



State of California—Health and Human Services Agency
Department of Health Care Services



**California Department of Health Care Services
Mental Health and Substance Use Disorder Services**

MHSUDS Integration Task Force Meeting

November 10, 2014

Meeting Summary

Introduction

The California Department of Health Care Services (DHCS) convened a meeting on November 10, 2014, to identify short-term and long-term strategies for transforming California's behavioral health system into a high-performing, fully integrated system. The meeting brought together leaders from California's mental health (MH) and substance use disorder (SUD) treatment systems, counties, Medi-Cal managed care and mental health plans, clinicians and Medi-Cal program experts. Members of DHCS' leadership team and numerous advisory and program staff were present in-person and via telephone. About thirty members of the public were in attendance. One hundred and twenty individuals were on listen-only mode on the telephone. Jennifer Clancy, Karen Linkins, Darren Urada, and Julie Stone facilitated the discussions.

Facilitators encouraged the meeting participants to share their unique perspectives through a structured and facilitated dialogue. The intent was to encourage the maximum participation of the invited experts while also providing an opportunity for the public to offer comments and recommendations.

Participants were asked to think broadly and strategically about practical solutions that would advance California's behavioral health system incrementally along a continuum toward a fully integrated, high-performing health system. DHCS hoped that this open and frank discussion could be the first of many over the next several years that can help to shape and implement a shared vision for transformation.

The facilitators acknowledged that the concepts and ideas put forward in this meeting could inform the development of strategies in the near and long-term. Such strategies might include the use of Medicaid state plan amendments (e.g., §1905(a), §1915(i) of the Social Security Act (SSA)); Medicaid waivers (e.g., §1115, §1915(b) of SSA); the Medicaid Health Home Benefit (§2703 of ACA, §1945 of SSA); or other regulatory or programmatic changes.

This report is not meant to document all comments and recommendations made, nor to capture all of the nuances of the discussion. Rather, it is intended to summarize the key themes and topics discussed throughout the day. The meeting agenda and list of task force members can be found at the end of this report.

Purpose

The purpose of the Mental Health and Substance Use Disorder Integration Task Force meeting was to inform DHCS on strategies to develop and advance the behavioral health system in California. The implementation of the federal Affordable Care Act (ACA) and the merging of the two former departments of Mental Health and Alcohol and Drug Programs into DHCS create an optimal opportunity to increase the quality and effectiveness of the service delivery system by enhancing integration across systems. Information and strategies gathered from the experts will be developed and shared with DHCS leaders, the 1115 Waiver work group participants, stakeholders, and the general public.

Many of the strategies contained in this document intersect with the focus of the 1115 Waiver work groups. The intersections range from workforce expansion and development issues, housing and shelter, plan/provider incentives; DSRIP; and outcome measures. In addition, several programmatic concepts for better integration in primary care settings, hospitals and behavioral health settings that support whole person care are discussed; including health homes for persons with behavioral health conditions.

History

DHCS and its county and community partners are committed to furthering behavioral health integration across the state to better serve low-income patients with severe and persistent mental health conditions and substance use disorder treatment needs. Yet behavioral health integration cannot be accomplished in California's safety net without real practice transformation designed to enable county and providers to, among other things, share electronic health information, perform advanced care coordination, quickly and efficiently implement evidence-based clinical practices, share lessons learned, and facilitate easy and fast communication among providers.

Practice transformation in California is not an easy lift. California's county and behavioral health systems currently experience access and flow challenges, geographic disparities in provider supply; and fragmented communication among the mental health and substance use disorder service providers. In addition, providers continue to be paid largely under a fee-for-service system that incentivizes volume over efficiency and discourages integration. In some cases services provided through California's behavioral health systems are not coordinated well enough with those provided by physical health providers when treating a patient.

System-wide reforms are particularly challenging given the patient population are among the state's hardest to serve. Many experience co-occurring mental health, substance use, and physical health morbidities, are homeless or reside in transitional housing, and experience other socio-economic determinants of poor health.

DHCS is currently in the process of developing proposals to the Centers for Medicare and Medicaid Services (CMS). These proposals, if approved by federal regulators, would provide strategic opportunities for California to invest in transformation of California's BH system. Proposals would implement reforms to California's substance use disorder treatment system and a successor to "Bridge to Reform," under section 1115 waivers, and establish a new Medi-Cal state plan benefit for health homes under a state plan amendment.

Medicaid Health Home State Plan Option

The Medicaid Health Home State Plan Option, authorized under Section 2703 of the Patient Protection and Affordable Care Act (ACA), allows states to create Medicaid health homes to coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by beneficiaries with chronic conditions. If implemented in California, the federal government will pay an enhanced federal matching percentage (FMAP) of 90% for the first 8 quarters. The California Endowment (TCE) has volunteered to pay the remaining 10% of funds (up to \$25 million per year) required for these additional services during the same two year period.

Assembly Bill 361 (AB361), enacted in 2013, authorized California to submit a Section 2703 application, subject to several conditions, including cost neutrality and an evaluation after the first two years.

Through a complementary planning process, the California State Innovation Model (CaSIM) initiative, developed a recommendation to create “Health Homes for Patients with Complex Needs” (HHPCN). This HHPCN is one of four initiatives in the CaSIM Testing application that California made to the Center for Medicare and Medicaid Innovation (CMMI). These initiatives are multi-payer. Approval of the testing grant application is expected to be announced in the fall of 2014.

In collaboration with the CaSIM initiative and with respect to the requirements of Section 2703 and California’s AB 361, the state is in the process of obtaining feedback from stakeholders to inform the specifications of this new benefit in terms of eligibility, services, eligible providers, etc. DHCS intends to submit a Section 2703 state plan amendment (SPA) application in summer/fall of 2015 in an effort to obtain federal regulatory authority for implementing the HHPCN model for Medicaid beneficiaries.

Section 1115 Waiver Renewal Proposal

California’s existing Section 1115 “Bridge to Reform” Waiver (2010-2015) gave California the legal flexibilities and federal financial support to pursue coverage expansion, quality improvement, and delivery system reform in an effort to prepare for the state’s implementation of the Patient Protection and Affordable Care Act (ACA). Under “Bridge to Reform,” the state extended Medi-Cal managed care to seniors and persons with disabilities, enrolled over 600,000 low-income adults in an early Medi-Cal expansion for low-income adults, allowed public hospitals to draw down safety net pool funds to cover services for the uninsured, and provided a mechanism for public hospital systems to invest in service delivery transformation through the nation’s first-ever Delivery System Reform Improvement Program (DSRIP).

With this waiver scheduled to expire in October 2015, the DHCS will propose that CMS grant approval for the state to use the renewal process to further the delivery of high quality and cost efficient care, ensure long term viability of the delivery system, and expand the innovations begun under the “Bridge to Reform” waiver.¹ Several waiver workgroups are currently meeting to discuss mechanisms to achieve these goals. DHCS hopes to use this opportunity as a vehicle to advance practice transformation of California’s behavioral health system and achieve better integration with physical health services.²

¹ From the September 11, 2014 Section 1115 Waiver Renewal Concept Development presentation by Mari Cantwell, Chief Deputy Director, Health Care Programs, DHCS.

² The following is a link to a concept paper released by DHCS in July 2014 that describes these draft waiver concepts in greater detail, see http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/Initial_Concepts_for_2015_Waiver-July_2014.pdf.

Practice Transformation

The following describes the key topics discussed by the MHSUDS Integration Task Force and facilitators during this all day meeting.

Health Home for People with Complex Needs

DHCS has submitted a CA State Innovations Model Grant Application to CMMI. The CAL SIM Model includes a multi-payer Health Home proposal which includes ACA Section 2703 Health Homes for patients with complex needs. Brian Hansen, Health Program Specialist, Managed Care Quality and Monitoring Division at DHCS, discussed aspects of the program that are still in development. This included discussion of the target population, geographic areas in the state to consider phasing in Health Homes and leverage previous successful care coordination efforts, potential financing models, and provider capacity considerations.

DHCS requested feedback from the Experts on the panel to further advance their model. DHCS was particularly interested in key questions related to:

1. The role of Medi-Cal Health Plans, County Mental Health Plans, Behavioral Health (Mental Health, Substance Use Disorder, and Integrated MH/SUD) Providers and Federally Qualified Health Centers (FQHCs) /Primary Care Clinics in Health Homes for individuals with co-occurring behavioral health and physical health conditions
 2. Eligibility criteria for Health Home providers for this vulnerable population
 3. Eligibility criteria for individuals who would be served in Health Homes
- **Potential Roles of the MCOs in Supporting Community Based Care Management Entities with the Provision of Health Home Services**

While at the service delivery level care coordination can occur via partnerships, a critical component of Behavioral Health Homes is the identification of a single entity accountable for quality, health, and cost outcomes. In order to create health homes that effectively integrate behavioral health and lead to reduced hospitalizations / emergency department (ED) visits, improved patient engagement and health outcomes, it is important to consider the creation of a health home network structure that includes not only a lead agency but a single accountable entity.

This perspective was raised by a number of experts from the MHSUDS Integration Task Force Meeting. Some noted that behavioral health providers have taken a leadership role in shaping delivery systems that could serve as platform for behavioral health homes and they have been working very hard to build a delivery system with the Medi-Cal Managed Care Plans. An important role for Medi-Cal Managed Care Plans is identifying vulnerable populations and helping to build the integrated systems around them. Many experts noted the importance of Medi-Cal Managed Care Plans, CA County Mental Health Plans, and Behavioral Health Providers

collaborating and building on their strengths to create health homes for this population that meet their behavioral and physical health needs.

- **Strengths of Behavioral Health Providers in Serving as the Whole Person Care Coordination Entity**

It was noted by a number of MHSUDS Integration Task Force Members that there are behavioral health providers that can provide the care coordination required of a behavioral health home. However, panelists noted that California can learn from Washington State by considering the complex interplay between purchasers and providers. While behavioral health providers have the potential to serve as the Community-Based Care Management Entity, in order to be contracted to fulfill this function they need to meet criteria and demonstrate a care coordination model that can achieve “high-value measures” for the target population.

- **Geographic Areas in CA Ready for Health Home Implementation**

Because care coordination has not been developed panelists acknowledged that no geographic area will be completely prepared for health home implementation. However, the State can begin with the counties engaged in the Coordinated Care Initiative that have demonstrated the development of infrastructure and capacity to offer care coordination to the Medicare-Medical population. The state can also consider a regional approach between Partnership Health Plan and the rural counties they serve since Partnership has already been involved in pilots to build capacity and provider networks capable of offering care coordination to frequent and high utilizers of emergency rooms and in patient hospitalizations.

- **Which Individuals Should Be Eligible to Access Health Homes Where Behavioral Health Providers Serve as the Community Based Care-Management Entity?**

Panelists noted that the state and providers should not determine where it is appropriate for individuals to receive care. Ultimately individuals must identify what their primary health concern is (behavioral or physical) and allow that to guide where their appropriate health home is housed. It was noted that self-directed care has better outcomes and better recovery options; therefore the system should allow) individuals to self-direct where they believe their health home should be. It was also acknowledged that this could change over time as persons progress in their recovery. As a result, individuals must maintain final authority over where their health home resides.

Panelists agreed that eligibility for whole person care coordination under a behavioral health provider should account for a combination of consumer choice and eligible conditions/acuity. Panelists expressed this preference after noting that not every individual who is eligible to be in a Health Home offered by a behavioral health provider based on their co-occurring and chronic behavioral health and physical health conditions will want to have the BH provider serve as their Health Home provider.

Accountability – Behavioral Health Integration Measures

Transforming the current physical and behavioral health systems in California into a high performing, well coordinated system requires a shift in the focus of data collection for the purpose of reporting for compliance to the purpose of using data for quality improvement and program evaluation. Current measurement practices do not produce sufficient data to assess and track overall population health, and physical and behavioral health care system performance, which is essential for achieving the Triple Aim. Data also are not adequate to support decision-making by policy makers, public and private purchasers, providers, and other stakeholders.

Task Force members discussed the need to develop a set of core measures for integrated behavioral health that will enable a common way of tracking physical and behavioral health performance in California. The performance measures would be used to assess access, timeliness, quality, and coordination of care and compare performance across payors and providers working with the target population.

To ensure that the set of core measures is feasible, relevant, and effective for measuring integrated care, facilitators identified the following selection criteria for consideration by the expert panel:

- The set of core measures is of manageable size;
- Is based on *readily available* encounter data, surveys, and clinical data to enable timely implementation;
- Gives preference to nationally vetted measures, particularly measures endorsed by bodies such as the Centers for Medicare and Medicaid Services (CMS), the National Quality Forum (NQF), and the National Committee on Quality Assurance (NCQA);
- Infrastructure and capacity to collect data within systems and settings;
- Infrastructure and capacity to link and share data across systems;
- Expertise and capacity to analyze and use data in a meaningful way – for payers, administrators, providers, and clients;
- Reflects areas of physical and behavioral health services thought to have a significant impact on the Triple Aim (i.e., improving health, improving health care quality, and reducing per capita health care costs) and recovery for individuals with complex, chronic health and behavioral health conditions; and
- Is aligned to the extent possible with performance management system measures and common measure requirements specific to the Medi-Cal program.

Facilitators also proposed that performance measures be organized according to conditions. The following set of performance measures was presented to the expert panel with the hope triggering a thoughtful and informative discussion.

Condition or Area	Performance Measure (* denotes proposed CMS measures)
Asthma	<ul style="list-style-type: none"> • Use of appropriate medications for people with asthma
Cardiovascular Care	<ul style="list-style-type: none"> • Cholesterol management for patients with cardiovascular condition (LDL-C <100 mg/dL) • Controlling high blood pressure (<140/90)*
Diabetes Care	<ul style="list-style-type: none"> • Comprehensive Diabetes Care (HbA1c level below 7) • Comprehensive Diabetes Care: Cholesterol management (LDL-C <100 mg/dL)
Management of Behavioral Health Conditions	<ul style="list-style-type: none"> • Client perception of care – National Outcome Measure • Proportion of Days Covered of Medication
Schizophrenia	<ul style="list-style-type: none"> • Annual assessment of weight/BMI • Glycemic Control • Lipids
Bipolar Disorder	<ul style="list-style-type: none"> • Annual assessment of weight/BMI • Glycemic Control • Lipids
Clinical Depression	<ul style="list-style-type: none"> • Screening • Follow-up plan*
Substance Use	<ul style="list-style-type: none"> • Screening • SBIRT • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* • Smoking and Tobacco Use Cessation
Obesity	<ul style="list-style-type: none"> • BMI Assessment*
Utilization and Access	<ul style="list-style-type: none"> • Ambulatory Care – Sensitive Condition Admission (1. Grand Mal and other Epileptic Convulsions, 2. COPD, 3. Asthma, 4. Diabetes, 5. Heart failure and Pulmonary Edema, 6. Hypertension, 7. Angina)* • ED Utilization rates • ED Utilization rates – mental health and SUD • Inpatient Utilization rates • Inpatient Utilization rates – mental health and SUD • Follow-up after MH hospitalization* • Successful Linkages to Integrated Care
Access to Preventive/Ambulatory Health Visits	<ul style="list-style-type: none"> • All-Cause Readmission (number of acute 30-day readmissions for any diagnosis)

Condition or Area	Performance Measure (* denotes proposed CMS measures)
Care Coordination	<ul style="list-style-type: none"> • Timely Transmission of Transition Record (transition record sent to health home within 24 hours of discharge)* • Medication Reconciliation Post-Discharge • Release of Information for sharing PHI across providers • Care Coordinator Assignment: Percentage of clients in the target population with an assigned care coordinator • Common Care Plan: Percentage of clients in the target population with a physical and behavioral health care plan accessible by all providers and payers
Patient Experience	<ul style="list-style-type: none"> • Client Experience with Care • Client Confidence • Satisfaction with Coordination of Care
Recovery	<ul style="list-style-type: none"> • Milestones of Recovery Scale (Improved mental health outcomes) • Level of Involvement in Care • Housing Stability • Employment • Food Access

* CMS Health Home Core Quality Measure. Methodology still under development and review at CMS.

Overall, the panel experts agreed that a standard set of measures is important for ensuring the effectiveness of health and behavioral health systems, but also raised several issues and considerations for DHCS, including:

1. The measurement framework for complex conditions should include patient-centered measures.

For patients with complex conditions, consider measuring the condition that is most life threatening rather than targeting specific conditions. To adequately address patient experience in integrated care, it is important to include measures of transitions through levels of care.

2. Measures need to be relevant and meaningful for multiple stakeholders, including policy makers and health plans.

Providing legislators evidence of quality improvement and outcomes related to physical and behavioral health care system performance is an important way to inform government officials. In developing the set of measures, it is essential to include measures that are understandable and relevant to policy decision-making.

To understand the return on investment for investing in non-reimbursable services (e.g., care coordination, supportive housing, etc.) associated with improving outcomes for the complex, chronic population, it is essential to link medical data from the Medical Managed Care plans and Mental Health plans with data on these non-medical services, particularly as they relate to reduced emergency department visits and inpatient days.

3. Ensure that data collected can be used for a variety of programs and purposes.

To the extent possible, it is important for the measurement framework to be relevant and consistent across the range of behavioral health programs and funding streams, including MHPA full service partnership programs, Medicare, Medi-Cal, EPSDT, AB 109, Prop 47, block grant funding, as well as purposes, including quality improvement, evaluation, and identifying best practices. The Performance and Outcomes Systems (POS) workgroup is doing work on updating and refining measures, which should be better coordinated with this effort.

While it may be easier to capture data measures related to improvement of health outcomes (e.g., glucose), there need to be organizational and system level measures related to care coordination and integration that are captured systematically to allow for comparison across plans, counties, and regions.

4. Ensure that measures include those related to behavioral health and recovery outcomes for adults and children, and leverage existing data collected in related systems, such as welfare, education, and criminal justice.

To track recovery and improvements in behavioral health conditions it is important to measure non-health outcomes such as harm reduction, homelessness, employment, educational attainment, criminal justice involvement, and other indicators of stability, wellness, recovery, and the social determinants of health. The measurement framework needs to be tailored to address outcomes across the life course – children, adolescents, transition age youth (TAY), adults, and older adults. Pharmacy data related to medication compliance should also be included as part of the measurement framework for integration.

5. Data infrastructure to support collection, analysis, reporting and sharing needs to be established to support accountability and quality improvement.

Current data systems already capture a lot of data that would be helpful in supporting quality improvement and outcome tracking. However, there are barriers using the information due to confidentiality rules, lack of interconnectivity between data systems (e.g., primary care clinic Electronic Health Records (EHR) and behavioral health EHRs, or between hospital data systems and primary care). There is an opportunity for sharing data between health plans and providers, but providers need to take responsibility to seek the data. There is also a need for plans to share data on hospital and health care utilization through an exchange with mental health providers who do not otherwise have access to this information, except through self-reports from individuals in treatment.

6. The design of data collection requirements must align with federal initiatives.

One of the biggest barriers to advancing quality improvement through standardized data is that we are designing our data collection systems in silos. DHCS is taking on a federal Medicaid Information Technology Architecture (MITA) initiative. A common coding set is being tackled by [Health Insurance Portability and Accountability Act](#) (HIPAA). Panel experts suggest that Medi-Cal managed Care plans, Specialty Mental Health Plans and other providers coordinate activities under the DHCS MITA initiative.

Expanding Infrastructure and Work Force Capacity Building for Population Health and Improving Patient Experience

The following seven strategies were presented to the panel for discussion. Facilitators identified them as a short list of recommended programmatic changes that might contribute significantly to practice transformation.

- 1) Data System Infrastructure and Enhancement
- 2) Care Coordinators who Offer Comprehensive Care Coordination Services
- 3) Multidisciplinary Teaming
- 4) Peer Providers who Offer Comprehensive Services
- 5) Psychiatry and Primary Care Consultation
- 6) Cross System Training
- 7) SBIRT Expansion and Sustaining Training

Facilitators asked that the panelists comment on these proposed concepts as well as recommend additional strategies for achieving practice transformation. Below is a description of each of these seven strategies and a summary of the panels' commentary. Additional strategies recommended by the panel follow.

1. Data System Infrastructure and Enhancement

Behavioral Health Integration requires providers serving patients in common to share cost, quality, and clinical data via technology. Practice transformation must provide for enhanced data systems by expanding the functionality and content of electronic health records so that all health providers can use them to support their services and coordinate care. Providers need clinical information systems to support clinical integration and population health management across a broad array of providers. All data systems within a network must be able to access shared clinical information and communicate across providers and payers. Recommended functionality includes:

- Shared Care Planning;
- Clinical Prompts and Flags;
- Treatment Reconciliation;
- Treatment Progress and Measurement;
- Broad Range of Information Related to Claims and Costs;
- Patient Engagement;
- Ease of Adaptability, Access, and Use;
- Communication and Information Exchange;
- Proactive Care and Prevention; and
- Protected Health Information (PHI) Security.

The experts were largely supportive of this idea, with some identifying this as the first priority. Concerns were raised about county budget constraints and the high cost of data infrastructure. One expert suggested that in order to change people’s minds about how they work, it is necessary to help decision-makers “fall in love with information and data.” One way to accomplish this, experts stressed, is to let them harvest data locally, as opposed to the more usual practice of “dropping it in a black hole” and receiving no feedback. Similarly, another panelist commented that for data to be useful, it must feed into an EHR so primary care providers can access it easily. Another expert suggested that information be put into the hands of consumers, not just providers. The need for any strategy to account for HIPAA and federal policies, which can sometimes be barriers to efforts to enhance data systems for behavioral health, was also acknowledged.

2. Care Coordinators who Offer Comprehensive Care Coordination Services

An effective health care delivery system for this population must systematically coordinate care across payer and provider organizations to assure good health outcomes. Care coordinators³ can serve as the single point of contact for complex clients and for their providers. Some of these services are performed by the individual Care Coordinator while others are monitored by the Care Coordinator, but it is the responsibility of the Care Coordinator to ensure the care coordination is occurring and to routinely reconcile data associated with those processes in an electronic clinical information system. . Below is a list of services that comprise care coordination for complex clients with chronic physical and behavioral health conditions.

- Outreaching, engaging, and facilitating clients’ access to appropriate services
- Defining the Care Team (including natural supports) for each client/patient
- Ensuring and monitoring consent to share clinical information
- Ensuring and monitoring appropriate screening for medical, mental health, and substance use conditions
- Facilitating referrals
- Entering clinical information into caseload registry tool
- Conducting multidisciplinary clinical care conferences
- Ensuring and monitoring routine medication reconciliation
- Supporting client self-management
- Ensuring and communicating shared care plan goals among client/patient and providers (primary care, mental health, and substance use providers)
- Ensuring availability of ad hoc clinical case consultation
- Ensuring priority (streamlined) access to specialty mental health, substance use, or primary care

³ The Care Coordinator “systematically integrates behavioral health to intentionally ensure the necessary degree of screening, referrals, tracking, outcome measurement, and care coordination needed to assure good health outcomes.” Avery, M. (2014, Unpublished) The Role of the Care Coordinator in Providing Integrated Care for Safety-Net Populations.

- Monitoring transitions in care

Some panelists identified the need for greater reimbursement for high quality care coordination. Some of the issues raised were as follows:

1. care coordinators are paid by a health plan in several pilot projects
2. the need to classify care coordination as a medical treatment to avoid the combining of these costs with medical loss ratios
3. the need to tier the level of care coordination and payments by level of patient need
4. a need to tier payment rates for case coordination by acuity
5. delivering of care coordination with cultural competence

Care Coordinators are critical to assure good health outcomes for persons with complex needs who may have limited abilities to navigate the health and social service systems and receive effective services.

3. Multidisciplinary Teaming

More than seventy randomized control trials have shown that collaborative care for persons with comorbidities is more effective and cost effective than usual care. Behavioral Health Integration requires collaboration between providers, which can include care coordinators, clinical social workers, community health workers, psychiatrists, pharmacists, counselors, and other providers. Facilitators suggested enabling providers to finance and implement a collaboration model that fits their circumstances while encouraging use of core evidence based practices such as multidisciplinary teams conducting systematic caseload reviews.

Comments on multidisciplinary teaming mirrored those for care coordinators. Experts expressed a need to financing multidisciplinary teams.

4. Psychiatry and Primary Care Consultation

Although many individuals with mental health and substance use disorders are managed in primary care settings, services for these disorders are often minimally coordinated with primary care. An important feature of coordinated care is systematic caseload reviews⁴ that include psychiatric consultation. These consultations and reviews, however, are not generally reimbursable by Medi-Cal in primary care. Increasing flexibility for providers to implement and finance the consultation model that works best for their circumstances was suggested, to encourage the use of evidence-based practices such as systematic psychiatric caseload reviews and tele-mentoring.⁵

⁴ Huffman, J.C., Niazi, S.K., Rundell, J.R., Sharpe, M., & Katon, W.J. (2014). Essential articles from collaborative care models for the treatment of psychiatric disorders in medical settings: A publication by the Academy of Psychosomatic Medicine Research and Evidence-Based Practice Committee.

⁵ Robert Wood Johnson Foundation (2014). Project ECHO: Bridging the Gap in Health Care for Rural and Underserved Communities. Progress Report Grant ID: 63945, 69313, 69723, 70487, 70562. Retrieved from http://www.rwjf.org/content/dam/farm/reports/program_results_reports/2014/rwjf412743

Panelists agreed on the importance of consultation. Much of the discussion turned to the potential of tele-consultation. One panelist said that consultation is essential, including for substance use disorders related issues (e.g. pain management, buprenorphine). Panelists noted that the shortage of psychiatrists could be addressed by heavier reliance on telemedicine and tele-mentoring.

5. Peer Providers who Offer Comprehensive Services

One definition of peer support is the sharing of common concerns or problems and the provision of emotional support and coping strategies to manage problems and promote personal growth.⁶ The State of Tennessee defines peer providers as a “Certified Peer Specialist” who “has self-identified as a person with a mental illness or co-occurring disorder and has successfully navigated the service system to access treatment and resources necessary to build personal recovery and success with his or her life goals. This individual undergoes training recognized by the department on how to assist other persons with mental illness in fostering their own wellness, based on the principles of self-directed recovery.”⁷ Practice transformation could include the expanded use of peer providers. In particular, providers could hire Peer Provider Specialists and certify them to provide the following services as defined by OptumHealth and used nationally:

- **Peer coaching:** (for those with serious and persistent mental illness) Delivered by a trained peer who is in recovery and completed an approved training program and is credentialed through a state process. Coach provides face to face support with strength-based activation and self-care tools.
- **Peer Bridging:** (as handled in New York State) Connects a trained mental health peer with a peer in the hospital and helps them make a “soft landing” back into the community.
- **Recovery Coach:** (for those with substance use disorders) Support of a person in long term recovery.
- **Whole health coach:** (for those with mental health and chronic health conditions) Coach has additional training that allows them to serve a person with a mental health issue AND a physical health issue, like diabetes, COPD and more.
- **Parent Partner Coach:** (for Children) Trained parent whose child has successfully moved into resiliency and who is trained to offer support, engagement, activation, and self-care tools and services as well as navigation support to the parents of a child who is frequently hospitalized.

⁶ California Institute for Mental Health, NAMI California, United Advocates for Children and Families, and California Network of Mental Health Clients. (June, 2012). Certification of Consumer, Youth, Family and Parent Providers: A Review of the Research. 7. Retrieved from http://www.cibhs.org/sites/main/files/file-attachments/certification_of_cyfp_providers_wwt_0.pdf

⁷ Ibid.

6. Cross Training for all System Providers

Specific training in interventions with clients at risk for or with substance use disorders is often lacking among professionals in the medical and mental health fields. Therefore, providers often feel ill-equipped to deal with the complex problems of patients with these issues and they therefore often do not ask about substance use and/or do not know what to do about substance use issues if they are identified.^{8,9}

In order to ensure that providers are competent and confident in providing service inclusive of physical, mental health, and substance use disorders, cross training of providers in issues pertinent to the treatment of substance using patients is critical.

Interventions such as motivational interviewing (MI) and cognitive behavioral therapy (CBT) are well documented for their success in helping clients with substance use disorders to achieve treatment goals. They have also been shown to have beneficial effects for a variety of physical and mental health conditions.

12-step and other self-help programs are an important source of support for people as they work to achieve their substance use disorder treatment goals and in supporting the maintenance of these goals after treatment. However, many professionals do not know what these meetings consist of and are therefore reticent to advise patients regarding how to use self-help in their overall care plan.

Providing cross training on medication assisted treatment for substance use disorders would ensure that medical providers have the information that they need to provide these medications, if appropriate. Medical providers who subscribe these medications should ensure that the rest of the treatment team will understand the ways in which the medications work so that they can support adherence to medication protocols and help to identify side effects and/or symptoms that may indicate that adjustments may be needed in dosing (e.g., sedation and/or withdrawal symptoms).

Learning collaboratives, coaching, and technical assistance will be important tools. Learning to apply knowledge in complex patient care settings requires ongoing consultation and the ability to try new behaviors (e.g., integrated case conferencing) and then get feedback and support.

Although support was expressed for trainings, one panelist also pointed out that this would not be a cheap investment. Another advocated cross training with the goal of eventually having one provider with full competency.

7. SBIRT Expansion and Sustaining Training

In order to actualize the concept of “no wrong door for service,” it is important for patients to be screened for specific disorders regardless of whether they access services through physical

⁸ Danielsson, P.E., Rivara, F.P., Gentilello, L.M., & Maier, R.V. (1999). Reasons why trauma surgeons fail to screen for alcohol problems. *Archives of Surgery*, 134(5), 564-568

⁹ Friedmann, P.D., McCullough, D., & Saitz, R. (2001). Screening and intervention for illicit drug abuse; A national survey of primary care physicians and psychiatrists. *Archives of Internal Medicine*, 161(2), 248-251.

health, mental health, or substance use disorders systems. Training providers in appropriate screenings would ensure appropriate prevention and/or intervention services are delivered to the client. It was therefore suggested that SBIRT services be expanded in a few ways, detailed below.

- **Expand SBIRT locations:** Currently, SBIRT services are required for adult Medi-Cal patients in primary care settings. By expanding SBIRT services to other care settings, including, but not limited to trauma and emergency departments, inpatient hospitals, specialty care (e.g., cardiology, endocrinology, etc.), mental health settings, and even substance use settings, we would ensure that clients are screened regardless of where/how they access care.
- **Expand screening services to include other populations:** Research has clearly demonstrated the utility of brief intervention services for alcohol in adult populations. However, it is less clear how effective brief intervention services are for other substances or populations. Expanding screening and referral services to include substances other than alcohol, would ensure that needs are identified, a conversation opened and appropriate referrals are provided. Additionally, expanding reimbursable screening and referral to include adolescent and older adult populations, would ensure that the conversation is addressed with these populations.
- **Expand professionals who can supervise SBIRT services to Licensed Clinical Social Workers (LCSWs) and Licensed Marriage and Family Therapists (LMFTs):** Finding appropriately trained professionals who can bill Medi-Cal for SBIRT services is a challenge for many agencies. This challenge would be greatly reduced by including LCSWs and LMFTs as billable providers. There is no evidence that medical practitioners and psychologists are more effective at supervising SBIRT than LCSWs or LMFTs. Restricting supervision to medical practitioners serves as a barrier to wide implementation of SBIRT.
- **Expand training and technical assistance for SBIRT adoption and implementation.** Training in basic SBIRT skills is currently being provided but could be expanded and extended. Training includes instruction and skill practice on use of very brief screeners, strategies for patient education and increasing motivation, and effective referral strategies. Successful implementation requires program staff to examine the flow and structure of their program and identify SBIRT integration mechanisms that minimize disruption of daily clinic flow while ensuring that the services are provided effectively and with fidelity to the SBIRT model.
- **Expand training efforts to include learning collaboratives and technical assistance:** Telephone and web-based learning collaboratives and onsite technical assistance are strategies that can be utilized to provide training participants with ongoing coaching and

support in implementing a new plan, practice, or skill¹⁰. Technical assistance, or the process of providing targeted support to an organization or individual, may be delivered in many ways, such as one-on-one consultation or small group facilitation.

- **Develop local SBIRT Champions who could support ongoing implementation and fidelity at the local level:** Sustainability and ongoing support would be facilitated by developing a cadre of SBIRT Champions who have gained expertise in both the specific skills and in implementation of SBIRT. These champions could provide ongoing support and real-time problem solving for programs as they work toward full implementation. A combination of training, technical assistance/coaching, and ongoing support would be needed to develop these SBIRT Champions.

One panelist identified early successes of the use of SBIRT by stating that one managed care organization pays the salary of a staff person to conduct SBIRT and has realized a great return on investment. Panelists noted existing challenges with obtaining reimbursement for SBIRT and concern that once a SUD need is identified, there is no way for a health plan to fund subsequent referrals for treatment.

8. Other suggestions

The experts mentioned additional suggestions on a wide array of topics. Briefly summarized, these include the following:

- Make the Short Doyle system for health care services billing more effective and efficient.
- Address stigma among providers and patients.
- Utilize workforce in the community to its maximum.
- Allow FQHCS to bill for same day services. Currently California does not allow billing for physical and behavioral health visits on the same day, which was described as a barrier to integrated care and warm handoffs between providers.

¹⁰ North Carolina Department of Health and Human Services. (2014). *Building Capacity through Training and Other Technical Assistance*. Raleigh, NC.

Structural Improvements to Integrate Behavioral Health into the Health Care System

Pressure on California's behavioral health system to transform into a high-performing fully integrated system is greater now than ever before. In part, this is a result of the growing body of evidence revealing the consequences of untreated mental health and SUD needs on individuals, families and communities as well as on avoidable program costs. Also raising the bar for California are efforts within the U.S. Department of Health and Human Services and within many states to eliminate policy and financing barriers to integration through delivery system and financing innovation.

Within California, a great deal of innovation is occurring as well. California recently expanded Medi-Cal managed care statewide and established new requirements on these plans. For example: to cover mental health services for individuals with mild to moderate level needs and to provide Alcohol screening and brief interventions as needed for alcohol misuse. These innovations increase the demand for California's health care delivery systems to better integrate and/or coordinate care for individuals with behavioral health needs so as to promote a more seamless patient experience for those individuals whose levels of need fluctuate between moderate and severe. Finally, budget strain as a result of increasing health care expenditures on state budgets, superseding state spending on primary and secondary education, and the growth of Medicaid spending as a share of the federal gross domestic product are increasing pressure on payers and providers to quickly begin to implement strategies that will bend the cost curve and possibly incur savings.

Characteristics of a high-performing integrated system were defined during the panel's discussion as:

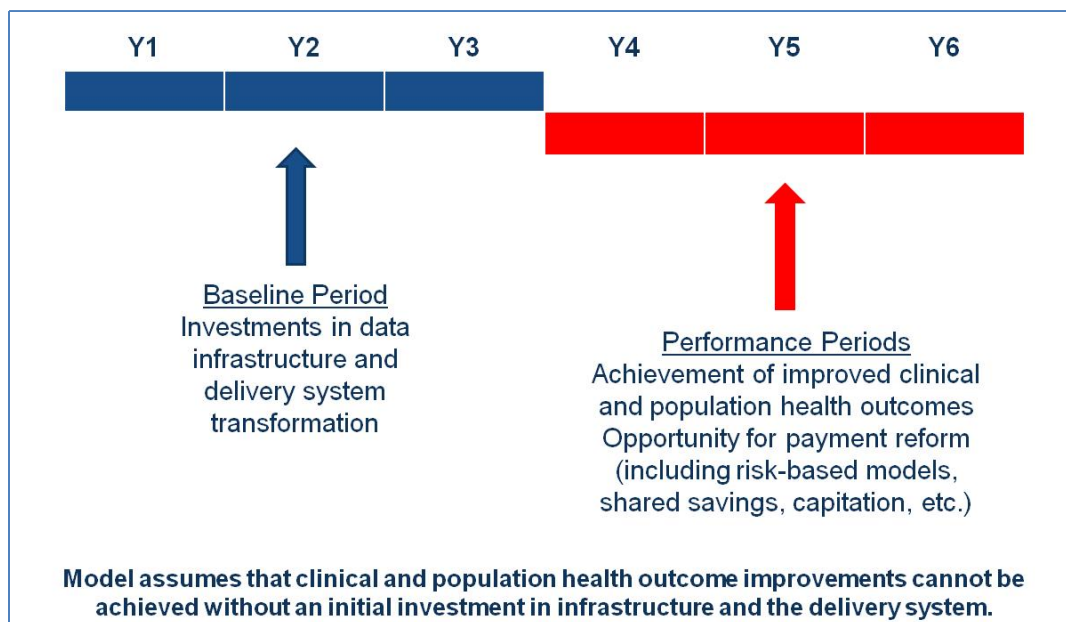
- 1) **Patient Experience.** A partnership between patients and their providers in which treatment decisions are made with activated patients based on patients' preferences, medical evidence and clinical judgment. Patients must also have access to care 365 days a year and twenty-four hours a day, among other characteristics;
- 2) **Delivery system.** A delivery system that relies on interdisciplinary teams, care managers and registries, clinical and population health analytics, a high level of information sharing and the flexibility to provide the most efficient care in the most appropriate setting;
- 3) **Service bundle.** A package of services that is comprehensive and includes physical, behavioral health, and social services; and
- 4) **Financing.** A financing system that aligns incentives through shared risk or pooled funding structures in which providers can tolerate both upside and downside risk.

Members of the expert panel acknowledged that transformation is a slow process and must be implemented strategically and incrementally. They also acknowledged that counties and providers across the state are at different levels of organizational readiness. Certain characteristics of organizational readiness were identified. These include an engaged leadership, a feedback loop for staff training and evidence-based approaches, an advanced

health information technology infrastructure, and the ability to conduct panel management, risk stratification and implement individualized care plans, among others. The panel acknowledged that no single blueprint for success exists and that each county and provider must approach transformation with an acknowledgement of its unique starting point.

Figure 1 was used during this discussion as an illustration of an incremental process toward practice transformation. It also demonstrates that any process of transformation must first involve the investment in data infrastructure and delivery system reform before improved performance outcomes can be achieved.

Figure 1. Transformation is Slow



The panel raised a number of potential strategies for consideration by DHCS. One proposal that sparked a productive sharing of ideas is the establishment of a Delivery System Reform Incentive Program (DSRIP) for California’s behavioral health system. Participants expressed an interest in establishing such a program to fund practice transformation and data infrastructure. Such investment in the early years, panelists explained, could result in improved clinical and population health outcomes in the later years. They also suggested that such a proposal could be modeled after California’s current DSRIP program for public hospital systems while also building upon lessons learned by CMS and other states since the program was first established in 2010.

Panelists suggested that programs under a potential BH DSRIP could (1) be targeted to specific populations who are high risk users of several systems (i.e. older adults), (2) emphasize recovery; (3) focus on improvements in care coordination and panel management; and (4) result in more meaningful use of available data.

Another participant suggested that any financing reform initiatives should enable providers to bill for care coordination. One participant explained that screening patients for MH and SUD treatment needs are critical to lowering costs.

Participants also made clear that any reform proposals would need to be voluntary for counties, take into account their different levels of readiness and financial capacities, and provide opportunities for counties to make regional partnerships to leverage shared resources and core capacities.

The Landscape of Changing Health Care System

The MHSUDS Integration Task Force Meeting culminated with a view of the changing health care system landscape offered by Senator Darrell Steinberg. Senator Steinberg noted that the Experts' discussion provided DHCS with a great deal to consider. He acknowledged that as a legislator who passed a preponderance of mental health bills, he was struck by all that needed to be considered on the ground to ensure that legislation ultimately resulted in better care, better outcomes, and reduced costs for this complex population. He reiterated that the California Medicaid program cannot achieve the Triple Aim and develop truly patient-centered care without aligning and integrating behavioral health into the health care system. Key strategies to get there include:

- An investment of additional resources through a Behavioral Health DSRIP to build the behavioral health system infrastructure as was discussed by experts
- Initiation of Statewide Planning for the *Certified Community Behavioral Health Clinics* (federal Excellence in Mental Health Act)
- Partnering with the legislature to ensure alignment around behavioral health integration strategies

Public Comments

Below are a summary of public comments offered during the Task Force Meeting:

- One participant said a recent Managed Care report card showed addiction treatment was really low for most plans and questioned what research is being done to find out why treatment is so low.
- One health home organization warned that it took various standards to build their model and that they had to build a 16 page matrix for outcomes, which included patient experience, outcomes, and cost effectiveness as domains. They did find a nurse-navigator approach most successful, preliminarily resulting in a large reduction in ER use.
- Another participant asserted that 1 million of 12 million annual ER visits in California visits are for people with Behavioral Health problems, and stressed the need to communicate well with hospitals. The participant also suggested looking at the health information exchange model in San Diego County which allows access to data regardless of who pays for services. She also reminded the panel that encounter data and claims data are separate. Not all encounters have claims.
- Another participant stated that Seriously Mentally Ill and Complex Condition cases have physical health issues that impact their mental state. The participant felt making data on mental health available is important.
- One participant expressed frustration that the Department's health home effort is looking at 2012 data which won't include expansion population or Low Income Health Program. With 11 million Medi-Cal enrollees, 5% could be way too many people to measure effectively (more than 500,000). The participant advocated for tiering services and payment, thinks care coordination should be close to the consumer (not calling a plan), and that housing and food access are selection factors they strongly support.
- Another participant stated most evidence is being directed at adult system of care and pointed out that the children's system is unique, needs are different, and its uses are different,
- One participant decried a lack of standards for peer counselors, and suggested a pilot project, return to the sunrise review of the licensing entity. The participant suggested a need for more early access to care for a professional who is licensed in a patient's neighborhood.
- Another participant suggested that peer provider training should happen through community college system or at the state level, not through university as others had suggested, because in a general education setting, peers may not feel as comfortable disclosing their mental health conditions due to stigma.
- Interest was also expressed in better coordination between DHCS and the Mental Health Services Oversight and Accountability Commission to support the data infrastructure improvements needed for behavioral health integration.

Acknowledgements

Special thanks to the California Health Care Foundation for making this meeting possible and to their unwavering commitment to advancing behavioral health integration for the millions of low-income children, adults and families participating in California's Medi-Cal program. We would also like to thank Senator Darrell Steinberg for his leadership during this meeting and his long-term commitment to improving mental health and substance use disorder treatment services in California's safety net. This meeting summary was authored by Jennifer Clancy, California Institute for Behavioral Health Solutions; Karen Linkins, Integrated Behavioral Health Project; Julie Stone, Mathematica Policy Research; and Darren Urada, UCLA, Integrated Substance Abuse Programs.

APPENDIX 1: Meeting Agenda

**CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Mental Health and Substance Use Disorders Services (MHSUDS)
Integration Task Force Meeting**

Monday, November 10, 2014 - 10:00am – 4:00pm

1700 K Street, 1st Floor Conference Room

Sacramento, CA

Telephone: 888-942-8170

Passcode: 7481455

- 9:30-10:00 **Check In**
- 10:00-10:15 **Welcome, Purpose and Structure of the MHSUDS Integration Task Force Process**
- Welcome: *Toby Douglas, Director, DHCS; Senator Darrell Steinberg*
 - Introductions of MHSUDS Task Force: *Efrat Eilat, DHCS*
 - Purpose and Structure of the MHSUDS Integration Task Force Process: *Jennifer Clancy CIBHS/Karen Linkins, IBHP*
- 10:15- 12:00 **Practice Transformation: Suggestions**
- Health Home for People with Complex Needs: *Brian Hansen, DHCS*
 - Accountability - Behavioral Health Integration Measures: *Karen Linkins*
 - Achieving the Triple Aim - Introduction to Practice Transformation: *Marc Avery, AIMS*
- Task Force Discussion and Feedback: *Karen Linkins and Jennifer Clancy, facilitators*
- 12:00-12:15 **Public Comment**
- 12:15- 1:00 **Lunch on your own**
- 1:00-2:45 **Practice Transformation: Suggestions - Continue Discussion**
- Work Force Capacity Building for Population Health and Improving Patient Experience: *Jennifer Clancy*
- Task Force Discussion and Feedback: *Karen Linkins and Jennifer Clancy, facilitators*
- 2:45-3:30 **Advancing Behavioral Health Integration in California - Potential Concepts**
- Structural Improvements to Integrate Behavioral Health into Health Care System : *Julie Stone, Mathematica and Jennifer Clancy*
 - The Landscape of Changing Health Care System: *Darrell Steinberg*
- Task Force Discussion and Feedback: *Karen Linkins and Jennifer Clancy, facilitators*
- 3:30-3:50 **Public Comment**
- 3:50-4:00 **Next Steps: Efrat Eilat**

APPENDIX 2: Task Force Members

MHSUDS Integration Task Force Members

Marty Adelman – Mental Health Program Coordinator, Council of Community Clinics

William (Bill) Arroyo – Medical Director, Children’s System of Care, Los Angeles County

Marc Avery – Associate Director for Clinical Services, AIMS Center Division of Integrated Care & Public Health Department of Psychiatry & Behavioral Sciences University of Washington

Sonja Bjork – Staff, Partnership Health Plan

Molly Brassil - Associate Director Public Policy, County Behavioral Health Directors Association

Peter Currie – Clinical Director of Behavioral Health, Inland Empire Health Plans

Gabriele Hooks – Program Manager, Corporation for Supportive Housing

Erynne Jones, - Associate Director of Policy, California Primary Care Association (CPCA)

Jennifer Kent – Executive Director, Local Health Plans of California

Don Kingdon – Consultant, Harbage Consulting

Marty Lynch – Executive Director, LifeLong Administrative Offices

Judith Martin - Medical Director for City and County of San Francisco, Substance Abuse Services and former President of the California Society of Addiction Medicine

Sandra Naylor Goodwin – President and CEO of the California Institute for Behavioral Health Solutions

Traci Reickman – Research Assistant Professor, Oregon Health Sciences University and Principal Investigator, Northwest Addiction Technology Transfer Center

Rusty Selix – Executive Director, Mental Health Alliance of California

Al (Albert) Senella – President, California Association of Drug and Alcohol Program Executives

Lisa Smusz - Past Executive Director, Peers Envisioning and Engaging in Recovery Services

Darrell Steinberg, - Senator, California State Senate

Catherine Teare, - Senior Program Officer, California HealthCare Foundation

Abbie Totten – Director, State Programs, California Association of Health Plans