in which primary care practices participating in the project (with trained care managers, registries/tracking, and psychiatric consultants) are being reimbursed a monthly care management fee (case rate); this has been called “the first depression treatment program in the nation to integrate a collaborative care model with an effective, sustainable reimbursement structure.”¹²

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Alignment of Current Financing



Maximize Federal Match/Other Financing Sources

**Master Settlement Agreement
Tobacco Settlement Funds**

Some Counties use for Care
Coordination Services for
Targeted Populations including
Medi-Cal

- Lots of variability among counties in how funds are used

First Five/Prop 10

Need MH/SU Service Codes to Match
Early Intervention Services

- Developmental assessment
- Family needs assessments
- Child care MH consultations

MHSA/Prop 63

Continuation of Earmarked
Rollouts Reduce Local
Flexibility

Use as Match for CSS
Provided to Medi-Cal
Eligibles

Need MH/SU Service Codes
to Match Early Intervention
Services

Need Clarification on
Audits/Supplanting

**Lack of approaches
to maximize
federal match
funds**

Overmatch Beyond Maintenance
of Effort Requirements

Overlap to MH/SU Need in
Other Populations

- General Relief
- Medically Indigent Healthcare
- Veteran’s Services
- Public Guardian/Conservator
- Adult Protective Services

Mandated 10% County
Match

Costs Incurred, Not Yet
Reimbursed

Need MH/SU Service
Codes to Match Early
Intervention Services

CMSP

Fund Balance Policies

- Segregate to transfer to MH operating funds

AB3632

- Not billed to insurance when families are covered
- Costs incurred not yet reimbursed

County General Funds

EPSDT

Realignment

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As noted earlier, the work groups used fishbone diagrams to brainstorm the complex barriers to integration. The purpose of a fishbone diagram, as a quality improvement tool, is to identify the contributing factors/issues that affect the problem to be solved. This ensures that planning prioritizes problem solving among contributing factors that have the most leverage. There are six main issue areas in the Alignment of Current Financing fishbone. Selected examples of issues on the fishbone and their relationship to state or national activities are discussed below

- Service Codes/Allowable Codes
- Site of Service
- Who Can Provide/Bill
- Service Limits
- Target Populations
- Consumer Coverage

Service Codes/Allowable Codes

It was widely believed that the “same-day billing restriction” was a federal regulation, however, it has recently been clarified that this is not federal policy.¹⁰ Current California law specifically restricts FQHCs from billing Medi-Cal for both a primary care encounter and a mental health encounter on the same day, although it allows for billing both a primary care encounter and a dental encounter on the same day. The result is to undermine the clinical model of an embedded behavioral health consultant on a primary care team taking a “warm hand-off” from the primary care provider—a technique that has been demonstrated to improve engagement with the behavioral health consultant and primary care-based MH/SU services.

For other sources of reimbursement, a change in payor policy is required. The 2005 National Correct Coding Initiative Policy Manual for Medicare Services, Chapter XI, Evaluation and Management Services, C; Psychiatric Services contains the following language: *When medical services, other than psychiatric services, are provided in addition to psychiatric services, separate evaluation and management codes cannot be reported. The psychiatric service includes the evaluation and management services provided according to CMS policy.* This is a variation on the prohibition on billing same day services for behavioral health and primary care. In these instances the prohibition is likely either explicit payer policy or unknowingly embedded in claims processing systems that were structured originally to process Medicare claims.

Site of Service

As noted above, psychiatric consultation provided to a primary care practitioner or behavioral health consultant, when the person has not been directly seen by the psychiatrist, is not a billable event, except in pilots like the DIAMOND project, which is a widespread implementation of the IMPACT model in Minnesota. Yet, this is a cost-effective and proven strategy to improve mental health services in primary care, using the limited resources of psychiatry in a way that expands access to appropriate care.

Who Can Provide/Bill

The originating legislation for FQHCs defined FQHC providers as individual health care professionals who exercise independent judgment as to the services rendered to health center patients and document services in the patient’s record on behalf of the health center; it specified physicians, physicians’ assistants, nurse practitioners, clinical psychologists, and clinical social

workers (Section 1861(aa) of the Social Security Act). Over the years, other types of behavioral health providers have been licensed to practice in most states (e.g., Marriage and Family Therapists [MFT] and Licensed Professional Counselors [LPCs]). While some states have determined that they will reimburse for the services of these other types of behavioral health providers, California has retained the original federal classifications. There is currently a movement at the federal level to remove this barrier.

Medi-Cal Mental Health Service Limits and Target Populations

The most frequently mentioned concern about MH service limits is the perception that county Medi-Cal Mental Health Plans (MHPs) are restrictive about the process of establishing eligibility for services and determining the amount and type of services that are received by Medi-Cal beneficiaries. This is both a matter of capacity and a matter of regulatory compliance. In regard to capacity, note the finding in the IPI Continuum that the mental health system appears to serve about 1 in 3 of those with Serious or Severe needs for services. This is consistent with earlier reports from the Little Hoover Commission, which estimated that the system was financed to provide about 50% of what was needed. Similar analyses in other states have routinely documented the public mental health system as being under-financed and lacking in sufficient capacity to serve the high need population. These analyses have seldom gone on to calculate the needs for mild to moderate services, most of which should be delivered in primary care.

In regard to the regulatory environment, the MHPs operate under the California Code of Regulations, Title 9. These regulations were adopted pursuant to the original 1995 Medi-Cal Managed Care 1915(b) federal Freedom of Choice waiver. Under this waiver program, each MHP contracts with the Department of Mental Health (DMH) to provide medically necessary specialty mental health services to the beneficiaries of the county. The first phase, in 1995, was the Medi-Cal psychiatric inpatient hospital services consolidation. The second phase, in 1997, added the outpatient system. The waiver is reviewed, modified and renewed on a two year cycle.

The second phase consolidated Short Doyle Medi-Cal (Rehabilitation Option) with FFS Medi-Cal (Physicians, psychologists, hospitals, and nursing facilities) into carved out specialty MHPs—the county Mental Health Plans. However, “General Mental Health” care for Medi-Cal beneficiaries remained under the Department of Health Care Services (DHCS), as did pharmacy costs. Title 9 defines specialty MH services (1810.247) as: “Rehabilitative services, psychiatric inpatient, targeted case management, psychiatrist services, psychologist services, EPSDT services, and psychiatric nursing facility services.” Excluded services (1810.355) named are: “*specialty MH services provided by FQHCs, IHCs, and RHCs.*” Medical necessity (1830.205): specifies a list of included diagnoses, impairment, the expectation that intervention will address impairment, and that “*the condition would not be responsive to physical health care based treatment.*”

While some aspects of the Title 9 regulations may be amenable to revisions to support the Collaborative Care Continuum, the basis for the regulations continues to be the federal waiver. None of the states currently operating a 1915 (b) waiver for mental health services has moved to restructure their waiver to support collaborative care—California could be the first state to rise to this challenge and rethink care in the context of healthcare reform, person-centered healthcare homes, and collaborative care.

One aspect of Title 9 that might be addressed outside of the waiver is the documentation requirements. *“Policies at both the federal and state levels are seldom consciously structured to encourage and support collaborative practice; instead they frequently act as barriers. This is particularly true of state regulations regarding behavioral health treatment planning and service documentation, which result in lengthy and time consuming paper and work processes that are not a good match to the pace of primary care, in either the behavioral health or the primary care setting.”*² The California Client and Service Information (CSI) System incorporates MH enrollment and ongoing care documentation that, while necessary for the Serious/Severe levels in the Collaborative Care Continuum, are burdensome for Mild/Moderate levels of service.

Consumer Coverage

The County Medical Services Program (CMSP) has integrated care pilots underway in 12 clinics, as summarized in Volume III. However, the issue of medically indigent individuals and their access to MH/SU services in non-CMSP counties is another cause of tension in the relationship with primary care. There is variation among the counties in their policies regarding MH/SU access for non-Medi-Cal individuals. This is not unique to California. *“Many states have shifted their mental health general fund financing to Medicaid match, leaving few to no funds for the indigent uninsured population, even if these individuals have serious mental illness. This policy environment has created strain on the relationships between CHCs and CMHCs, at a time when collaboration in provision of integrated care to safety net populations is needed.”*² Nationally, there are over thirty million Americans who are both indigent and uninsured, and only one-third of these individuals are served by the nation’s network of community mental health centers.¹³ Ideally, this will be resolved through federal healthcare reform efforts that will expand healthcare coverage with MH/SU benefits to indigent uninsured populations.

Questions were raised during the IPI process regarding the responsibilities of counties for Section 17000 coverage for mental health services for medically indigent individuals. The discussion included the fact that several lawsuits resulted in findings that counties were not required to provide these services. In California, it is estimated that there are almost 700,000 indigent, uninsured persons with Serious Mental Illness or Serious Emotional Disturbance and only 29% have been served in the community mental health system. Another 460,000 indigent, uninsured persons are estimated to have Mild to Moderate conditions that could be treated in primary care and only 10% have been served in the community mental health system.¹³

Related to this issue is the fact that the California 1115 Medicaid Waiver (Hospital Financing Waiver) is up for renewal in 2010, and the state must put together a concept paper for the federal government this fall. The current waiver has coverage initiatives that cover some medically indigent adults (MIAs) in ten California counties—the Health Care Coverage Initiative (HCCI). The HCCI, initiated in September 2007, have implemented components of the patient-centered medical home and the Care Model, with variations across the 10 sites. None of the sites appear to have focused on bringing the MH/SU component into their models to date.¹⁴

The renewal request could continue these initiatives, revise or expand them to some or all California counties.

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Another idea related to the 1115 Waiver is to better manage the care and costs of High Cost Medi-Cal Fee-for-Service Beneficiaries (the top 10% utilize 76% of the resources). This idea, related to the idea of medical homes and focused care management, would be stronger if it included MH/SU services and adoption of the Person-Centered Healthcare Home model.

The Frequent Users of Health Services Initiative, a joint project of The California Endowment and the California HealthCare Foundation, showed that multi-disciplinary, coordinated care can reduce hospital visits and costs, while helping to improve stability and quality of life for patients. The results included a 61% decrease in emergency department visits and a 62% decrease in hospital inpatient days for clients enrolled in the programs for two years. (For those clients on Medi-Cal at enrollment, ED visits decreased by 60% and inpatient days decreased by 69% after two years in the programs.) One of the four building blocks for success was Collaboration and Integration for Systems Change, including MH/SU services as well as housing, benefits, and increased access to services: *“Examples of systems change can include adjustments in eligibility requirements, benefits, and provider hours of operation; co-location of services; establishment of referral arrangements; and the sharing of information across multiple agencies, programs, and providers. It can also mean identifying service gaps and adding new services where needed, such as medical respite care, sobering centers, and supportive housing, or integrating existing programs.”*¹⁵

Findings from the Frequent Users Initiative are echoed in a recent report on Seattle’s Downtown Emergency Service Center (DESC) 1811 Eastlake Housing First program, which is targeted at homeless individuals with severe SU/co-occurring conditions. *“The lesson for policymakers and practitioners alike is that for this subset of the homeless population, providing housing and on-site services without requirements of abstinence or treatment is significantly more cost-effective than allowing them to remain homeless. DESC’s 1811 Eastlake saved taxpayers more than \$4 million dollars over the first year of operation. Annual average costs per person while homeless, the year before moving in, were \$86,062. By comparison, it costs \$13,440 per person per year to administer the housing program. A significant portion of the cost offsets were caused by decreases in residents’ use of Medicaid-funded health services.”*¹⁶

Maximize Federal Match

In addition to looking at the financing and regulatory barriers to collaborative/integrated care, the Finance Work Group considered the fact that there are current sources of state and local financing that are not being used to leverage federal Medicaid funding. There are six main tax revenue areas in the Maximize Federal Match/Other Financing Sources fishbone.

- Master Settlement Agreement/Tobacco Settlement Funds
- First Five/Proposition 10
- Mental Health Services Act/Proposition 63
- County General Funds
- Early, Periodic Screening, Detection and Treatment (EPSDT)
- Realignment

The sub heading in each of the issue areas are relatively self-explanatory. One of the emerging and overarching issues, however, is that the Medi-Cal program does not currently have service codes that support Early Intervention Services. Adoption of such codes would facilitate the use of First Five and Mental Health Services Act Prevention and Early Intervention (PEI) funds as

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match, and would support early developmental assessment and interventions for the Medi-Cal child populations served through the Early, Periodic Screening, Diagnosis and Treatment (EPSDT) program.

Workforce Development

A great deal has been accomplished in implementing models for integrated care in California, but there are limitations to how much more can be done without addressing the barriers to integration that are identified in this Report. Starting from an initial listing of barriers developed by the Advisory Group, Work Groups were convened to focus on barriers and recommendations; Work Group members added to the listing of barriers. The listings incorporate the issues identified by the individuals participating in the process, and represent a range of perspectives. The groups went on to focus on the key issues to be addressed, as reflected in the Recommendations and these working paper discussions.

Workforce

1. Lack of recognition of provider limitations—both BH and PC have to get better at identifying BH and health conditions and get better at clinical treatments
 - Clinical competence in integrated service models (MH/SU and BH/PC)
 - Cultural competence and linguistic capacity
 - MH knowledge in PC providers
 - Health knowledge in BH providers
2. Workforce capacity (current and future workers)
 - Shortage of workers, especially PCPs and Psychiatrists
 - Clinical competence in integrated service models
 - Cultural competence and linguistic capacity
 - Lack of mental health training in internal medicine programs (residency accreditation requirements)

<i>Delivery System Design Recommendations</i>
8. Link to statewide workforce development initiatives (see Volume II: Workforce Development) to assure they support the IPI Vision/Principles/ Continuum (e.g., develop core competencies in co-occurring disorders and integration approaches)

The scope of the IPI Process did not allow separate work group activities focused on workforce development and healthcare information technology. Despite the significant impact of these issues on the success of collaborative care, it was determined that many other federal and state initiatives are emerging in these arenas, and that the IPI Recommendations should focus on linking to these initiatives to promote congruence with the IPI Vision/Principles/Continuum. The following discussion is a brief overview of current initiatives and needs identified by the work groups.

“There is a shortage of both primary care¹⁷ and behavioral health practitioners to work in either setting. One stated intent of the patient-centered medical home initiative is to make the financing of primary care more attractive, in order to address the dwindling number of physicians choosing primary care. To adequately address the needs of people with serious mental illnesses and people with chronic health conditions, more primary care and behavioral health practitioners will be required. Telemedicine initiatives will also play a role in addressing workforce issues, especially in rural communities.”²

Federal Initiatives

Nationally, draft healthcare reform legislation incorporates significant new initiatives and financing for healthcare workforce development. For example (the pace of legislation precluded tracking the marked-up legislation as it moved in both the House and Senate), Title IV of the Kennedy/HELP bill would establish a National Health Care Workforce Commission and National Center for Health Care Workforce Analysis, identifying high priority topics that include:

- Workforce planning that identifies skills needed and maximizes the skill sets of health care professionals across disciplines
- Workforce capacity, projected demands, and integration within the health care delivery system (includes nursing, oral health, mental and behavioral healthcare, allied health and public health care)
- The bill proposes competitive state health care workforce development planning (\$8M for 2010) and implementation grants (\$150M for 2010), as well as grants for state and regional Centers for Health Workforce Analysis (\$4.5M/year for FY2010 through FY2014).
- Subtitle C, Increasing the Supply of the Health Care Workforce, addresses federally supported student loan funds including a section on the pediatric healthcare workforce (medical subspecialty, surgical subspecialty, child and adolescent mental and behavioral health care) and expansion of the National Health Services Corps, growing from a proposed \$320M in FY 2010 to a proposed \$1.1B in FY2015.
- Subtitle D, Enhancing Health Care Workforce Education and Training, addresses primary care training and enhancement grants (\$125M/year for FY2010 through FY2014). Among the priorities in making grant awards are: *innovative approaches to clinical teaching using models of primary care, such as the patient centered medical home, team management of chronic disease, and interprofessional integrated models of health care that incorporate transitions in health care settings and integration [of] physical and mental health provision, and teach trainees the skills to provide interprofessional, integrated care through collaboration among health professionals*. Other training initiatives are targeted to oral health, geriatrics, mental and behavioral health, nursing, community health workers, and public health.
- Subtitle E, Supporting the Existing Health Care Workforce, proposes grants through Area Health Education Centers (AHECs) and other entities to provide continuing education for current healthcare providers. It would also establish Primary Care Extension Programs to provide support for primary care providers and educate them regarding: *preventive medicine, health promotion, chronic disease management, mental health services, and evidence-based and evidence-informed therapies and techniques*.

California Initiatives

In California, the Mental Health Services Act has provided financing for the development of both state and local workforce plans and workforce development initiatives. Workforce development needs related to primary care integration could/should be addressed at all levels. Examples of these initiatives include:

- Workforce development funds have been distributed among state, regional and local programs. Statewide programs include financial incentives such as the loan repayment

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program for professionals working in hard-to-fill or hard-to-retain positions for Psychologists, Marriage and Family Therapists, Social Workers, Psychiatrists and Psychiatric Mental Health Nurse Practitioners (\$2.5M annually). Additionally, increasing the number of designated Mental Health HPSA designations provides access to federal benefits designed to bring mental health professionals to designated shortage areas and improve the distribution of such professionals. Benefits include student loan repayment, scholarships and scholar placement programs, visa waiver programs, bonuses to psychiatrists, and a drug discount program

- Statewide stipend programs help defray education costs of consumers and family members in the California university system. There is also a statewide technical assistance center “Working Well Together” that provides training and technical assistance for consumer and family member employment in the public mental health sector.
- Regional Workforce Collaboratives (\$1.8M for each of the state’s five regions) promote and support partnerships among county mental health departments, higher education institutions, consumers/family members and other stakeholders for the purpose of coordinating curriculum, clinical internship placement sites, and developing programs at the certificate, AA, BA , Master’s and Doctorate levels for mental health professionals. Regional Collaborative monies also support regional training and other county level initiatives as well as disseminating state and national policy and elevating local policy issues to the state level. Some regions are partnering on projects with other government and private entities that have shared workforce needs to develop an infrastructure of coordinated educational programs for positions like psychiatric technicians, psychiatric nurse practitioners, social workers and peer counselors.
- Each County has a MHSA Workforce, Education and Training plan that addresses local priority needs regarding workforce staffing support, training and technical assistance, mental health career pathways, and financial incentive programs.

Opportunities for Advocacy

As implied by the ideas in the federal legislation, the skills needed to work on a collaborative, multidisciplinary healthcare team are not generally part of academic training for clinicians, and the success of person-centered healthcare homes will depend on bridging the cultural differences between primary care and MH/SU practitioners.

Training and technical assistance for the current workforce as well as those in the academic pipeline is required. As federal, state and local initiatives and financing for workforce development move forward, the work groups identified the following issues to be incorporated into those processes.

- Transform organizational culture through a significant, coordinated effort
- Engage the entire staff of provider organizations (e.g., professionals/other direct service [MAs] through support staff [receptionists] and administration)
- Expand diversity of providers (e.g., culture, language) and assure culturally competent service delivery
- Define future roles (navigator, coach, health educator, others) for peers/family partners and develop methods to recruit, train and certify them in these roles

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- Identify a set of shared core competencies and train to that for current staff and in the educational pipeline, including:
 - Collaboration models
 - Evidence-based practices for collaborative care
 - Co-occurring competencies (and dually certified practitioners)
 - Age-specific competencies
 - Person-centered approaches
- Engage all community partners for local MHSA workforce plans,
- Seek clinical training program curriculum adjustments that support collaborative practice

Healthcare Information Technology

A great deal has been accomplished in implementing models for integrated care in California, but there are limitations to how much more can be done without addressing the barriers to integration that are identified in this Report. Starting from an initial listing of barriers developed by the Advisory Group, Work Groups were convened to focus on barriers and recommendations; Work Group members added to the listing of barriers. The listings incorporate the issues identified by the individuals participating in the process, and represent a range of perspectives. The groups went on to focus on the key issues to be addressed, as reflected in the Recommendations and these working paper discussions.

Information Technology

1. Lack of common IT systems in BH and PC
 - No common outcome measures
 - EHRs don't support population health approaches
 - EHRs unable to combine PC, MH, SU information

<i>Delivery System Design Recommendations</i>
7. Link to statewide healthcare information technology initiatives (see Volume II: Healthcare Information Technology) to assure they support the IPI Vision/Principles/ Continuum (e.g., making information sharing seamless as a part of collaborative care)

The scope of the IPI Process did not allow separate work group activities focused on workforce development and healthcare information technology. Despite the significant impact of these issues on the success of collaborative care, it was determined that many other federal and state initiatives are emerging in these arenas, and that the IPI Recommendations should focus on linking to these initiatives to promote congruence with the IPI Vision/Principles/Continuum. The following discussion is a brief overview of current initiatives and needs identified by the work groups.

Federal Initiatives

The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the federal stimulus legislation known as the American Recovery and Reinvestment Act of 2009 (ARRA), authorizes roughly \$36 billion in outlays over six years for health information technology. The Administration has indicated that the ARRA funds allocated to health care are a down payment on the much larger amount needed to effect meaningful reform of health care in the United States. This summary of the legislation was drawn from a report prepared by the California Healthcare Foundation.¹⁸

- The vast majority of funds —approximately \$34 billion —are expected to be distributed between 2011 and 2016 as adoption incentives through Medicare and Medicaid to qualified health care providers who adopt and use electronic health records (EHRs) in accordance with the Act's requirements. The HITECH Act's EHR adoption incentive investments will be distributed based on statutorily defined formulas. Qualified health care providers are entitled to receive incentive payments if they meet the Act's requirements for being "meaningful" EHR users. The requirements to meet the "meaningful use" test are currently

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being developed during the rule-making phase.

- It is expected that a significant amount of the HITECH Act's infrastructure investments will be used to support health information exchange (HIE) projects [also known as Regional Health Information Organizations or RHIOs] designed, built, and operated in accordance with emerging federal policy requirements. The Act allows these investments to be made through states or qualified state-designated entities. These entities are defined as multi-stakeholder, nonprofit organizations that are designated by a state to conduct activities to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards.
- To be eligible to draw upon the billions of dollars in funds provided by the HITECH Act for EHR adoption and use, health care providers must be connected in a manner that provides for the electronic exchange of health information to improve the quality of health care. California will only be able to meet this statutory requirement if the state collaborates with private stakeholders to create health information exchange capabilities that serve all California residents. The HITECH Act authorizes grants to states and qualified state-designated entities to develop and implement programs for HIE.
- The HITECH Act recognizes that effective adoption and use of EHRs represents a significant challenge. As a result, the Act directs the Secretary of HHS to establish Health Information Technology Regional Extension Centers (RECs) to provide technical assistance, disseminate best practices, and assist with implementations at the local level. Specifically, the Regional Extension Centers are charged with providing technical and change-management assistance to health care providers in adopting and using EHRs. They are to provide services to all providers in a region, but must prioritize assistance to public, nonprofit, and critical access hospitals; federally qualified health centers (FQHCs); rural or other providers that serve uninsured, underinsured, or medically underserved patients; and individual or small group practices.
- Workforce Training Grants are also provided for states. The effective use of health information technology requires a team, and while physicians may provide the clinical oversight for patient care, its delivery depends on nurses, medical assistants, front office staff, and other clinical providers (such as nutritionists, behaviorists, and social workers). In order for electronic health record systems to fully support this team, its members must all have basic IT literacy, an understanding of state privacy laws and Health Insurance Portability and Accountability Act (HIPAA) requirements, and the ability to make effective use of the EHR as part of their workflow. There is a shortage of qualified allied health professionals in California, as well as a national shortage of health workers with IT literacy.

California Initiatives

In California, a by-product of the carve-out and administrative separation of specialty mental health, substance use and physical health services for Medi-Cal beneficiaries is the siloing of health information. As such, currently service agencies and the individual providers within them do not have access, timely or otherwise, to the range of health information necessary to provide integrated care. Rather, they are usually limited to only that information they generate or that is provided by individuals served. While local efforts to integrate data have and will likely continue to make some headway in supporting provider-level integration, state-level data integration that provides local access is critical to the achievement of the envisioned IPI

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Continuum. Further, given the size and diversity of providers, both organizational and individual, state-level efforts that minimize duplicative and/or incompatible development of tools and approaches for integrating, sharing and using data is critical.

The Care Model calls for agencies to “*organize patient and population data to facilitate efficient and effective care.*” This organization of data should include the development of the following capabilities, in terms of the necessary functionality of a clinical information system:

- Provide timely reminders for providers and patients
- Identify relevant subpopulations for proactive care
- Facilitate individual patient care planning
- Share information with patients and providers to coordinate care
- Monitor performance of practice team and care system

The model further puts forward that “*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.*”¹⁹

In California, state-level leadership to guide achievement of this access has been initiated with two Executive Orders issued by Governor Schwarzenegger: the first, Executive Order S-12-06²⁰ on July 25, 2006 and the second Executive Order S-06-07²¹ on March 14, 2007. The first order led to the development of a Department of Health and Human Services initiative: Health Information and Technology and Exchange. In this initiative, the California Health and Human Services Agency (CHHSA) serves as the lead agency on HIE and HIT issues for the State. CHHSA works with the State Chief Information Officer (OCIO), the Department of Managed Care and the Business, Transportation and Housing Agency to oversee the State’s HIE and HIT related efforts.²² The State HIE initiative, under the direction of HIT Deputy Secretary Jonah Frohlich, has six workgroups,²³ charged with the drafting of requirements, conducting background research, and preparing documentation for proposals to the Federal government.

- EHR Loan Funds: The loan funds workgroup seeks ways to provide capital to assist physicians and hospitals purchase and upgrade certified electronic health records (EHRs), and train staff and personnel to become meaningful users of EHRs. They also will investigate how to provide capital to support the secure exchange of health information. Finally the workgroup will develop a business plan, sustainability model, ROI, underwriting and solvency requirements for the loan fund.
- Regional Health IT Extension Centers: The REC workgroup aims to facilitate the purchase and meaningful use of electronic health records (EHRs) by 85% of physicians and 55% of hospitals including 45% of critical access hospitals by 2014 to meet Federal goals. It will also identify centers to provide services to improve health care quality, safety and efficiency, including sharing and disseminating best practices in health IT adoption and use. Finally, it will establish governance, operational, business, and sustainability models for the REC that will meet the needs of the diverse group of priority audiences.
- Research and New Technologies: The RNT workgroup’s overarching goal is to innovate and apply technology to maximize integration, utilization, effectiveness and efficiency of electronic healthcare information. It will also seek to maximize the potential for stimulus funding for research meaningful to achieve California HIT objectives by creating a powerful, broad-based multi-disciplinary consortium. Finally the workgroup will establish process for

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disseminating knowledge, technology, education and training from Healthcare Information Enterprise Integration Research Consortium (HIEIRC) efforts.

- Workforce Training and Development: The workforce workgroup will develop plans to ensure an ample and adequately trained workforce exists to support broad dissemination of HIT to improve the quality and safety of health care. It is also charge with the goal of expanding medical health informatics programs for health care and IT students, with a preference for existing programs less than 6 months in length. Finally the workgroup seeks to maximize federal stimulus funding payments to create and support the HIT workforce in California.
- Broadband/Telehealth: The purpose of this is to ensure that the State's Health IT and Exchange Strategic Plan includes the critical issues of Broadband and Telehealth/Telemedicine services in California.
- Overall State Health Information Exchange Plan: California's strategic plan for health information exchange (HIE) is being developed by this group. Although this effort is seeking statewide input, this group is not using a workgroup setting in the same manner as the four other workgroups (Loans, Regional Extension Centers, Research and New Technologies, and Workforce Training and Development). This group is gathering data from stakeholders through its outreach in surveys and stakeholder meetings. The products of the other workgroups will be incorporated into the strategic plan.

Several other state-level organizations have undertaken efforts to promote or otherwise support health information exchange and integration, in conjunction with the Governor's orders:

- The California HealthCare Foundation (CHCF).²⁴ To support the advancement of health information technology, including information exchange, CHCF regularly conducts research and commissions surveys and reports on emerging technology trends and related policy and regulatory issues. Further, in response to the Governor's executive orders and their own leadership in the field, the California HealthCare Foundation (CHCF) has prepared an issue brief outlining ten recommendations to help shape the agenda and contribute to the State's HIE/HIT undertakings: "*California Can Lead the Way in Health Information Technology - Recommendations to Governor Schwarzenegger's eHealth Action Forum.*"²⁵
- California Regional Health Information Organization (CalRHIO): CalRHIO, an independent organization launched in 2005, is committed to establishing access to HIE throughout California and making it affordable, reliable and sustainable for users. CalRHIO describes its role as a neutral coordinator and integrator of information that sits between data and technology vendors and HIE participants and as such is a collaborative effort to incrementally build the structure and capabilities necessary for a secure statewide health information exchange system that enables California's health care providers and patients to access vital medical information at the time and place it is needed.
- A statewide system to provide physicians with secure electronic access to critical patient information is launching in 23 Orange County emergency departments. The health information exchange initiative (HIE) is a collaboration between the statewide California Regional Health Information Organization (CalRHIO) and the Orange County Partnership Regional Health Information Organization (OCPRHIO). Initially it will provide emergency department physicians with medical record information on 360,000 patients enrolled in CalOptima, which provides coverage for people in Medi-Cal, Medicare, and Healthy Kids. The CalRHIO website tracks HIEs across the state.

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- Department of Mental Health (DMH): DMH is undertaking to facilitate health information exchange with particular emphasis on assuring inter-operability of systems developed by county mental health plans, and in turn the viability of exchange of data. Approximately \$400 million from the MHPA fund has been appropriated to support California county Capital Facilities and Technology Component needs. Technology spending is a portion of the total county Component allocation, based on community need. Technology dollars are being used by counties to support their goals of modernization/transformation and client/family empowerment through technology, as they move toward an Integrated Information Systems Infrastructure (IISI). Most counties are making use of MHPA Technology funding in support of the following:
 - Electronic Health Record (EHR) system implementations, including infrastructure development, security, privacy assurance, practice management systems, clinical data management, computerized provider order entry, and interoperability (for example, standard data exchanges with other counties, contract providers, labs, pharmacies)
 - Client and family empowerment projects, including client/family access to computing resources, Personal Health Record (PHR) system implementation, online information resource development, (expansion/leveraging information sharing services)
 - Projects that support MHPA operations, including telemedicine and other rural/underserved service access methods, pilot projects to monitor new programs and service outcome improvement, data warehousing projects / decision support, imaging / paper conversion projects, etc.

While these state-level initiatives have and will continue to play a critical role in the advancement of integrated clinical information systems in California, there is a large array of regional and local endeavors to integrate data and make it accessible both at the point of service as well as retrospectively to study system performance. The following is a general overview of some of these efforts to develop clinical information systems that support integrated, collaborative care in California.

- Disease registries are a well established means of providing timely reminders for providers and patients in primary care; however, very few mental health provider agencies in California currently use this tool. Currently there are no state-level initiatives facilitating the development of mental health or integrating/collaborative registries, although CalMEND is planning to pilot test a registry for use in mental health settings to support integrated care. Access to low cost, simple to use registries or similar tools is vital to overcoming the obstacles otherwise associated with integrating care. To assure the timeliness of reminders as individuals move through the care continuum, registries must be developed with sufficient inter-operability to support data sharing among entities across the continuum. Given the size of California, a state-level initiative is required to support establishment of standards, as well as facilitate economies of local development and implementation.
- In California, a variety of initiatives are advancing the capabilities to identify relevant subpopulations for proactive care. Most of these initiatives are local and driven by county agencies. For instance, in Alameda County, the behavioral health care agencies and Medi-Cal managed care agency are collaborating to identify individuals with serious mental illness who are at risk for serious physical conditions.
- Within the Department of Health Care Services (DHCS), several initiatives are underway which use health information to identify individuals to target for proactive care. The Systems

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of Care Division is developing a pilot to operate in five California counties: Coordinated Care Management for individuals with serious mental illness and chronic physical conditions. This pilot will be funding a contracted entity to support prevention and early intervention by improving access to and coordination of services, as well as self-management – and founded on using existing DHCS health information to identify target Medi-Cal beneficiaries

- Another proactive DHCS endeavor is the development of predictive model using the same DHCS health information. On behalf of CalMEND, the DHCS MIS/DSS division and its health IT contractor, Ingenix, has studied historical utilization patterns to develop a method that identifies current beneficiaries at risk for physical and/or mental health complications. This prototype model is intended to facilitate identification of relevant subpopulations for which integration of services will be critical to their current and future health.
- Foundational to individualized care planning on an integrated basis is provider access to comprehensive patient/client data – which is usually only achieved through multi-organization health information exchange. As discussed above, the CalRHIO has begun to facilitate and support this kind of exchange. Also, through the CalRHIO and a wide variety of local endeavors, HIE that supports sharing information with providers and patients to coordinate care has begun. However many obstacles remain that impede the scope, pace and viability of its spread – including financial, technical and logistical challenges – resulting in progress that is slow and uncertain.
- Progress towards monitoring performance of practice team and care system is highly varied across the state and lacks a common approach that allows efficient adoption and ongoing use, and eventually meaningful comparison across systems. As described in other sections of this report, outcome measurement is progressing in some settings – largely where an existing, validated tool is available, and almost entirely within the primary care arena. System performance, in terms of process quality, has advanced more than outcome-related quality, particularly due to adoption of HEDIS and other practice measures indicative of quality outcomes. Again, mental health lags behind physical health in this area.

Opportunities for Advocacy

There are two levels of opportunity to improve information sharing for collaborative care:

- The clinical level, via electronic health records (EHRs), personal health records (PHRs) and registries/chronic disease management systems
- The aggregate level, via Health Information Exchanges (HIEs) or Regional Health Information Organizations (RHIOs)

Clinical Level

“The evolving electronic health record (EHR) systems for behavioral health and primary care do not easily intersect, and some of the EHRs being developed for use in behavioral health settings do not have data fields for health status and the healthcare services provided to people with serious mental illnesses. An emerging opportunity is the development of personal health records (PHRs) to support individuals managing chronic medical conditions, and application of that technology to support individuals living with serious mental illnesses.”²

Please see the discussion under Service Delivery Design for Privacy Policy Issues related to IT. This discussion focuses on the technical capacities of the system. A California Healthcare Foundation fact sheet provides a simple framework to help identify the differences between the

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most commonly used tools in the ambulatory setting: electronic health record (EHR) systems and chronic disease management systems (CDMS), also known as registries. Of all the IT tools, these two are especially important in terms of potential to improve the clinical care of patients with chronic conditions.²⁶

- *The most important question that an organization needs to answer in choosing its IT system is: “What problem(s) are we trying to solve?” After requirements development and selection, implementation must be addressed. All too often, organizations implementing EHRs or CDMSs fail to take advantage of the full capability of whichever system they select. The optimal use of either type of technology requires a change in how clinical care is practiced—in paper-based systems, workflows are designed to deal with paper “tools” while electronic tools require new workflows and training.*
- *Use of CDMSs to improve population care (often for chronic disease management) can be thought of as a “stepping stone” toward more comprehensive computerization of data (including EHR and electronic documentation). CDMS systems often provide the opportunity to create and support new team working relationships but do not require all those “touching” the system to use the computer as part of their daily interactions with patients. Provider teams become accustomed to pulling up appropriate information to support planned visits for patients, relying on a computer (or computer printout) for key prompts and reminders, and using reports to support patient follow-up and outreach. These systems are well suited to organizations focusing on quality improvement and that might not have significant resources to finance an EHR purchase and implementation or have a large support staff to maintain it. Most off-the-shelf EHR systems, however, do not support population management systems well.*
- *Even the most sophisticated implementations, such as Kaiser Permanente’s Health Connect and the Computerized Patient Record System (CPRS) used by the Veterans Health Administration, rely on separate population management systems used in parallel with their EHR. However, some EHR purchasers (including clinic networks) have worked closely with EHR vendors to customize their systems to offer some of the needed functionality.*

Aggregate Level

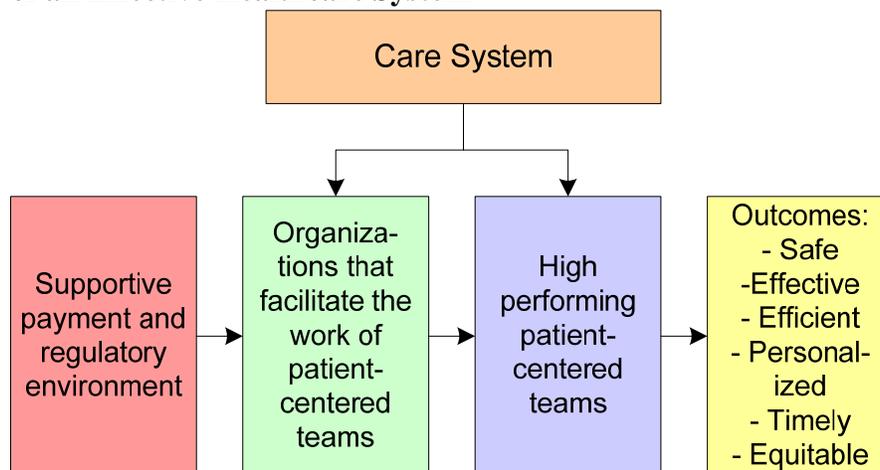
To date, it is not entirely clear how California MH/SU providers, consumers and families have participated in the discussion regarding HIEs. In other parts of the country (e.g., Washtenaw County, Michigan) the safety net HIE includes information regarding participation in MH/SU services, integrating basic information such as demographics pharmacy, lab values, vital signs, key contacts, and most recent visits. These systems hold promise for reducing the redundancy that consumers experience when they seek services.

Even more promising for consumers are PHRs, which they control, containing all of their basic health history information. Currently, a research project in Atlanta, Georgia is conducting a randomized controlled trial in which consumers from the public mental health system are working with a nurse care manager to accurately complete their health histories, advance directives, and other components of their PHRs. Focus groups conducted prior to the initiation of the project found that most consumers have access to computers through peer centers, libraries, families, or other sites. They expressed excitement regarding the idea, seeing it as truly empowering, in an environment that provides them with fragmented care.

The Quality Chasm Aims and Rules

In *Crossing the Quality Chasm: A New Health System for the 21st Century*²⁷ the IOM described the components of an effective healthcare system, including the need to have a supportive payment and regulatory environment that supports provider organizations in developing and maintaining high performing patient-centered teams that will result in the outcomes, or aims of the system. This framework is illustrated below.

Components of an Effective Healthcare System



Six Aims for Improving the Healthcare System

1. Health care must be **safe**. This means much more than the ancient maxim "First, do no harm," which makes it the individual caregiver's responsibility to somehow try extra hard to be more careful (a requirement modern human factors theory has shown to be unproductive). Instead, the aim means that safety must be a property of the system. No one should ever be harmed by health care again.
2. Health care must be **effective**. It should match science, with neither underuse nor overuse of the best available techniques—every elderly heart patient who would benefit from beta-blockers should get them, and no child with a simple ear infection should get advanced antibiotics.
3. Health care should be **patient [or person]-centered**. The individual patient's culture, social context, and specific needs deserve respect, and the patient should play an active role in making decisions about her own care. That concept is especially vital today, as more people require chronic rather than acute care.
4. Care should be **timely**. Unintended waiting that doesn't provide information or time to heal is a system defect. Prompt attention benefits both the patient and the caregiver.
5. The health care system should be **efficient**, constantly seeking to reduce the waste—and hence the cost—of supplies, equipment, space, capital, ideas, time, and opportunities.
6. Health care should be **equitable**. Race, ethnicity, gender, and income should not prevent anyone in the world from receiving high-quality care. We need advances in health care

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delivery to match the advances in medical science so the benefits of that science may reach everyone equally.

Ten Rules to Guide the Redesign of Health Care

1. **Care based on continuous healing relationships.** Patients should receive care whenever they need it and in many forms, not just face-to-face visits. This rule implies that the health care system should be responsive at all times (24 hours a day, every day) and that access to care should be provided over the Internet, by telephone, and by other means in addition to face-to-face visits.
2. **Customization based on patient needs and values.** The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.
3. **The patient as the source of control.** Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision making.
4. **Shared knowledge and the free flow of information.** Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.
5. **Evidence-based decision making.** Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.
6. **Safety as a system property.** Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.
7. **The need for transparency.** The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.
8. **Anticipation of needs.** The health system should anticipate patient needs, rather than simply reacting to events.
9. **Continuous decrease in waste.** The health system should not waste resources or patient time.
10. **Cooperation among clinicians.** Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

The Substance Abuse and Mental Health Services Administration’s National Consensus Statements on Recovery

<i>Mental Health</i> <i>The 10 Fundamental Components of Recovery</i> ²⁸
<i>Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.</i>
<i>Self-Direction: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.</i>
<i>Individualized and Person-Centered: There are multiple pathways to recovery based on an individual’s unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.</i>
<i>Empowerment: Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.</i>
<i>Holistic: Recovery encompasses an individual’s whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services (such as recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.</i>
<i>Non-Linear: Recovery is not a step-by step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.</i>
<i>Strengths-Based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships</i>
<i>Peer Support: Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.</i>
<i>Respect: Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one’s self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.</i>

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<i>Responsibility: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.</i>
<i>Hope: Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.</i>

Substance Use Guiding Principles of Recovery²⁹
<i>Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence [or harm/risk reduction] and improved health, wellness and quality of life.</i>
<i>There are many pathways to recovery. Individuals are unique with specific needs, strengths, goals, health attitudes, behaviors and expectations for recovery. Pathways to recovery are highly personal, and generally involve a redefinition of identity in the face of crisis or a process of progressive change. Furthermore, pathways are often social, grounded in cultural beliefs or traditions and involve informal community resources, which provide support for sobriety. The pathway to recovery may include one or more episodes of psychosocial and/or pharmacological treatment. For some, recovery involves neither treatment nor involvement with mutual aid groups. Recovery is a process of change that permits an individual to make healthy choices and improve the quality of his or her life.</i>
<i>Recovery is self-directed and empowering. While the pathway to recovery may involve one or more periods of time when activities are directed or guided to a substantial degree by others, recovery is fundamentally a self-directed process. The person in recovery is the “agent of recovery” and has the authority to exercise choices and make decisions based on his or her recovery goals that have an impact on the process. The process of recovery leads individuals toward the highest level of autonomy of which they are capable. Through self-empowerment, individuals become optimistic about life goals.</i>
<i>Recovery involves a personal recognition of the need for change and transformation. Individuals must accept that a problem exists and be willing to take steps to address it; these steps usually involve seeking help for a substance use disorder. The process of change can involve physical, emotional, intellectual and spiritual aspects of the person’s life.</i>
<i>Recovery is holistic. Recovery is a process through which one gradually achieves greater balance of mind, body and spirit in relation to other aspects of one’s life, including family, work and community.</i>
<i>Recovery has cultural dimensions. Each person’s recovery process is unique and impacted by cultural beliefs and traditions. A person’s cultural experience often shapes the recovery path that is right for him or her.</i>
<i>Recovery exists on a continuum of improved health and wellness. Recovery is not a linear process. It is based on continual growth and improved functioning. It may involve relapse and other setbacks, which are a natural part of the continuum but not inevitable outcomes. Wellness is the result of improved care and balance of mind, body and spirit. It is a product of the recovery process.</i>
<i>Recovery emerges from hope and gratitude. Individuals in or seeking recovery often gain hope from those who share their search for or experience of recovery. They see that people can and do overcome the obstacles that confront them and they cultivate gratitude for the opportunities that each day of recovery offers.</i>
<i>Recovery involves a process of healing and self-redefinition. Recovery is a holistic healing process in which one develops a positive and meaningful sense of identity.</i>
<i>Recovery involves addressing discrimination and transcending shame and stigma. Recovery is a process by which people confront and strive to overcome stigma.</i>
<i>Recovery is supported by peers and allies. A common denominator in the recovery process is the</i>

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presence and involvement of people who contribute hope and support and suggest strategies and resources for change. Peers, as well as family members and other allies, form vital support networks for people in recovery. Providing service to others and experiencing mutual healing help create a community of support among those in recovery.

Recovery involves (re)joining and (re)building a life in the community. Recovery involves a process of building or rebuilding what a person has lost or never had due to his or her condition and its consequences. Recovery involves creating a life within the limitation imposed by that condition. Recovery is building or rebuilding healthy family, social and personal relationships. Those in recovery often achieve improvements in the quality of their life, such as obtaining education, employment and housing. They also increasingly become involved in constructive roles in the community through helping others, productive acts and other contributions.

Recovery is a reality. It can, will, and does happen.

Resource List

June 16, 2009

- The Integrated Behavioral Health Project has launched a website that includes information on a wide range of resources and a focus on California initiatives.
<http://www.ibhp.org/index.php>
- The California Primary Care Association has conducted policy analysis and advocacy regarding integration of behavioral health into primary care and has a number of documents that are specific to community clinics in California.
 - The Vital Role of Community Clinics and Health Centers
<http://www.cPCA.org/about/documents/vitalrole.pdf>
 - Fact Sheet: Community Clinics and Health Centers & Mental Health Services
 - Integrated Behavioral Health Care: An Effective and Affordable Model
 - CPCA Priorities Related to the Promotion of Integrated Behavioral Health
- The National Council for Community Behavioral Healthcare website includes a resource center focused on integrated/collaborative care, with access to the documents listed below and other resources http://www.thenationalcouncil.org/cs/new_at_the_resource_center
 - [Integration and the Person-Centered Healthcare Home](#), April 2009
 - [Healthcare Payment Reform and the Behavioral Health Safety Net: What's on the Horizon for the Community Behavioral Health System Report.pdf](#), April 2009, looks at future financing mechanisms for integrated care in healthcare homes
 - [Mind and Body Reunited: Improving Care at the Behavioral and Primary Healthcare Interface](#), March 2007
 - [National Council Magazine](#) issue on behavioral health and primary care coordination, featuring expert perspectives and provider success stories, Winter 2009
 - [Finance, Policy, and Integration of Services](#), July 2006
 - [The Four Quadrant Model and Evidence-Based Practices](#), February 2006
 - [Environmental Assessment Tool, State Level Policy and Financing](#), Spring 2004
 - [Behavioral Health/Primary Care Integration Models, Competencies, And Infrastructure](#), May 2003
- The National Association of State Mental Health Program Directors has issued two papers related to integration, and a paper on key health indicators to track in the population with Serious Mental Illness. <http://www.nasmhpd.org/publicationsmeddir.cfm>
 - [Measurement of Health Status for People with Serious Mental Illnesses](#)
 - [Morbidity and Mortality in People with Serious Mental Illness](#)
 - [Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities](#)
- CMHS/SAMHSA sponsored a Wellness Summit in September 2007 and has published an action agenda, along with a vision statement and pledge to reduce morbidity and mortality in people with serious mental illnesses (The 10 by 10 Campaign). <http://www.bu.edu/cpr/resources/wellness-summit/index.html>

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- The MacArthur Foundation sponsored the original improvement initiative regarding depression in primary care. <http://www.depression-primarycare.org/>
- The Chronic Care Model has influenced the development of the patient-centered medical home and is foundational to the Health Disparities Collaborative. <http://www.improvingchroniccare.org/change/index.html>
- The Health Disparities Collaborative has been sponsored by HRSA for Community Health Centers, including a Depression Collaborative. <http://www.healthdisparities.net/hdc/html/home.aspx>
- The IMPACT program was informed by the Chronic Care model and several initiatives such as the Partners in Care study at UCLA / RAND and the MacArthur Foundation's initiative. The original IMPACT research was a randomized controlled trial in older adults, focused on depression in primary care. The IMPACT model is now being used/studied for all age groups and many other mental health conditions found in primary care. <http://impact-uw.org>
- Cherokee Health Systems has been developing integrated care for many years and is both a Community Health Center and a Mental Health Center. <http://www.cherokeehealth.com>
- The Collaborative Family Healthcare Association sponsors annual conferences that focus on integrated care. <http://www.cfha.net/>
- One of the CFHA leaders is Alexander Blount, who heads a post-graduate certificate program in integrated care at the University of Massachusetts and has a website focused on integrated care. <http://www.integratedprimarycare.com>
- CMHS/SAMHSA initiated a website, What a Difference a Friend Makes, which is targeted at supporting recovery. Mental health recovery is a journey of healing and transformation, enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. <http://whatadifference.org/>
- CMS/SAMHSA/HRSA has recently published a report on financing for mental health services in primary care settings. <http://download.ncadi.samhsa.gov/ken/pdf/SMA08-4324/SMA08-4324.pdf>
Additional information about billing for mental health services is available at: <http://hipaa.samhsa.gov/hipaacodes2.htm>.

Please access additional information and materials utilized in the Integrated Policy Initiative on the CiMH website at <http://www.cimh.org/Services/Special-Projects/Primary-Care.aspx>

Map of Selected California Integration Initiatives



Updated: July 14, 2009

Glossary

ADP	Department of Alcohol and Drug Programs (CA)
AHRQ	Agency For Health Research and Quality (U.S. Health And Human Services)
ARRA	American Recovery and Reinvestment Act
ASAM	American Society of Addiction Medicine
ASI	Addiction Severity Index
BMI	Body Mass Index
BPHC	Bureau of Primary Health Care (HRSA)
CADPAAC	County Alcohol And Drug Program Administrators Association Of California
CALMEND	California Mental Health Care Management Program
CALOMS	California Outcomes Measurement System (ADP)
CDSMP	Chronic Disease Self Management Program (Lorig/Stanford)
CHC	Community Health Center
CiMH	California Institute for Mental Health
CIOM	Clinically Informed Outcomes Management (CalMEND)
CMHDA	California Mental Health Directors Association
CMSP	County Medical Services Program (CA)
CPCA	California Primary Care Association
CPE	Certified Public Expense
CSI	Client And Service Information (DMH)
CSS	Community Supports and Services (MHSA)
DHCS	Department Of Health Care Services (CA)
DMH	Department Of Mental Health (CA)
EHR/EMR	Electronic Health Record/Electronic Medical Record
EPSDT	Early, Periodic Screening, Detection and Treatment
FFS	Fee For Service
FQHC	Federally Qualified Health Center
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act

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HITECH	Health Information Technology For Economic And Clinical Health Act (ARRA)
HRSA	Health Resources and Services Administration (U.S. Health And Human Services)
IBHP	Integrated Behavioral Health Program
IHI	Institute For Healthcare Improvement
IOM	Institute Of Medicine
IPI	California Primary Care, Mental Health and Substance Use Services Integration Policy Initiative
LPC	Licensed Professional Counselor
MFT	Marriage and Family Therapist
MHP	Mental Health Plan (Medi-Cal)
MHSAOAC or MHOAC	Mental Health Services Act Oversight And Accountability Commission
MHSA	Mental Health Services Act
MHSIP	Mental Health Statistics Improvement Program (SAMHSA)
MOU	Memorandum Of Understanding
NAMI	National Alliance on Mental Illness
NCQA	National Committee For Quality Assurance
PAM	Patient Activation Measure
PCMH	Patient-Centered Medical Home
PCP	Primary Care Provider/Practitioner
PEI	Prevention and Early Intervention (MHSA)
PHR	Personal Health Record
RHC	Rural Health Clinic
RHIO	Regional Health Information Organization
SAMHSA	Substance Abuse And Mental Health Services Administration (U.S. Health And Human Services)
SBIRT	Screening, Brief Intervention, Referral and Treatment

Endnotes

- ¹ http://www.integratedprimarycare.com/Certificate%20Program_Email.htm
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- ³ *Eliminating stigma and discrimination against persons with mental health disabilities*. Mental Health Services Act Oversight and Accountability Commission. Draft 2007. <http://www.dmh.ca.gov/MHSOAC/docs/StigmaAndDiscriminationReport07Jun12.pdf>
- ⁴ Hibbard, J. et al. *Development of the Patient Activation Measure (PAM): Conceptualizing and measuring activation in patients and consumers*. Health Serv Res. 2004 August. <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1361049>
- ⁵ Agency for Healthcare Research and Quality. *Integration of mental health/substance abuse and primary care*. Fall 2008. <http://www.ahrq.gov/clinic/tp/mhsapctp.htm>
- ⁶ Hogg Foundation for Mental Health. *Connecting body and mind: A resource guide to integrated health care in Texas and the United State*. Fall 2008. http://www.hogg.utexas.edu/programs_RLS15.html
- ⁷ <http://impact-uw.org/about/research.html>
- ⁸ <http://www.healthdisparities.net/hdc/html/home.aspx>
- ⁹ Mauer, B, Druss B. *Mind and body reunited: Improving care at the behavioral and primary healthcare interface*. Manuscript in review. Based on paper presented at presented at the 2007 American College of Mental Health Administration Summit.
- ¹⁰ Mauch, D, Kautz, C., Smith, S. *Reimbursement of mental health services in primary care settings*. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. February 2008.
- ¹¹ Mauer, B. *Finance, policy, and integration of services*. The National Council for Community Behavioral Healthcare. July 2006. http://www.thenationalcouncil.org/cs/business_practice_areas/primary_care
- ¹² *Groundbreaking depression initiative expands to 10 Minnesota clinics*. Mental Health Weekly Vol. 18, No.22, June 2, 2008.
- ¹³ Jarvis, D. *Examining the unmet mental healthcare needs of indigent, uninsured Americans*. The National Council for Community Behavioral Healthcare. To be published soon.
- ¹⁴ Pourat, N. et al. *Health Coverage in the safety net: How California's coverage initiative is providing a medical home to low-income uninsured adults in ten counties, interim findings*. UCLA Center for Health Policy Research, June 2009. <http://www.healthpolicy.ucla.edu/pubs/publication.asp?pubID=364>
- ¹⁵ <http://www.csh.org/index.cfm?fuseaction=Page.viewPage&pageId=4224&parentID=3803>
- ¹⁶ http://www.desc.org/documents/DESC_1811_JAMA_info.pdf
- ¹⁷ *Access transformed: Building a primary care workforce for the 21st century*. National Association of Community Health Centers. Robert Graham Center, The George Washington University School of Public Health and Health Services. August 2008.
- ¹⁸ California Healthcare Foundation. *An unprecedented opportunity: Using federal stimulus funds to advance health it in California*. February 2009. <http://www.chcf.org/topics/index.cfm?topic=CL108&PgNum=2>

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¹⁹ <http://www.improvingchroniccare.org>

²⁰ <http://www.gov.ca.gov/executive-order/2616/>

²¹ <http://www.gov.ca.gov/executive-order/5626/>

²² <http://www.chhs.ca.gov/initiatives/HealthInfoEx/Pages/Default.aspx>

²³ <http://www.chhs.ca.gov/initiatives/HealthInfoEx/Pages/Workgroups.aspx>

²⁴ <http://www.chcf.org/topics/view.cfm?itemid=125646>

²⁵ <http://www.chcf.org/documents/healthit/eHealthActionForum.pdf>

²⁶ California Healthcare Foundation. Electronic health records versus chronic disease management systems: A quick comparison. March 2008.

<http://www.chcf.org/topics/index.cfm?topic=CL108&PgNum=4>

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²⁹ *National Summit on Recovery Conference Report*, Center for Substance Abuse Treatment, 2005.