California Primary Care, Mental Health, and Substance Use Services Integration Policy Initiative

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Volume I: Report

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

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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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Executive Summary

Launched in 2008, the Integration Policy Initiative (IPI) is a collaborative project, led by the California Institute for Mental Health (CiMH), the California Primary Care Association (CPCA) and the Integrated Behavioral Health Project (IBHP). The IPI is a project of CiMH and funded by The California Endowment with additional financial support provided by IBHP.

As a time-limited project, developed to address the pressing need for improved linkages between the physical, mental and substance use healthcare systems serving California's Safety Net Population, its goals were to:

1. Develop a set of policy recommendations enhancing the interface between physical, mental and substance use healthcare.
2. Advance these recommendations through a report to local and state policy makers identifying changes in law, regulation and practice to support integration of mental health, primary care and substance use services.
3. Accelerate the systems integration needed to enhance the health outcomes of underserved populations and to promote efficiencies across the safety net systems.

The IPI process examined researched models and built on the substantial body of work already underway in California, examples of which are summarized at right and in Volume II and III of the Report. A great deal has been accomplished 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.

The IPI Report describes a Vision, Principles, and a Collaborative Care Continuum, and makes Recommendations to frame the future development of integrated care for California's Safety Net Population.[1] The IPI development process included the participation of individuals and organizations that also serve populations other than the safety net population. It is hoped that these integration concepts will have relevance for all Californians.

California Integration Examples

There is considerable energy and activity in California regarding integrated, or collaborative, care. Some examples include:

- The IBHP is a four-year initiative to accelerate the integration of behavioral health services into primary care settings with the goals of enhancing access to behavioral treatment services, improving treatment outcomes for underserved populations, and reducing the stigma associated with seeking such services. Phase II includes 27 California clinics and clinic consortia.
- Shasta County has contracted with two community-based FQHCs to provide mental health services in their primary care settings. Santa Clara County Mental Health is involved in a detailed design process to integrate psychiatry and social workers into 3 county-operated FQHC's—increasing access and avoiding larger budget cuts to the MH system.
- Integration and stepped care initiatives are being designed and implemented by County Mental Health Departments—including early pilots of mental (behavioral) health care homes which provide primary care services within mental health clinics.
- The County Medical Services Program (CMSP) has integrated care pilots underway in 12 clinics.
- Of the 37 counties with approved Mental Health Services Act-Prevention/Early Intervention (PEI) Plans (as of 6-1-09) fifteen have identified providing mental health services in primary care as one of their PEI activities.

Vol. II contains a map of selected system integration initiatives; Vol. III contains descriptions and materials from selected initiatives.

Vision: Overall health and wellness is embraced as a shared community responsibility

To achieve individual and population health and wellness (physical, mental, social/emotional/ developmental and spiritual health), healthcare services for the whole person (physical, mental

and substance use healthcare) must be seamlessly integrated, planned for and provided through collaboration at every level of the healthcare system, as well as coordinated with the supportive capacities within each community. Ten principles are articulated as the foundation for that collaborative activity. The principles introduce the expectation that planning and implementation ensure that:

- Each individual has a person-centered healthcare home, which provides mental health (MH) and substance use (SU) services in the primary care setting or primary care services in the MH/SU setting.
- Each community has established a Collaborative Care Mental Health/Substance Use Continuum (the IPI Continuum). The IPI Continuum is a framework for service development that identifies population need across MH/SU levels of risk/complexity/acuity and assigns provider responsibilities within any given community for delivering those services. The community dialogue to establish the Continuum should result in mechanisms for stepped MH/SU healthcare back and forth across the Continuum, mechanisms to address the range of physical health risk/complexity/acuity needs of the population, and collaborative links between the integrated healthcare system and other systems, community services and resources.
- Measurement is aligned to support the IPI Continuum, Quality Improvement and fidelity implementation of proven models as well as evaluation of emerging models, with accountability, transparency and measures matched to the levels of the Continuum.

The IPI project specifically focused on the interface between MH/SU services and primary care. As indicated in the recommendations, the intent is that every California community will develop a local IPI Continuum over the next five years, supported by training, technical assistance, clinical guidance and revised financing, regulatory and measurement structures. MH/SU services and primary care are challenged to engage in boundary spanning collaboration and integration while each system is concurrently pursuing its own transformative improvements. For example, the Mental Health Services Act (MHSA) in California has led to focused local planning and system improvement processes involving consumers, family members, providers and system partners from health, justice and social services.

The primary care world is involved in a whole range of concurrent conversations regarding the improvement of general healthcare, from work with the community on prevention and health promotion, to work with specialty medical/surgical providers and hospitals on improving access and services for people with significant physical healthcare needs. While these related issues were not a part of the IPI process, resolution of them at the community level is also a priority.

It is acknowledged that California's Mental Health and Substance Use agencies are responsible for providing systems of care that operate as specialties—much as there are specialty services in the physical health care arena. Integration as envisioned in the IPI enhances, but does not replace, these specialty systems of care, which include comprehensive treatment and community support services critical for individuals with the most serious mental health and substance use needs.

California providers' experience with barriers to collaborative care implementation guided the development of recommendations for state and local actions to improve integration in the safety net system. The Advisory Group and Work Groups identified barriers and issues that will need to be addressed, summarized into the following categories:

- ***Delivery System Design*** (for example, problems of fragmented communication and siloed care and the need for integrated clinical assessment and care guidelines)
- ***Financing*** (for example, separate payment, cost and reporting systems)
- ***Regulatory*** (for example, HIPAA and confidentiality rules or the myths about them as barriers to communication)
- ***Workforce*** (for example, the need for clinical competence in integrated models and cultural competence/linguistic capacity)
- ***Healthcare Information Technology*** (for example, lack of common electronic health records or registries for primary care and MH/SU)

Volume I, Appendix A, lists the brainstormed barriers. Volume II, Working Papers, examines the areas summarized above in more detail, providing the foundation for the IPI Recommendations.

The IPI created a unique venue for leaders from the physical, mental and substance use healthcare systems to co-create a shared Vision of the future and craft relationships and strategies to begin to translate the Vision into practice. 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 and chronic under-funding. The IPI process has surfaced some of these core issues and may provide a vehicle for further dialogue and positive collaboration. The potential developments in healthcare reform and the recommended actions and issues identified in the details of the IPI report make it clear that to transition the current operation of these systems in mid-2009 to dramatically more collaborative operation by 2014 requires significant ongoing coordination, partnership and leadership. This leads to a first, overarching recommendation.

Continue policy and model development through an ongoing IPI-like initiative, supported by a public/private coalition, to serve as a high-level champion and nimble advocate for the ideas articulated in the IPI report. The initiative would function as a convenor/think tank, with strategic relationships across the mental health, substance use and physical healthcare systems, to work in support of the IPI recommended actions and timelines. It would include the system representatives that have collaborated on IPI as well as forge new connections to healthcare reform, healthcare workforce development, and healthcare information technology initiatives in California. The initiative would work with public agencies and private sponsors (such as the foundation community) to move forward this set of IPI Recommendations.

Delivery System Design Recommendations	
1.	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
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)
Financing Recommendations
1. Obtain approval to pay for same day MH/SU and PC services • 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 • 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) • 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 including Behavioral Health Care Homes.
4. Develop the business case for integration (with an emphasis on the safety net system) while acknowledging the role of specialty services within MH/SU and health care
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 requirements 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 as well as the need for comprehensive mental health systems of specialty care and address: • 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 Mental Health 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 improvements 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
Measurement Recommendations
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) • 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 • 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 IPI Volume I: Report, Volume II: Working Papers and Volume III: Examples for Dissemination can be found on the CiMH website at http://www.cimh.org/Services/Special-Projects/Primary-Care.aspx.

IPI Overview

This Integration Policy Initiative (IPI) Report describes a Vision, Principles, Collaborative Care Continuum, and Recommendations to frame the future development of integrated care for California's Safety Net Population.[1] Launched in 2008, the IPI is a collaborative project, led by the California Institute for Mental Health (CiMH), the California Primary Care Association (CPCA) and the Integrated Behavioral Health Project (IBHP). The IPI is a project of CiMH and funded by The California Endowment with additional financial support provided by IBHP.

As a time-limited project, developed to address the pressing need for improved linkages between the physical, mental and substance use healthcare systems serving California's Safety Net Population,[1] its goals were to:

1. Develop a set of policy recommendations enhancing the interface between physical, mental and substance use healthcare.
2. Advance these recommendations through a report to local and state policy makers identifying changes in law, regulation and practice to support integration of mental health, primary care and substance use services.
3. Accelerate the systems integration needed to enhance the health outcomes of underserved populations and to promote efficiencies across the safety net systems.

What is integrated healthcare? "*It has been defined in many ways, but in essence integrated healthcare is the systematic coordination of physical and behavioral health care. The idea is that physical and behavioral health problems often occur at the same time. Integrating services to treat both will yield the best results and be the most acceptable and effective approach for those being served… The question is not whether to integrate, but how. Neither primary care nor behavioral health providers are trained to address both issues. Systems that pay for these services typically are set up to pay for them separately. Shifting to integrated health care requires a fresh perspective, new skills and radical changes in service delivery*."[2]

The IPI process was a series of dialogues among representatives from the physical, mental and substance use healthcare systems that included the participation of individuals and organizations that also serve populations other than the safety net population. There are tensions among the physical, mental and substance use healthcare systems in California, as there are in other parts of the country—the legacy of many years of working in silos. The IPI process examined researched collaborative care models and built on the substantial body of work already underway in California, some examples of which are summarized in Volume III of the Report. California providers' experience with barriers to implementation guided the development of recommendations for state and local actions to improve integration in the safety net system. It is hoped that these ideas also will be found compelling and useful in planning for all Californians.

One of the unique features of the IPI process has been the participation of experts from the field of addictions—very few collaborative/integration projects nationally have worked across all three fields of physical, mental and substance use healthcare. The IPI process has used the broad term of Substance Use (recently adopted by the Institute of Medicine for reports relating to improving quality in mental health [MH] and substance use [SU] services). The term encompasses awareness of the need for early identification and interventions, as in the Screening, Brief Intervention, Referral and Treatment (SBIRT) model, as well as the more

traditional categories of substance abuse and substance dependence. Collaborative care works to address all of the intertwining issues of general health, mental health and substance use—for example, if an individual has diabetes and a bipolar disorder, then substance use (that is less than abuse) will likely need to be addressed as well.

The report's ideas and recommendations offer a bridge from how the physical, mental and substance use healthcare systems operate in 2009 to how they might operate by 2014. The dialogues creating these ideas and recommendations have occurred in the context of California's unprecedented budget crisis and proposed budget reductions that will significantly impact the healthcare system. Nonetheless, participants believed it important to keep building these ideas and partnerships, remaining optimistic about the long-term future. The IPI uniquely created a venue for leaders from these systems to co-create a shared Vision of the future, begin to understand each system and its issues, build initial relationships (through the Advisory Group, Work Groups and Steering Committee) and start to develop a mutually informed voice.

The IPI also developed in the context of a national healthcare reform discussion that has three components: insurance reform, delivery system reform and payment reform. While the specifics of healthcare reform are not yet clear, it seems certain that healthcare systems will be structured to operate differently in the future. Hopefully, healthcare reform will result in insurance coverage for most Californians, with benefit designs that include parity MH/SU services. However, it is assumed that a large population of individuals—many with complex co-occurring problems—will continue to receive their services from safety net providers. Safety net providers will face continued challenges in working collaboratively in this new environment and the IPI Recommendations are intended to support them in successful collaboration. The intent of the IPI is to ensure that healthcare reform in California supports the IPI Vision of integrated care. The foundation of the IPI Vision is the following statement:

> ***Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity***. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

IPI Vision

Overall health and wellness is embraced as a shared community responsibility.

IPI Principles

To achieve individual and population health and wellness (physical, mental, social/emotional/developmental and spiritual health), healthcare services for the whole person (physical, mental and substance use healthcare) must be seamlessly integrated, planned for and provided through collaboration at every level of the healthcare system, as well as coordinated with the supportive capacities within each community. The IPI Principles are the foundation for that collaborative activity.

1. The Institute of Medicine report, *Improving The Quality Of Health Care For Mental And Substance-Use Conditions*,[3] made two overarching recommendations:
   - "*Health care for general, mental, and substance use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind/brain and the rest of the body.*

- *The aims, rules, and strategies for redesign set forth in Crossing the Quality Chasm should be applied throughout mental/substance use health care on a day-to-day operational basis but tailored to reflect the characteristics that distinguish care for these problems and illnesses from general health care."*

2. Person-centered healthcare and recovery/resiliency are central to achieving overall health and wellness, as described in the Quality Chasm aims/rules and the MH/SU Recovery statements in Volume II of this report.
3. Individuals need timely access to healthcare for the whole person, based on each person's preferences, beliefs, needs, culture, family and support systems, views about wellness and individual strengths and resources.
4. When a child/youth is being served, healthcare services apply not only for the individual, but for the family. Services that are child-and-family-centered involve family members' participation in educational and other services and attention to the healthcare needs of the family members
5. Addressing population disparities in physical, mental and substance use healthcare means ensuring parity of access (e.g., notwithstanding race, ethnicity, gender, sexual orientation, age, cognitive ability, insurance/economic status, geography) and providing culturally competent services without stigma in the context of the individual's primary language and cultural, spiritual and value systems.
6. Positive relationships, communication, acknowledgement of interdependence and collaborative learning among physical, mental and substance use healthcare providers are critical.
7. Providers in primary care and MH/SU settings will demonstrate core competencies in physical, mental and substance use healthcare screening/identification of need, referral protocols and collaborative care models.
8. Services are delivered through person-centered, team-based care with consistent use of proven collaborative care models.
9. Prevention and early intervention, evidence-based practices and promising practices are used wherever possible to optimize health and well-being as well as effective clinical outcomes and cost effectiveness.
10. Planning and implementation ensures that integration is achieved at both the person-level and the community/population-level:
    - Each individual has a person-centered healthcare home, which provides MH/SU services in the primary care setting or primary care services in the MH/SU setting.
    - Each community has established a Collaborative Care Mental Health/Substance Use Continuum (the IPI Continuum). The IPI Continuum is a framework for service development that identifies population need across MH/SU levels of risk/complexity/acuity and assigns provider responsibilities within any given community for delivering those services. The community dialogue to establish the Continuum should result in mechanisms for stepped MH/SU healthcare back and forth across the Continuum, mechanisms to address the range of physical health risk/complexity/acuity needs of the population, and collaborative links between the integrated healthcare system and other systems, community services and resources
    - Measurement is aligned to support the IPI Continuum, Quality Improvement and fidelity implementation of proven models as well as evaluation of emerging models, with accountability, transparency and measures matched to the levels of the Continuum.

Barriers/Opportunities

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.

- A Delivery System Design Work Group identified organizational barriers to implementation and initiated thinking about universal measurements for the system design including potential process, capacity and outcome measures; and
- A Finance Work Group identified and prioritized policy barriers related to regulatory requirements or financing of an integrated delivery system and developed recommendations for change.

Volume I, Appendix A, lists the brainstormed barriers. Volume II, Working Papers, examines the areas summarized below in more detail, providing the foundation for the IPI Recommendations. The listings incorporate the issues identified by the individuals during the process, and represent a range of perspectives.

- ***Delivery System Design*** (for example, problems of fragmented communication and siloed care and the need for integrated clinical assessment and care guidelines)
- ***Financing*** (for example, separate payment, cost and reporting systems)
- ***Regulatory*** (for example, HIPAA and confidentiality rules or the myths about them as barriers to communication)
- ***Workforce*** (for example, the need for clinical competence in integrated models and cultural competence/linguistic capacity)
- ***Healthcare Information Technology*** (for example, lack of common electronic health records or registries for primary care and MH/SU)

To further analyze the issues related to these areas, the Work Groups developed fishbone diagrams. 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. Three fishbone diagrams were developed through brainstorming with work group members; these relate to three of the recommendations outlined below—articulating strategic approaches to changing organizational cultures while reducing stigma, leveraging the financing of physical, mental and substance use healthcare and maximizing federal matching funds. Along with the fishbone diagrams, there are summaries in Volume II of key issues regarding delivery system design, measurement, financing and regulation, workforce development and information technology, providing details of the thinking behind the Recommendations.

The scope of development and change is massive when viewed in total. The implementation process must break this down into strategies and supports to be disseminated over time. Everyone involved in the future change process should read a recent article, *Initial Lessons from the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home*.[4] This initial evaluation report describes six lessons from thirty-six family practice settings across the country that participated in a two-year practice transformation project:

1. *"Becoming a patient-centered medical home (PCMH) requires transformation.*
2. *Technology needed for the PCMH is not plug-and- play.*

3. *Transformation to the PCMH requires personal transformation of physicians.*
4. *Change fatigue is a serious concern even within capable and highly motivated practices.*
5. *Transformation to a PCMH is a developmental process.*
6. *Transformation is a local process."*

The findings and recommendations in the article resonate with the experience in implementing integrated care—this is also a process of transforming personal and organizational practice in the context of local relationships—ideally, these medical home and integration changes can be woven together.

IPI Recommendations to Support the Vision, Principles and Continuum

The members of the IPI Advisory Group and Work Groups prioritized actions to address the barriers and issues and developed specific, focused recommendations to move the Vision forward. In doing so, IPI participants acknowledged the current budget crisis in California, but felt it important to keep building partnership and momentum towards implementation of the Vision.

Potential healthcare reform developments and the recommended actions and issues identified in the details of the IPI Report make it clear that to transition from current siloed systems in mid-2009 to collaborative operation by 2014 requires significant ongoing coordination, partnership and leadership. While many states have sponsored pilot initiatives for integrated/collaborative care (for example, Massachusetts, North Carolina, Minnesota, Missouri), policy-level leadership and direction for the overall healthcare system has been slow to emerge. The Texas State Legislature recently adopted a bill (HB2196) establishing a workgroup to recommend best practices in policy, training and service delivery that integrate health and behavioral health services. The legislation requires a report by August 2010 that describes the "*best practices for health and behavioral health integration, barriers to implementing the best practices in the state, and policy considerations for improving integrated service delivery to the citizens of the state.*" In large part, this is the work that the IPI has completed—California is ready to take the next step of establishing ongoing capacity to keep the work moving forward. This leads to a first, overarching recommendation.

Continue policy and model development through an ongoing IPI-like initiative, supported by a public/private coalition, to serve as a high-level champion and nimble advocate for the ideas articulated in the IPI report. The initiative would function as a convenor/think tank, with strategic relationships across the mental health, substance use and physical healthcare systems, to work in support of the IPI recommended actions and timelines. It would include the system representatives that have collaborated on IPI as well as forge new connections to healthcare reform, healthcare workforce development, and healthcare information technology initiatives in California. This recommendation is predicated on the idea that the initiative would work with public agencies and private sponsors (such as the foundation community) to move forward this set of IPI Recommendations

Delivery System Design Recommendations
1. 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
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)
Financing Recommendations
1. Obtain approval to pay for same day MH/SU and PC services • 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 • 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) • 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 including Behavioral Health Care Homes.
4. Develop the business case for integration (with an emphasis on the safety net system) while acknowledging the role of specialty services within MH/SU and health care
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 I: Financing and Regulation), preparatory to renewal of 1915(b) Waiver
6. Examine Drug Medi-Cal benefit and current programmatic/geographic requirements 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 I: 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 as well as the need for comprehensive mental health systems of specialty care and address: • 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 Mental Health 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 improvements 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
Measurement Recommendations
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 I: Measurement) • 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 • 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

IPI Continuum

As noted in the IPI Principles, there is a need for communities to work together to assure seamless services to individuals. The IPI Continuum is a framework for service development that identifies population need across levels of MH/SU risk/complexity/acuity and assigns provider responsibilities within any given community for delivering those services. This framework is intended to articulate in more detail the ideas supporting Principle 10 and incorporate ideas from several national models for improving primary care and the integration of MH/SU services, as described in the following discussion.

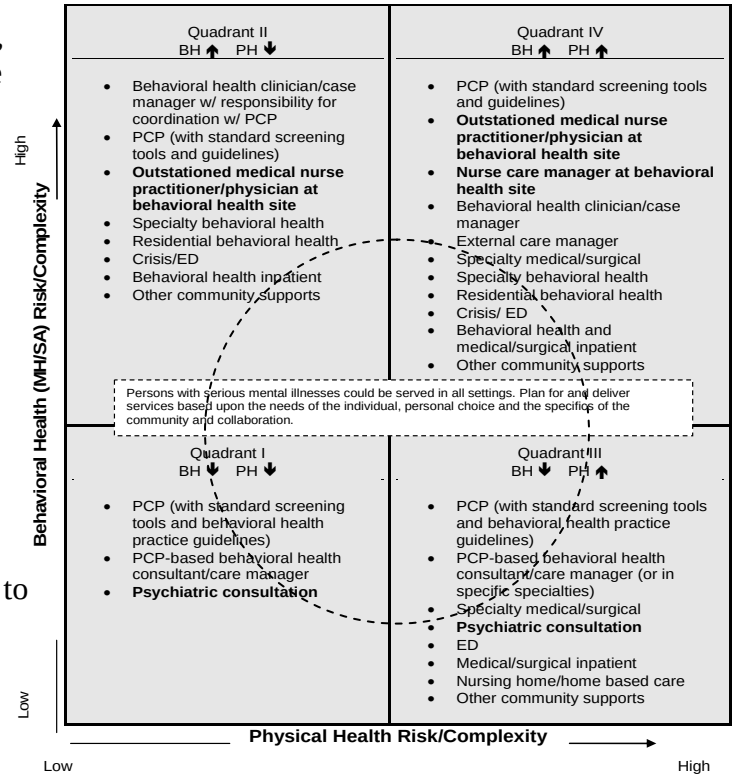
The National Council for Community Behavioral Healthcare's ***Four Quadrant (4Q) Model*** [5] is a planning tool for addressing the needs of the population in each community (system planning must be population-based, while service planning must be person-centered).

The 4Q Model indicates that there are levels of care in the mental health, substance use and physical healthcare systems (from primary care to specialty providers, hospitals and emergency rooms) and that the integrated care model needs to be articulated at all these levels.
The 4Q model provides a structure for a community to plan across the physical, mental and substance use healthcare systems; the IPI Continuum provides detail for thinking about four levels of MH/SU services while not attempting to also articulate the levels of physical healthcare (the horizontal axis of the 4Q model). The primary care world is also involved in a whole range

of concurrent conversations regarding the horizontal axis, from work in clinical settings and with communities on prevention and health promotion (including addressing the social determinants of health), to work with specialty medical/surgical providers and hospitals on improving access and services for people with high physical healthcare needs. Access to specialty medical/surgical services continues to be difficult for safety net providers and the populations they serve; there are other initiatives underway in California specific to this set of relationships.[6]

This project specifically focused on the interface between MH/SU services and primary care. The IPI Continuum, therefore, focuses on MH/SU risk and complexity (the vertical axis of the 4Q Model), and further articulates levels of MH/SU care (from two in the 4Q Model to four in the IPI Continuum), derived from an integration model developed at ***Intermountain Healthcare***.[7] The IPI Continuum uses the Intermountain idea of defining levels of care and expands the levels to include the needs of individuals with severe and persistent mental illnesses, describing the characteristics of the populations in each level and the types of MH/SU services that should be available to them. Use of the IPI Continuum is intended to help communities clarify provider roles, especially in relationship to the area within the dashed circle in the 4Q diagram—where decisions about which services are provided in which organizations by which practitioners can be confounding.

The Four Quadrant Clinical Integration Model



Another model that is a foundation for the IPI Continuum is the ***Patient-Centered Medical Home***. The defining principles for the Patient-Centered Medical Home include:[8]

1. *"Each patient has an ongoing relationship with a personal physician*
2. *The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients*
3. *The personal physician is responsible for providing for all of the patient's healthcare needs or appropriately arranging care with other qualified professionals*
4. *Care is coordinated and/or integrated across all elements of the healthcare system*
5. *Quality and safety are hallmarks*
6. *Enhanced access to care is available*
7. *Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home."*

A proposed name change to ***Person-Centered Healthcare Home***[5] signals that MH/SU services are a central part of healthcare and that healthcare includes using these services to support a person's capacity to set goals for improved self-management. ***The Person-Centered Healthcare***

Home is envisioned as bidirectional: provide MH/SU services in primary care settings and provide primary care services in MH/SU settings.

The ***Care Model***,[9] developed to improve primary care for people with chronic health conditions, such as diabetes or cardiovascular disease, underpins the Patient-Centered Medical Home concept. The Care Model expands the view beyond the clinical setting, incorporating self-management and the resources of the family/neighborhood/community. Care Model Elements[9] include:

1. *"Health System: Create a culture, organization and mechanisms that promote safe, high quality care*
2. *Delivery System Design: Assure the delivery of effective, efficient clinical care and self-management support*
3. *Decision Support: Promote clinical care that is consistent with scientific evidence and patient preferences*
4. *Clinical Information Systems: Organize patient and population data to facilitate efficient and effective care*
5. *Self-Management Support: Empower and prepare patients to manage their health and health care*
6. *The Community: Mobilize community resources to meet needs of patients"*

The Care Model has recently been adapted for use in MH improvement planning[10] in California, as shown in the diagram, in which the community element has been further clarified to add *Social Inclusion & Opportunity*. Future evolution of the Care Model in California will need to incorporate SU services as well.

The ***IPI Continuum*** incorporates all of these ideas and focuses on four stepped levels of MH/SU care. In order to plan for and implement the IPI Continuum, there is significant detailed work to be done at the state and local level—identifying each system's capacity, services and roles, including where integrated services are possible and where specialty service access is necessary. This detailed planning is necessary to create mechanisms for seamless services that offer real choice for consumers of healthcare. The work includes ensuring that:

1. A population-based systematic approach is created, through community planning and implementation, that identifies and serves those who will benefit from collaborative, integrated services, meets the needs and convenience of those seeking or in need of services and reduces redundant services.
2. Prevention and early intervention services are available across the entire IPI Continuum (for example, an individual receiving mental health services for a high level of MH/SU need would also receive primary prevention services for general health):

3. MH/SU services collaborate effectively to achieve true healthcare integration. Co-occurring Disorders competency is a core value in implementation of integration.[11]
4. A clear clinical process and set of collaborative workflows is established in each clinical site. Co-located care is necessary but not sufficient to achieve collaborative care.
5. Standardized screening and assessment/evaluation methods are used consistently across systems and settings and guide stepped care.
6. Bi-directional service capacity provides MH/SU services in primary care settings and primary care services in MH/SU settings. "No wrong door" is made operational, ensuring easy access to stepped care, including:
   - Capacity to respond wherever a person seeks services as well as connection to other points of origin (such as the criminal justice system).
   - Capacity to respond as a person's needs change over time, with mechanisms for individuals to step back and forth to the right level of Continuum services.
7. The resources of the community are organized to support individuals across the IPI Continuum. The person-centered healthcare home is located in a neighborhood/community and consumers/families/friends and a broad sector of the community is actively involved in developing the local IPI Continuum.
8. The IPI Continuum is adopted by physical, mental and substance use healthcare providers and the set of Continuum services is consistently available statewide**;** however, the organizational setting of services will vary depending on the local community's agreements regarding the use of resources and capacities to build the IPI Continuum.
9. The IPI Continuum is implemented so that lead roles at points on the Continuum are clear and agreed upon by all providers in the community, through protocols or other mechanisms.
10. Information technology is used to maximize service planning and bring together strands of services into a single plan for achieving an individual's health and wellness. Registries help the person-centered healthcare team track individual's self management goals and the impact of the care and supports provided.
11. There is systematic attention to workforce development (e.g., training for existing staff, peers and volunteers, as well as academic training of future staff) which is required to achieve improved system performance and must address the need for cultural and linguistic competence, stigma reduction and collaborative care skill development across all healthcare settings.
12. Finance, policy and regulation are aligned to support the IPI Continuum.

The IPI Continuum is intended to support further community-level and statewide discussions of integrated, collaborative healthcare. The Continuum is a learning tool and developing document as California providers work together to define and implement integrated healthcare. Volume II contains a worksheet to support these community-level discussions, in which it is anticipated that:

- It is important to decide how safety net organizations will work together for a seamless system 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.
- It is important to reach community agreement on which organizations will provide which levels of MH/SU services. 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).

- In addition to developing agreements on which organizations will provide which levels of MH/SU services, collaborative planning is required to determine where and how the healthcare needs of individuals with serious/severe mental and/or substance use disorders can be met, to assure access to healthcare homes that meet the needs and preferences of these consumers.

The following table was derived from Intermountain Healthcare materials, all rights in which are reserved. For more information please contact Brenda Reiss-Brennan at Intermountain Healthcare.

The IPI Continuum:
A Collaborative MH/SU/Primary Care Continuum for the Safety Net Population[1]

(This Continuum details the vertical MH/SU axis of the 4Q Model and does not attempt to span the horizontal axis, which considers the range of general healthcare services from prevention/health promotion to specialty medical/surgical and inpatient services. The supportive services and systems in the community are also not detailed here, however it is anticipated that development of a locally specific IPI Continuum would describe these as a part of defining seamless services.)

	Mild MH/SU Complexity	**Moderate MH/SU Complexity**	**Serious MH/SU Complexity**	**Severe MH/SU Complexity**
Characteristics of the population with MH/SU needs to be served in each level—for all ages (children, youth, adults, older adults)	• No comorbidities • Family/community supports OR • Need for health behavior change related to medical presentation (e.g., sleep disorder, pain), chronic medical conditions (e.g., cardiovascular, diabetes), developmental/parenting concern	• Medical comorbidity, including pain, or MH/SU comorbidity, and/or • Isolated or chaotic family/ community environment	• Multiple, complex medical, MH/SU comorbidities, and/or • Isolated or chaotic family/ community environment, and/or • Previous treatment ineffective	• Adults 18 years and over, with a severe and/or persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment, but for whom long-term 24-hour care in a hospital, nursing home, or protective facility is unnecessary or inappropriate (NIMH). *(In CA, referred to as Serious and Persistent)*
	• Standardized assessment tool[12] indicates mild to moderate symptoms or developmental concern	• Standardized assessment tool[12] indicates moderate to severe symptoms and their impact on functioning	• Standardized assessment tool[12] indicates severe symptoms and their impact on functioning	• Individuals with SU disorders that require ASAM Level III or IV services
	• Diagnostic examples include V-codes, mild depression, mild anxiety, sleep disorder, somatic disorder, SU disorder	• Diagnostic examples include moderate depression, moderate anxiety (including PTSD), sleep disorder, somatic disorder, SU disorder (abuse)	• Diagnostic examples include severe depression, severe anxiety (including PTSD), schizophrenia, bipolar disorder, schizoaffective disorder, personality disorders, SU disorder (abuse/dependence)	• Diagnostic examples include schizophrenia, schizoaffective disorder, bipolar disorder, SU disorder (abuse/dependence)

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	Mild MH/SU Complexity	**Moderate MH/SU Complexity**	**Serious MH/SU Complexity**	**Severe MH/SU Complexity**
Estimated population needing MH/SU services	26% of the U.S. population 18+ will need MH services during a given year.[13] ***In CA, this is 7,039,623 persons 18 and above***. Older persons (65 years and above) have the highest suicide rates of any age group. The suicide rate for individuals age 85 and older is the highest, at about 21 suicides per 100,000, a rate almost twice the overall national rate of 10.6 per 100,000. The high suicide rate among older people is largely accounted for by white men, whose suicide rate at age 85 and above is about 65 per 100,000.[15] Recent research makes it possible to stratify the levels of MH need in the 18 and older population as shown below. Note that in FY 05/06, DMH/CA[14] served approximately 437,000 individuals 18 and older or about 1 in 3 of the population with serious/severe need. 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.			
	10.5% of the U.S. population 18+ will fall into this level of MH need.[13] ***In CA, this is 2,851,699 persons 18+.***	9.7% of the U.S. population 18+ will fall into this level of MH need.[13] ***In CA, this is 2,634,427 persons 18+.***	3.12% of the U.S. population 18+ will fall into this level of MH need.[13] ***In CA, this is 847,362 persons 18+.***	2.6% of all adults are even more seriously affected by having "severe and persistent" mental illness.[15] ***In CA, this is 706,135 persons 18+.***
	20% of children will need MH services during a given year.[15] ***In CA, this is 1,878,835 children/youth under 18***. For children, it is possible to stratify levels of MH need into mild/moderate and serious/severe.			
	From 11 to 15% of children ages 9 through 17 have an emotional disturbance. The range varies depending on the level of poverty in the community.[15] ***In CA, 11% represents 1,033,359 children/youth under 18***		From 5 to 9% of children ages 9 through 17 have a serious emotional disturbance. The range varies depending on the level of poverty in the community.[15] ***In CA, 9% represents 845,476 children/youth under 18.***	
	12.7 % of persons aged 18+ have substance dependence or abuse.[16] ***In CA, this is 3,449,198 persons 18+.*** Research is needed to stratify the levels of SU need in the population. There is an overlap in the MH and SU populations. Nearly 60% of individuals with bipolar disorder and 52% of persons with schizophrenia have a co-occurring SU disorder. Approximately 41% of individuals with an alcohol use disorder and 60% of individuals with a drug use disorder have a co-occurring mood disorder.[17]			
Healthcare Home physical health services to be made available	• Preventive screening/ health services • Acute primary care	• Preventive screening/ health services • Acute primary care	• Preventive screening/ health services • Acute primary care	• Preventive screening/ health services • Acute primary care

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	Mild MH/SU Complexity	**Moderate MH/SU Complexity**	**Serious MH/SU Complexity**	**Severe MH/SU Complexity**
for all ages (children, youth, adults, older adults) at each MH/SU level. Individuals at each level of MH/SU complexity could be anywhere on the medical complexity continuum (4Q horizontal axis)	• Women and children's health • Management of chronic health conditions • Pharmacy • Access to dental, medical /surgical specialties and hospital care • End of life care Supported by enabling services, electronic health records, registries, and access to lab, x-ray.	• Women and children's health • Management of chronic health conditions • Pharmacy • Access to dental, medical /surgical specialties and hospital care • End of life care Supported by enabling services, electronic health records, registries, and access to lab, x-ray.	• Women and children's health • Management of chronic health conditions • Pharmacy • Access to dental, medical/ surgical specialties and hospital care • End of life care Supported by enabling services, electronic health records, registries, and access to lab, x-ray.	• Women and children's health • Management of chronic health conditions • Pharmacy • Access to dental, medical /surgical specialties and hospital care • End of life care Supported by enabling services, electronic health records, registries, and access to lab, x-ray.
Optimal MH/SU services for each MH/SU level, for all ages (children, youth, adults, older adults) [Note: varying resources may not permit availability of all services within each level in every community, but all four levels of care should be available]	• Screening and assessment of commonly presenting MH/SU conditions and developmental progress for children and youth	• Screening and assessment of commonly presenting MH/SU conditions	• Screening and assessment of commonly presenting MH/SU conditions	• Screening and assessment of commonly presenting MH/SU conditions
	• Care management as needed • Self management goal setting (for MH/SU **and** physical health conditions) education, activation	• Care management/registry tracking of those receiving services • Self management goal setting (for MH/SU **and** physical health conditions) education, activation and relapse planning	• Care management/registry tracking of those receiving services • Assessment and monitoring of key health indicators[18] • Self management goal setting (for MH/SU **and** physical health conditions) education, activation and relapse planning	• Care management/registry tracking of those receiving services • Assessment and monitoring of key health indicators[18] • Self management goal setting (for MH/SU **and** physical health conditions) education, activation and relapse planning/Wellness

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	Mild MH/SU Complexity	Moderate MH/SU Complexity	Serious MH/SU Complexity	Severe MH/SU Complexity
				Management and Recovery[19]
	• Brief problem-oriented counseling/therapy • Prescribing • "Watchful waiting" • Stepped care (changes in the types and intensity of services, medications) within this level or to another level Note: school health centers have been effective in providing this level of service and reaching children and youth who might not otherwise be identified.	• Brief treatment of MH conditions, crisis plan • Prescribing • Pain Clinic • Psychiatric consultation for care manager/PCP • Stepped care (changes in the types and intensity of services, medications) within this level or to another level	• Risk assessment and crisis plan • Person-centered treatment plan • Treatment of MH disorders using evidence-based practices • Prescribing • Psychiatric consultation for care manager/PCP • Stepped care (changes in the types and intensity of services, medications, crisis and inpatient services) within this level or to another level	• Risk assessment and crisis plan • Person-centered treatment plan • Full Service Partnership (MHSA CSS)/Intensive Case Management Team/Assertive Community Treatment[19] (these services provide "whatever it takes" to support consumer recovery goals) • Family Psychoeducation[19] • Medication Management[19] • Supported Education[19] • Supported Employment[19] • Supported Housing[19]/Housing First models • Consumer-Operated Service Programs[19] • Children's Services[19] • Stepped care (changes in the types and intensity of services, medications) within this level or to another level
	• For SU disorder, ASAM Level 0.5 early intervention[20]	• For SU disorder, ASAM Level I outpatient services (including ambulatory detoxification), medication assisted treatment, including Buprenorphine (by certified PCP) and	• Detoxification • For SU disorders, medication assisted treatment, ASAM Level II intensive outpatient and partial hospitalization[20] • Co-occurring treatment for	• Detoxification • For SU disorders, medication assisted treatment, ASAM Level III residential services and medically monitored intensive inpatient services or Level IV medically managed

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	Mild MH/SU Complexity	**Moderate MH/SU Complexity**	**Serious MH/SU Complexity**	**Severe MH/SU Complexity**
		Methadone (by specialty provider)[20]	MH/SU conditions/ Integrated Dual Diagnosis Treatment[19]	intensive inpatient services[20] • Co-occurring treatment for MH/SU conditions/ Integrated Dual Diagnosis Treatment[19]
	• Peer and family supports • Referral to community and educational resources	• Peer and family supports • Referral to community and educational resources	• Peer and family supports • Referral to community and educational resources, including housing and other community supports	• Peer Counselor/Family Partner supports • Clubhouse • Housing/residential settings • MH Residential Treatment • Referral to other community and educational resources
			• Mental health crisis outreach • Psychiatric emergency room/crisis triage center • Psychiatric inpatient • Criminal Justice (adults and youth) assessment and liaison	
Examples of evidence-based/ effective MH/SU interventions (See Volume II Delivery System Design for a discussion of models)	• IMPACT[21] • Cognitive Behavioral Therapy • Motivational Interviewing • Screening, Brief Intervention, Referral and Treatment (SBIRT)[22]	• IMPACT[21] • Cognitive Behavioral Therapy • Motivational Interviewing • Screening, Brief Intervention, Referral and Treatment (SBIRT)[22]	• IMPACT[21] • Cognitive Behavioral Therapy • Motivational Interviewing • Dialectical Behavioral Therapy • Functional Family Therapy	• See SAMHSA Evidence-Based Practices KITS available or in development[19] [listed above] • Cognitive Behavioral Therapy • Motivational Interviewing • Dialectical Behavioral Therapy
MH/SU measurement of process, capacity and/or outcome measures [23]	• Change in standardized assessment tool[12] • Achievement of goals defined by the person	• Change in standardized assessment tool[12] • Achievement of goals defined by the person	• Change in standardized assessment tool[12] • Achievement of goals defined by the person	• Change in standardized assessment tool[12] • Achievement of goals defined by the person

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	Mild MH/SU Complexity	**Moderate MH/SU Complexity**	**Serious MH/SU Complexity**	**Severe MH/SU Complexity**
Individual examples Population examples [See Volume II for an extended discussion of measurement]	receiving services • Aggregate change in standardized assessment tool • % of patients treated for depression or anxiety meeting remission criteria at 12 weeks, 6 months • SU reduction/abstinence	receiving services • Aggregate change in standardized assessment tool • % of patients treated for depression or anxiety meeting remission criteria at 12 weeks, 6 months • SU reduction/abstinence	receiving services • Aggregate change in standardized assessment tool • % of patients treated for depression or anxiety meeting remission criteria at 12 weeks, 6 months • SU reduction/abstinence • Increase in employment or educational participation	receiving services • Aggregate change in standardized assessment tool • Reduction in residential / hospital use • Reduction in justice system involvement • Reduction in homelessness • SU reduction/abstinence • Increase in employment or educational participation

Setting for Each Level—It is anticipated that:

- 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 *seamless system* 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

Primary Care	**Generally provided here**	**?**	**?**	
Specialty MH		**?**	**?**	**Generally provided here**
Specialty SU		**?**	**?**	**Generally provided here**

Appendix A: Brainstormed Barriers/Opportunities

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 brainstorming of barriers by the Advisory Group, work groups were convened to focus on barriers and recommendations.

- A Delivery System Design Work Group identified organizational barriers to implementation and initiated thinking about universal measurements for the system design including potential process, capacity and outcome measures; and
- A Finance Work Group identified and prioritized policy barriers related to regulatory requirements or financing of an integrated delivery system and developed recommendations for change.

The listings incorporate the issues identified by the individuals participating in the process, and represent a range of perspectives. The Work Groups went on to focus on the key issues to be addressed, as reflected in the Recommendations and the Volume II Working Papers.

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. MHSA has created tensions with CHCs and other systems in some communities

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

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)

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

Appendix B: IPI Process and Participants

Launched in 2008, the Integration Policy Initiative is a collaborative project, led by the California Institute for Mental Health (CiMH), the California Primary Care Association (CPCA) and the Integrated Behavioral Health Project (IBHP). The IPI is a project of CiMH and funded by The California Endowment with additional financial support provided by IBHP. As a time-limited project, developed to address the pressing need for improved linkages between the physical, mental and substance use healthcare systems serving California's Safety Net Population, its goals were to:

1. Develop a set of policy recommendations enhancing the interface between physical, mental and substance use healthcare.
2. Advance these recommendations through a report to local and state policy makers identifying changes in law, regulation and practice to support integration of mental health, primary care and substance use services.
3. Accelerate the systems integration needed to enhance the health outcomes of underserved populations and to promote efficiencies across the safety net systems.

Integration is as a promising vehicle for improving both accessibility and quality of services, and there is a growing body of research and experience about what should be done to achieve it. IPI's objective was to turn "what should be done" into action and to support the transition of these recommendations from paper to practice throughout California. To that end, IPI engaged in the following activities:

1. Convened a statewide Project Advisory Group of leaders with expertise from each of the systems, to participate in an extensive planning process. Led and facilitated by the national integration expert Barbara J. Mauer, the Project Advisory Group developed an initial *Vision Statement, Principles and Collaborative Care Continuum* that was vetted statewide among key stakeholder groups. The Project Advisory Group also launched two working groups:
   - A *Delivery System Design Work Group*: identified organizational barriers to implementation and initiated thinking about universal measurements for the system design including potential process, capacity and outcome measures; and
   - A *Finance Work Group:* identified and prioritized policy barriers that impact financing of an integrated delivery system and developed recommendations for change.
2. Provided IPI presentations and briefings to consumer and family organizations, mental health, primary care and substance use system stakeholders.
3. Met with other key constituents, community-based organizations, academia, and state and national leaders on the IPI and the opportunity for IPI recommendations/findings to be included in health reform discussion, including the renewal of California's Medicaid Waivers.
4. Partnered to plan for the *Collaborative Family Healthcare Association Policy Summit:* a national, annual conference to be preceded by a day of policy discussions on October 22, 2009 in San Diego.
5. Briefed key state legislators/policy makers in Sacramento.
6. Disseminated the IPI Report and process to leaders and organizations engaged in national and state health reform efforts underway that seek to advance systems integration.

Advisory Group Roster

Name	Organization
Sergio Aguilar-Gaxiola, MD, PhD Director	Center for Reducing Health Disparities U.C. Davis School of Medicine
Elaine Batchlor, MD Chief Medical Officer	LA Care
Delphine Brody Director, Mental Health Services Act	California Network of Mental Health Clients
Catherine Camp	At-Large Representative
Marjorie McKisson Assistant Deputy Director, Program Services Div.	Department of Alcohol and Drug Programs, Program Services Division - Treatment
Alan Edwards, MD Medical Director	Behavioral Health Services Orange County Health Care Agency
Susan Fleischman, MD VP Medicaid	Kaiser Foundation Health Plan, Inc.
Linford Gayle Director for Office of Consumer & Family Affairs	San Mateo County, Mental Health Administration
C. Dean Germano, M.H.S.C., F.A.C.H.E Chief Executive Officer	Shasta Community Health Center
Barry Handon, MD	Pharmacy Benefits Division California Department of Health Care Services
Don M. Hilty, MD Professor of Clinical Psychiatry	UC Davis, Department of Psychiatry and Behavioral Sciences
Nicole Howard, MPH Director of Programs	Council of Community Clinics, San Diego
Denise Hunt, MFT Behavioral Health Director	Stanislaus County Behavioral Health and Recovery Services
Gene (Rusty) Kallenberg, MD Professor and Chief	Division of Family Medicine University of California, San Diego
David Kears Agency Director (Retired)	Alameda County Healthcare Services Agency
Lee D. Kemper, MPA Administrative Officer	County Medical Services Program
Don Kingdon, Ph.D. Deputy Director/ Small Counties Liaison	California Mental Health Directors Association
Penny Knapp, MD Medical Director	California Department of Mental Health
Victor Kogler Executive Director	Alcohol and Drug Policy Institute
Flora Gil Krisiloff, FNP Westside Sr. Field Deputy	Deputy on Mental Health and Homelessness for LA County Supervisor Zev Yaroslavsky
Gwen Lewis-Reid Interim Executive Director	California Network of Mental Health Clients
Marty Lynch CEO	Life Long Medical Care
Harriet Markell Association Director	California Council of Community Mental Health Agencies (CCCMHA)
Robert McCarron, DO Training Director	Department of Psychiatry and Behavioral Sciences Sacramento County Mental Health Treatment Center
Elizabeth Morrison, LCSW, MAC Clinical Director of Behavioral Health Services	Golden Valley Health Centers

Name	Organization
Nancy Pena, PhD Mental Health Director	Mental Health Department Santa Clara Valley Health and Hospital System
Tom Renfree Executive Director	County Alcohol & Drug Program Administrators Association of California

Steering Committee Roster

Name	Organization
Neal Adams, M.D., MPH Director, Special Projects ***Note: Neal's participation ended April 2009***	California Institute for Mental Health
Gale Bataille, MSW Emeritus Mental Health Director, Interim Deputy Director CiMH	California Institute for Mental Health
Molly Brassil, MSW Associate Director of Policy	California Primary Care Association
Jennifer Brya, MA, MPP Research and Evaluation Consultant	Consultant
Allison Homewood Policy Analyst	California Primary Care Association
Mandy Johnson	Integrated Behavioral Health Project
Karin Kalk CalMEND Project Manager	California Institute for Mental Health
Karen Linkins, PhD	Consultant
Barbara J. Mauer, MSW, CMC Managing Consultant	MCPP Healthcare Consulting
Miles Murch Project Support	California Institute for Mental Health
Sandra Naylor Goodwin, PhD, MSW President & CEO	California Institute for Mental Health
Mary Rainwater, LCSW Project Director	Integrated Behavioral Health Project
Alice Washington Training, Policy, and Research Associate	California Institute for Mental Health

Workgroups Roster

Name	Affiliation
Bev Abbott, LCSW	Emeritus Mental Health Director, Consultant
William Arroyo, MD	Regional Medical Director for Child Services LA County Department of Mental Health
Sheila Baler, PhD, MPH	APS Healthcare
Lin Benjamin, MSW, MHA	Geriatric Mental Health Specialist

Name	Affiliation
	Long Term Care and Aging Services California Department of Aging
Susan Bower, MSW, MPH (CADPAAC)	Deputy Director Alcohol & Drug Services County of San Diego, Health and Human Services Agency
James Cunningham, PhD	Sr. Comm. Mental Health Psychologist, LA County Department of Mental Health, Older Adult Program Administration
Mark D. Edelstein, MD	Board Certified Child & Adolescent Psychiatrist
Ann Evans	Consultant
Brenda Goldstein	Psychosocial Services Director Lifelong Medical Care
Tiffany Ho, MD	Medical Director Santa Clara County Mental Health
Bruce Gurganus, MFT	Mental Health Director, Marin County Division of Community Mental Health Services
Don Kingdon, PhD	Deputy Director/Small County Liaison California Mental Health Directors' Association
Phil Lenowsky, MBA	CFO/CIO, North County Health Services
Esker D. Ligon, NP	Mental Health Services Manager Glide Health Services
Lester Love, M.D.	Life Long Medical Care
Michael Mabanglo, LCSW, PhD	Director of Behavioral Health Mendocino County Mental Health Clinics, Inc.
Kevin Mannel	Deputy County Administrative Officer Health & Social Services
Marta McKenzie, R.D., M.P.H.	Director, Shasta County Health & Human Services Agency
Lea Nagy	Liaison & NAMI, Family Member Humboldt County Mental Health
David Pating, MD	Chief, Addiction Medicine Kaiser San Francisco Medical Center, Chemical Dependency Recovery Program
Jonathan Porteus, PhD	Deputy Director of Clinical Services, *The Effort*
Leslie Preston, LCSW	Behavioral Health Director, La Clinica De La Raza
Mark Refowitz	Deputy Agency Director, Orange Co. Health Care Agency-Behavioral Health Services
Tom Renfree	Executive Director, County Alcohol & Drug Program Administrators Association of California
Dianne Sceranka, RN	Integrated Healthcare Clinic Manager County of San Bernardino Department of Behavioral Health
Albert Senella	Chief Operating Officer, Tarzana Treatment Centers, Inc.
Vicki Smith, MS, NP	Glide Health Services
Suzanne Tavano, BSN, PhD	Deputy Director of Mental Health, Contra Costa County

Name	Affiliation
Cheryl Trenwith, MA, MFT (CADPAAC)	Program Manager, Placer County Alcohol & Drug Program
Richard Van Horn	President Mental Health America of Los Angeles
Lucien Wulcin, Jr.	Health Law Attorney, *Insure the Uninsured* Project

Endnotes

[1] The Safety Net population includes those covered by SCHIP, Medi-Cal or Medi-Cal/Medicare, those uninsured under 200% poverty (including CMSP), those in rural settings

[2] 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

[3] *Improving the Quality of Health Care for Mental and Substance-Use Conditions*, Institute of Medicine, 2005

[4] Nutting, P. et al. *Initial Lessons From the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home.* Annals of Family Medicine. May/June 2009.

[5] Mauer, B. *Behavioral health/primary care integration and the healthcare home*. National Council for Community Behavioral Healthcare, 2009. http://www.thenationalcouncil.org/

[6] For a series of reports on safety net specialty referrals, along with a review of web based referral systems, see http://www.chcf.org/topics/view.cfm?itemID=133947

[7] http://intermountainhealthcare.org/Pages/home.aspx

[8] http://www.patientcenteredprimarycare.org

[9] http://www.improvingchroniccare.org

[10] The revised Care Model was developed as part of the California Mental Health Care Management Program, CalMEND. http://www.calmend.org/

[11] *Mental Health Services Oversight and Accountability Commission Report on Co-Occurring Disorders: Transforming the Mental Health System Through integration*. MHSOAC, 11/10/08.

[12] Tools include: PHQ-9 or QIDS for depression; MDQ or CIDI for bipolar disorder; GAD-7 for anxiety including PTSD; CAGE or AUDIT-C for substance use; and ASAM for determination of level of service needed for substance use disorder. For children, tools include: ASQ-SE for early childhood and Pediatric Symptom Checklist (PSC) for children and youth. Note that USPSTF has recently recommended universal depression screening for youth 12-18. For more information on many of these tools, see http://www.cqaimh.org/stable_toolkit.html

[13] http://www.hcp.med.harvard.edu/ncs/index.php Some studies report MH/SU need in the Medicaid population at 40%-47% (CO, WA) and the uninsured population at 51% (Mauksch). Mauksch also reports alcohol abuse in the low income population at 17%.

[14] *A Report on California's Community Mental Health Performance Outcomes*, California Department of Mental Health, March 2008.

[15] *Mental Health: A Report of the Surgeon General, 2000*. http://www.surgeongeneral.gov/library/mentalhealth/home.html. Serious mental illness is a term defined by Federal regulations that generally applies to mental disorders that interfere with some area of social functioning. Tillman Farley of Salud (CO) estimates about 10-15% of a safety net primary care practice falls across the serious and severe and persistent levels. Federal regulations also define a sub-population of children and adolescents with more severe functional limitations, known as serious emotional disturbance (SED).

[16] National Survey on Drug Use and Health, 2007. CDC reports 10.7%, NIH reports 13.4%.

[17] Verduin, M. et al Substance Abuse and Bipolar Disorder. Medscape Psychiatry and Mental Health. 2005.

[18] *Measurement of Health Status for People with Serious Mental Illnesses*, NASMHPD, 2008. http://www.nasmhpd.org

[19] http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/evidence_based/kits.asp

[20] American Society of Addiction Medicine Patient Placement Criteria. http://www.asam.org/PatientPlacementCriteria.html

[21] http://impact-uw.org/about/research.html

[22] http://sbirt.samhsa.gov/about.htm

[23] http://www.cqaimh.org/index.html