HEALTH MANAGEMENT ASSOCIATES

ONE MICHIGAN AVENUE BUILDING
120 NORTH WASHINGTON SQUARE
SUITE 705
LANSING, MICHIGAN 48933
TELEPHONE: (517) 482.9236
FAX: (517) 482.0920

HEALTH MANAGEMENT ASSOCIATES
of Illinois
180 NORTH LASALLE STREET
SUITE 2305
CHICAGO, ILLINOIS 60601
TELEPHONE: (312) 641.5007
FAX: (312) 641.6678

THE HUNTINGTON PLAZA
BUILDING
37 WEST BROAD STREET
SUITE 1150
COLUMBUS, OHIO 43215
TELEPHONE: (614) 224.2500
FAX: (614) 221.1437

8888 KEYSTONE CROSSING
SUITE 1300
INDIANAPOLIS, INDIANA 46240
TELEPHONE: (317) 575.4080
FAX: (317) 575.4180

2100 M STREET
SUITE 605
WASHINGTON, D.C. 20037
TELEPHONE: (202) 785.3669
FAX: (202) 833.8932

KLEMAN PLAZA
301 SOUTH BRONOUGH
SUITE 500
TALLAHASSEE, FLORIDA 32301
TELEPHONE: (850) 222.0310
FAX: (850) 222.0318

BANK OF AMERICA CENTER
515 CONGRESS AVENUE
SUITE 1760
AUSTIN, TEXAS 78701
TELEPHONE: (512) 473.2626
FAX: (512) 473.2642

Integrating Publicly Funded Physical and Behavioral Health Services: A Description of Selected Initiatives FINAL REPORT

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Middletown, Connecticut

Hogg Foundation for Mental Health
Various Locations, Texas

Horizon Health Services
Buffalo, New York

Kaiser Permanente Southern California Depression Care Program

Massachusetts Behavioral Health & Primary Care Integration Initiatives
Various Locations, Massachusetts

Rebuilding Lives PACT Team Initiative
Columbus, Ohio

Vermont Depression in Primary Care and Medical Home Projects
Various Locations, Vermont

Washington Medicaid Integration Pilot
Snohomish County, Washington

Washtenaw Community Health Organization
Ypsilanti, Michigan

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Executive Summary

Very rarely do mental health and substance use problems exist in isolation. The conditions frequently co-occur along with a medical illness such as heart disease, cancer, diabetes and neurological illnesses (Institute of Medicine, 2005). Even more disturbing are findings that suggest that those with serious behavioral health conditions experience earlier death as a result of under-treated medical conditions (Surgeon General's Report, 1999). Patients with co-morbid behavioral health conditions experience significantly higher medical costs than patients without behavioral health complications and research has shown that treatment of mental health and substance abuse conditions results in lower overall health care costs (Olfson, Sing, and Schlesinger, 1999).

Provider and payer systems have begun implementing strategies that enable more effective coordination of care and collaboration among clinicians in order to integrate physical and behavioral health services. In fact, the recent Institute of Medicine (IOM) report, *Improving the Quality of Health Care for Mental and Substance-Use Conditions*, recommends that collaboration and coordination of mental and substance use conditions be the norm. The report further recommends that providers of services should establish "clinically effective linkages within their own organizations and between providers of mental health and substance use treatment."

Service integration can mean different things and may take on many forms, ranging from providing educational resources to clinicians to facilitate referrals, co-locating clinicians in the same setting, coordinating care across providers and systems, collaborating and jointly deciding on treatment, and jointly planning and financing services. The path toward integration varies depending on the goals, the resources, and the system reach of the implementer. This report illustrates the variety of integration goals and approaches undertaken by providers, payers and public agencies in the pursuit of improved service integration.

This report also highlights commonalities across initiatives, including the existence of a conceptual framework, the use of improved communication tools and processes, the consistent use of screening tools, collaboration in the use of identified clinical approaches, the identification of funding mechanisms, and the need for sustainability planning. It also identifies considerations for future planning. These include the need for communicating about effective strategies, understanding opportunities to take advantage of "low-hanging fruit," developing sufficient funding to test various strategies, identifying training resources to support implementation of promising practices and actively engaging payers in dialogues about integration expectations.

Findings suggest that sustainable integrated service initiatives were able to either connect financial costs and resultant benefits within a single health care payer or to broaden the range of participating stakeholders beyond health services payers. The latter approach connects services beneficiaries (i.e., clients) with an array of systems funders (i.e., law enforcement, criminal justice, social services, etc.) and allows all stakeholders to realize or anticipate a return on their investment in integrated services. Findings also suggest that there is significant improvement that can result from effective integration efforts, both in terms of improved care and significant cost savings in the treatment of physical health conditions. Finally, the report touches on significant barriers presented by the fragmented public policy and payment systems that exist today for mental health, substance use disorder treatment and physical health services and argues that federal, state and local policy makers need to view integration of publicly funded services for vulnerable populations as a shared imperative.

Background

Research has shown that underlying mental health and substance use disorder (SUD) problems account for up to seventy percent of all primary care visits. Depression, in particular, is predicted to be the second leading cause of disability in the United States by 2020. The World Health Organization reports that mental illnesses affect and are affected by chronic conditions such as cancer, heart and cardiovascular diseases, diabetes and HIV/AIDS. In addition, substance abuse is one of the nation's most prevalent health problems and alcohol is the number one drug of choice among both adolescents and adults. Alcoholism and alcohol-related disorders occur in up to twenty-six percent of general medical patients. The health care costs for individuals with alcohol problems are twice those of individuals without alcohol problems. Alcohol problems are frequently implicated in cancer, stroke, cirrhosis of the liver, cardiovascular diseases, depression, falls, burns and intentional injuries (Bureau of Primary Health Care, 2004).

Several state and local health policymakers, managed care organizations and providers have recently implemented programs designed to address both the behavioral (mental and SUD) and physical health needs of individuals. As the topic of integrated physical and behavioral health garners increasing attention, The Robert Wood Johnson Foundation (RWJF) sought assistance in understanding the facets of existing integrated services initiatives in order to have knowledge of the approaches, treatment models and services used to achieve integration. RWJF is the nation's largest philanthropy dedicated to improving health and health care. RWJF supports training, education, research and projects that demonstrate effective ways to deliver health services, particularly for the most vulnerable individuals.

Purpose

The aim of the *Integrating Publicly Funded Physical and Behavioral Health Services* report is to identify and describe existing models of publicly funded integrated service programs. The term "integrated services" has been described in various forums and can mean anything ranging from placing behavioral health and primary care clinicians in the same setting, to facilitating referrals across systems, to jointly planning and financing services. Since there is no uniform definition of integration and since there are multiple players in services delivery (e.g., mental health providers, substance abuse treatment providers, primary care clinicians, managed care organizations, funders, etc.), the goal of this project was to include initiatives that reflect a broad range of approaches and settings.

As a result, this report includes initiatives geared toward increasing the effectiveness of primary care services (Cleveland, Ohio and New Hampshire), those that focus on ensuring the effectiveness of mental health and substance use treatment (Columbus, Ohio and New York), and those that facilitate the piloting of strategies in various settings to determine their effectiveness (Texas and Vermont). This report also contains strategies implemented at the level of the service provider as well as those implemented by managed care organizations, state Medicaid agencies and other state-level authorities. Since the project focused on publicly-funded initiatives, this report describes programs with service populations that are largely Medicaid eligible or uninsured.

Project Limitations

This report focuses on the identification and description of various initiatives and does not evaluate the effectiveness of programs. In addition, time and resources did not permit exploration of how certain aspects of delivery systems (e.g., Medicaid regulations, public financing, state licensure) facilitated or impeded the goals of each initiative. While examples of Medicare and Veterans Administration integrated service programs were identified, they were not the focus of this review.

Methodology

Sixteen programs conducting varying methods of integrated services were initially identified for participation in phone interviews. Based on a preliminary review of the programs (e.g., integration goals, implementation strategy, service location, outcomes, etc.), a list of priorities was developed to assist in narrowing down interview participants. The goal was to include initiatives that:

1. Represent a variety of geographic locations and target populations;
2. Are currently operational or were recently concluded;
3. Represent substance abuse, mental health and primary care efforts;
4. Deliver services across various settings (e.g., clinics and individual medical practices);
5. Reflect a broad range of program implementation (provider-level, managed care, state-level implementation); and
6. Have outcomes or evaluation results.

A fifty-five question interview guide was used during phone interviews that enabled understanding of the following program elements:

- Project goals and problems to be resolved
- Key partners and the process for key partner involvement
- Overall project description, including service locations and scope
- Background on the larger service system (role of managed care, authority for behavioral health services)
- Clinical approach (clinical model used, training, clinical team composition, role of clinical management, process for family involvement)
- How key partners are organized (use of MOU/MOA, contracts, billing responsibility, diagnostic responsibility, staffing model)
- Populations and services (target populations, use of evidence-based or promising practices)
- Payment and funding (sources and uses of funds, integrated funding approaches)
- Technology (use of electronic medical records, patient registry systems)
- Communication and outreach tools and methods
- Outcomes measurement and evaluation processes
- Implementation barriers and lessons learned
- Future plans for the initiative

This report is based on interviews of thirteen sites. Some sites initially interviewed are not described in this report due to overrepresentation of geography and/or approach. Individual summaries of each initiative follow.

Findings

Integration Implementers and Goals Varied

This project identified integration initiatives being carried out across a range of stakeholders; from efforts by individual providers or clinics, to community-based initiatives that engaged a wide cross-section of social service organizations, to efforts undertaken by managed care plans, to initiatives sponsored by public agencies. Many were supported, at least initially, by grant funds.

Even as sponsors and implementers varied, so too, did the specific problems that initiatives were designed to overcome. In one initiative, a coalition was established to increase urban pediatricians' ability to identify emotional problems in individual medical practices and facilitate referrals to the specialty behavioral health system. In another, a single rural pediatric practice developed a regional approach for diagnosis, care planning and treatment using a defined set of evidence-based SUD

treatment services. In yet another initiative, a philanthropic organization provided start-up funding to enable individual primary care settings to test methods of mental health service delivery for ethnically diverse and geographically dispersed citizens in its state. A fourth initiative utilized a statewide approach to pilot the creation of an infrastructure across primary care and mental health systems to support the use of psychoeducational and self-management techniques in the primary care setting as well as the use of primary care case management in mental health treatment settings.

Integration Approaches Vary

While all the integration sites shared an understanding that large numbers of their service population experienced co-morbid, and often chronic, physical and behavioral health conditions, each initiative was designed around the particular set of local or statewide problems to be solved. None of the initiatives set out to "do integration" in a cookie-cutter way; rather, the nature and scope of the system redesign differed based on the target population, provider and service capacity, funding constraints, reimbursement and regulatory restrictions as well as other factors described in individual reports.

Listed below are brief examples of approaches used by many of the initiatives to achieve integration goals. Interestingly, none of the approaches are used in isolation. While a particular approach may be the primary focus of an initiative, other elements play equally important roles.

One approach involves **educating** clinicians on available community resources, which is a key feature of the Cleveland pediatric initiative. However, an equally important approach in the Cleveland example involves the use of screening and diagnostic tools to support **collaboration** between the primary care and specialty behavioral health system providers.

Co-location of primary care and behavioral health staff is a central component in several project sites. In Vermont, program implementers found that productive interaction among co-located staff was essential and that co-location by itself was no guarantee of meaningful collaboration. Vermont also experienced improvements as a result of encouraging **patient self-management** through education and other supports.

In the Columbus, Ohio project, team members were co-located in a shared space, which greatly facilitated their ability to **coordinate** care on a daily basis. Moreover, because all team members worked in close proximity to each other and **communicated** regularly, clients could access any team member and be reasonably assured that team members would provide assistance in addressing the client's specific needs.

In the Colorado pilot, centralized **case management**, including the use of decision support systems, was used to promote effective communication and coordination of the full range of services needed to effectively treat co-morbid conditions. And in New Hampshire, the integration project was focused on assuring that **evidence-based practices** were being used to support effective responses to patient needs.

Finally, the Michigan initiative demonstrates an effective use of **integrated funding** at a local level to promote sustainability of integration efforts over time.

Clearly, the goals of each initiative drive how programs operate, communicate and collaborate in order to achieve service integration. There is no linear path that programs take in pursuing integration. The path is different for individual practices than it is for clinics, different for behavioral health agencies than it is for medical service providers and different between managed care organizations and individual practices or clinics.

Commonalities Across Approaches

The IOM report on *Improving the Quality of Health Care for Mental and Substance-Use Conditions* calls attention to the need for cooperation among clinicians. The report states that clinicians and institutions should actively collaborate and communicate to ensure appropriate exchange of information and coordination of care. The report suggests that communication and collaboration are two prerequisites to coordination of care and that collaboration itself requires a shared understanding of goals and roles, effective communication and shared decision-making. All of the initiatives described in this report utilize some form of communication tools and require or promote collaboration among clinicians and systems. These are described in more detail below and in individual reports. In addition, there are other similarities across integration projects::

Existence of Conceptual Framework

At the core of each initiative rested an understanding of what the integrated service model means. First, all programs appeared to be vested in a shared belief that treating the whole person is paramount. This belief, to a large extent, guided clinical and organizational processes. Project sites reported being heavily influenced or informed by a variety of models that have been developed either with a focus on behavioral health treatment or on improved management of chronic care. These included Dr. Edward Wagner's chronic care model, Kaiser Permanente's planned care model, Dr. George Engle's approach and others described in individual reports.

Use of Communication Tools and Case Management

All programs either developed or recognized the importance of sharing information among stakeholders. Some programs instituted regularly scheduled meetings to review and discuss patients and caseloads (Colorado, Connecticut, New Hampshire, North Carolina and Columbus, Ohio). Other programs utilized information technology to achieve communication, including electronic health records, patient registries and decision support systems (Colorado, Michigan, North Carolina, Texas and Washington). All but one program (Cleveland, Ohio) utilized care managers or case managers to facilitate communication among clinicians, between clinicians and patients and between payers and providers.

Screening

All programs used routine screening and assessments to determine the presence of behavioral health disorders. In Colorado, clinicians incorporated depression screening (and subsequently other behavioral health screening methods) with physical health screenings for target populations. In addition, one behavioral health service provider routinely screened patients for chronic medical conditions such as respiratory disorders, diabetes and hypertension (New York).

Clinical Approach

Several programs were designed to deliver services in accordance with, or closely aligned to, prescribed models of treatment. A few programs utilized chronic disease management protocols for treatment of physical health conditions (Colorado, Michigan, North Carolina and Washington). Several programs employed the use of evidence-based and emerging behavioral health services practices such as medication management, Assertive Community Treatment, Integrated Dual Disorder Treatment, Wellness Recovery Action Plans and supported employment (California, Colorado, Michigan, New Hampshire, North Carolina, [Columbus] Ohio, Washington and Vermont). All but one program (Cleveland, Ohio) implemented care management strategies to support patients in managing their conditions.

Funding
Most programs received start-up funding to initiate integrated service. In some cases, programs identified additional funding streams to support or offset costs associated with delivering treatment services, though not all programs have pursued or maximized reimbursement under the available funding streams (New Hampshire and Columbus, Ohio).

Sustainability
While some initiatives are designed to be sustainable over the long haul (California, Colorado, Connecticut, Michigan, [Cleveland] Ohio and Washington), others have either revamped their programs or systems to support ongoing operations (New York and Vermont) or are continuing to address financial sustainability issues (Massachusetts, [Columbus] Ohio and Texas). In many cases, the challenge lies in identifying funding mechanisms for service coordination and linkage services, which are essential to care management.

Outcomes and Evaluation
Several programs were able to quantify and describe the financial benefits of integrating services (California, Colorado, Michigan, Vermont and Washington). One initiative described other results such as improvements in perception of quality of life and sustained housing (Columbus, Ohio). Others continue to collect data and refine outcome and evaluation strategies. Not surprisingly, programs that have demonstrated cost savings are also among those that are positioned for long-term sustainability.

Conclusions

It is evident that there is no single approach to integrating or coordinating services. However, there are critical success factors that vary depending on program goals, populations, the role and type of implementer among others. Individual reports provide greater detail behind what made programs work as well as the factors that impeded the achievement of stated goals.

As behavioral and physical health service providers, consumers, payer systems and public policy makers grapple with understanding how to accomplish integrated services; it may be useful to consider the following:

There is a need to communicate what strategies are in play and working.
Systems that are developing integrated service initiatives can greatly benefit from the experiences of other implementers (e.g., organizational and operational facets, financing strategies, lessons learned, clinical approaches and outcomes). Since most initiatives are local in nature, there is not widespread dissemination about their effectiveness. In addition, several individuals interviewed stated that they were not aware of what was "out there" in operation when they set out to attain their integration goals.

Dissemination of information about the size, variety and scope of integrated service strategies can assist providers and local, state and federal policymakers in engaging in more informed discussions about how such strategies can take shape. Convening individuals to discuss various strategies would also prove immensely helpful as new initiatives continue to crop up and problems with sustainable financing persist.

Planners should make use of straightforward strategies and know when complex solutions are needed.
In many cases, the delivery system in existence prior to a pilot was so fragmented, and co-morbidity so prevalent, that even relatively straightforward strategies - like making a screening tool available or coordinating patient plans of care within a managed care organization's case management team - could result in measurable improvements in care and cost. Several programs leveraged their provider

or reimbursement status to achieve goals, working within existing licensure, certification and reimbursement constraints. Others built on their capacity as the front-door or gatekeeper to introduce new processes that, over time, became the standard of practice.

Still others sought larger system reforms, such as integrated financing strategies, to remedy problems around fragmented payment policies. Within these efforts, going after the "low-hanging fruits" sometimes helped make more treatment resources available, but it took larger system reforms to realize this benefit. Changes in local system management or in state regulatory and reimbursement policy could be critical to providing access to essential service coordination and linkage supports or to achieving financial sustainability over time.

Federal policies, too, especially regarding financing and eligibility options, were cited as potential barriers to achieving true integration of the most effective service delivery.

Likewise, while improved identification, referral and access to existing services and providers may offer an improvement over a system in which individuals' needs are either not recognized or in which individuals fail to connect with providers, it is also clear that the quality of services delivered to those with co-morbid behavioral health and physical health care needs deserves attention. Establishing expectations regarding outcome and effectiveness of treatment requires a more complex set of system reforms, one that asks for more change from hands-on providers of care - and perhaps even from consumers of care - than required by case management and coordination strategies.

It may prove helpful to develop and disseminate a summary of straightforward solutions that behavioral health service providers, primary care providers, consumers, managed care organizations and policymakers can use as a reference when designing integrated service strategies. Those same resource materials can help identify a continuum of changes across systems (e.g., short-term, intermediate and long range) for clinical practice, reimbursement, licensure, coverage and regulatory issues.

Programs need to be able to test various strategies to find out what works.
Since many of the initiatives were initiated as pilot programs, they had grant funding to support staff, operations and training on various treatment and organizational approaches. The pilot status also provides the flexibility needed to test various approaches to find out what works best. Ideally, any new integrated services strategy would have access to grant or other flexible funds that would not otherwise be earned through service delivery so that the appropriate framework can be built at the outset and results can be evaluated. Immediately defaulting to a system of only covered services and reimbursement will not yield the scope of services and supports necessary to achieve integration (i.e., coordination, collaboration, communication, education, etc.).

There is a need for training resources.
Many initiatives utilized evidence-based treatment practices or other clinical approaches that guided service delivery and operations. Dedicated training funds enabled some programs to conduct training, continuing education and fidelity monitoring. Planners of integrated services should assure that sufficient training resources are available to implementers. The funding should also allow programs to adapt the training and application of promising practices to meet the unique circumstances of implementers, if the practices allow such adaptation.

Payers need to be actively engaged in dialogues about integration and expectations.
As policymakers and payers promote integrated services delivery, they should also be mindful of the resources needed for initial start-up, ongoing service delivery, training and outcomes monitoring. Successful, sustainable strategies require being able to link the benefits from improved outcomes and resultant savings to those stakeholders which are asked to support the up-front investments that may be required to achieve successful reform (e.g., state Medicaid agencies, federal funding programs, managed care organizations, hospitals, law enforcement, providers, etc.).

Policymakers should clearly define their expectations about integration and the extent they can financially support initiatives and provide regulatory relief to ensure their occurrence. Ideally, policymakers should consider the resource and regulatory commitments simultaneous with conceptualizing integration strategies.

Ongoing Challenges

Despite the successes of several initiatives, one of the biggest obstacles to integrated services is the fragmented public policy and payment systems for physical and behavioral health care. The silo effect of funding and regulatory processes becomes abundantly apparent through attempts to integrate medical services with mental health and SUD treatment services. Unfortunately, regulations surrounding Medicaid, federal block grants and state and local funding sources make integration difficult, as each system wants to ensure that funds are being used according to each system's requirements, without regard to the overall effectiveness across systems. True integration of services can occur no sooner than integration of financing for the services, as the experience of Washtenaw County, Michigan reveals.

Summary of Integration Approaches

Initiative Title (Implementer/Services By)	Integration of Primary Care with:		Populations		Primary Strategy		Integration Elements[1, 2]			Information Technology[3]		Funding Type
	MH	SUD	Child	Adult	Coordination	Collaboration	Co-Location	Use of EBPs	Integrated Funding	Decision Support System	Electronic Medical Record	
Center for Adolescent Health –New Hampshire (Specialty adolescent program / specialty adolescent program, primary care practice, community mental health centers (CMHC))		✓	✓			✓	✓	✓			✓	Grants
Cleveland Coalition for Pediatric Mental Health – Ohio (Community coalition / pediatric medical practices)	✓		✓		✓					✓		Grants Service revenue
Colorado Access (Medicaid managed care organization / primary care practices)	✓			✓	✓			✓	✓	✓	✓	Grants Service revenue
Community Care of North Carolina (Primary care case management program / primary care practices)	✓	✓	✓	✓		✓	✓				✓	Grants Service revenue
Community Health Center, Inc. Connecticut (Federally qualified health center (FQHC) / FQHC)	✓	✓	✓	✓		✓	✓	✓			✓	Service revenue
Hogg Foundation for Mental Health – Texas (Mental health foundation / primary care practices, FQHC, pediatric group practice)	✓		✓	✓		✓	✓	✓				Grants
Horizon Health Services – New York (CMHC / CMHC)	✓	✓		✓	✓		✓	✓			✓	Service revenue
Kaiser Permanente of Southern California (Integrated health system / CMHC)	✓			✓	✓		✓	✓	✓		✓	Service revenue
Massachusetts Behavioral Health & Primary Care Integration Initiatives (Behavioral health partnership / FQHCs, CMHCs)	✓	✓	✓	✓	✓*	✓*	✓	✓		✓	✓	Grants Service revenue
Rebuilding Lives PACT Team Initiative – Ohio (Community shelter board / CMHC, FQHC, Supportive Housing provider)	✓	✓		✓	✓		✓	✓		✓	✓	Grants Service revenue
Vermont Depression in Primary Care & Medical Home Projects (State Medicaid Agency / CMHCs, primary care practices)	✓			✓	✓		✓		✓			Grants Service revenue
Washington Medicaid Integration Pilot (Medicaid managed care organization / primary care practices, CMHCs)	✓	✓		✓	✓			✓	✓	✓	✓	Service revenue
Washtenaw Community Health Organization (Local service organization /CMHCs, primary care clinics)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	Grants Service revenue

[1]All initiatives incorporated Screening/Assessments into strategies; [2]All but one initiative (Cleveland) provided case management services; [3]Most programs used varying forms of Information Technology (e.g., patient registries, 24/7 call centers, web-based diagnostic/assessment and tracking tools, patient electronic care systems). *Programs with multiple sites that used either coordination or collaboration strategies.

Brief Description of Initiatives

1. **Center For Adolescent Health, Plymouth, New Hampshire**
   The Center for Adolescent Health is a general adolescent clinic in Plymouth, New Hampshire that provides biopsychosocial health services through a multidisciplinary and collaborative approach. With county and private foundation funds, the Center for Adolescent Health facilitates and provides evidence-based substance abuse treatment services onsite at its clinic location in collaboration with community partners.
2. **Cleveland Coalition for Pediatric Mental Health, Cleveland, Ohio**
   With grant funds from the Annie E. Casey and Woodruff Foundations, the Cleveland Coalition for Pediatric Mental Health has developed a web-based resource guide that is currently available to 400 primary care pediatricians and has begun pilot testing the Child Health and Development Interaction System in three local pediatric practices to improve access to mental health care in Cuyahoga County, Ohio.
3. **Colorado Access Integration Model**
   Colorado Access is a licensed managed care organization which serves Medicaid, Medicare and SCHIP members in Colorado. The health plan implemented a RWJF funded Depression in Primary Care pilot for its Medicaid enrollee population in Denver and surrounding areas in 2004. The care management program screened high risk health plan members for depression using the PHQ-9 and provided members with interventions designed to support guideline concordant depression treatment within primary care practices. Pilot results included significant reductions in the cost of physical health care for patients, making the integration approach economically sustainable.
4. **Community Care Of North Carolina Mental Health Integration**
   In July 2005, a collaborative approach to mental health and primary care integration was created by the State of North Carolina in four pilot sites. The goal of the pilot is to overcome inadequate access to behavioral health services and manage the behavioral and physical health needs of Medicaid enrollees served in the Medicaid primary care case management program. The four pilot projects are led by the North Carolina Community Care Network Board, comprised of primary care providers. The state Medicaid clinical director, regional Local Management Entities, and other state and local networks complete the integration initiative. The pilot projects, which are located in both urban and rural settings, all serve adult and pediatric populations and utilize the same standardized model components. All four projects are collecting comparable outcome, performance and cost measures. It is expected the four integration projects will achieve a cost-effective integrated model for Medicaid that can be expanded and replicated statewide.
5. **Community Health Center, Inc., Middletown, Connecticut**
   Community Health Center, Inc. is a multi-site federally qualified health center (FQHC) providing services in nine towns and cities throughout central, southeastern and southwestern Connecticut. Currently four of the sites provide co-located primary care and behavioral health services using a model that embeds behavioral health services within the center's operational framework allowing for seamless service delivery. Individuals identified as in need of mental health services are transitioned to behavioral health professionals who provide services onsite at the center. In its integrated services site, the interdisciplinary physical and behavioral health staff meets daily for a "morning huddle" to discuss caseloads and plan service delivery.
6. **Hogg Foundation Integration Grants**
   The Hogg Foundation for Mental Health created a grant program through which primary care providers in Texas are implementing collaborative mental health and physical health care. Grantees include urban and rural/frontier clinics. The target populations vary by site and include children and a largely uninsured adult population. The grant project is testing how primary care providers can overcome real world barriers to effective collaborative care models. Grantees anticipate serving approximately 3,500 individuals per year for 3 years. Grantees received direct funding in June 2006, and the Foundation has contracted with experts to provide technical assistance, including training. A formal evaluation is underway.

7. **Horizon Health Services, Buffalo, New York**
   Horizon Health Services is a state-certified provider of substance abuse and mental health services located in Buffalo, New York. Horizon began providing medical services onsite at several of its community mental health center (CMHC) locations in1987 in order to provide onsite access to medical care and facilitate coordination between substance abuse, mental health and medical services clinicians. While financial constraints resulted in the closure of several of Horizon's medical units, three of its locations continue to offer both behavioral health and primary care prevention, treatment and diagnostic services to behavioral health consumers as well as the general public.
8. **Kaiser Permanente Southern California Depression Care Program**
   In 2001, Kaiser Permanente of Southern California adopted the IMPACT model of collaborative care for depression, developed by Jurgen Unutzer, MD, MPH, at the University of Washington. Kaiser participated in an HMO pilot study with Dr. Unutzer, adapting the program through expansion to adults of all ages, expansion of the provider team to include a medical assistant, availability of a depression class, psychiatric supervision by telephone and training Kaiser staff at all 12 regional medical centers. The pilot study compared 300 "post-study patients" to 140 usual care and 140 intervention patients. Results were collected showing fewer care manager contacts during the Impact Study and benefits of the intervention program continuing after one year. Dissemination of the program at 12 regional medical centers and in one additional region accessed over 3 million Kaiser members.
9. **Massachusetts Behavioral Health and Primary Care Integration Projects**
   The State of Massachusetts selected six behavioral health care/physical health care service integration demonstration sites in 2005. Project sites, formed under the auspices of the Medicaid-serving Massachusetts Behavioral Health Partnership, represent partnership proposals between FQHCs, CMHCs, and other local Massachusetts networks. Full implementation is expected in early 2007, and is expected to target improved service delivery in both primary care and behavioral health specialty care settings, with an emphasis on evidence-based practice and principles of recovery.
10. **Rebuilding Lives PACT Team Initiative, Columbus, Ohio**
    The Rebuilding Lives PACT Team Initiative is a county collaborative of behavioral health, primary care, housing and other supports designed as part of a federal strategy to abolish chronic homelessness in the United States. The Initiative provides services to chronically homeless adults with moderate or severe mental illness and/or SUD. Partners in the Initiative include: a non-profit organization dedicated to developing a community response to homelessness; a developer, owner and manager of supportive housing services; a provider of mental health, addictions, pharmacy and clinic services; a network of FQHCs as well as veterans and other entitlement benefits coordinators.
11. **Vermont Depression in Primary Care and Medical Home Project**
    The Office of Vermont Health Access implemented two integration pilots. The Medical Home Project was implemented in 2003 with a grant from the Center for Health Care Strategies to integrate primary care services into community mental health clinic settings. The Depression in Primary Care project was implemented in 2004 with a grant from the RWJF to integrate mental health services into a primary care setting. Based on pilot outcomes, the Medicaid program is developing strategies to support on-going provision of integrated services; this has included authorizing the use of additional Medicaid billing codes to support case management.

12. Washington Medicaid Integration Pilot

The Washington Medicaid Integration Partnership was authorized by the Washington state legislature to operate as a pilot in Snohomish County, Washington. Molina Healthcare of Washington, Inc. is the HMO that won the contract to implement the pilot. The managed care pilot enrolls SSI clients, including those who are dually eligible for Medicare, into a comprehensive benefit package that includes mental health as well as physical health care services. Molina receives a combined capitation payment for all services, and provides care coordination across all health care needs. Mental health services were included with physical and drug treatment services beginning in October 2005. In October 2006, long term care services were added to the pilot.

To date, 2,700 individuals are enrolled in the integration project. Molina reports that 10 percent -15 percent have screened for behavioral health as a primary diagnosis. Overall, 20 percent - 25 percent have a mental health component of their care plan. Washington Medicaid will evaluate the pilot after year three before deciding whether to continue or expand the model to other geographic areas.

13. Washtenaw Community Health Organization, Ypsilanti, Michigan

The Washtenaw Community Health Organization is a service organization that administers primary care, mental health, substance abuse and developmental disability services in southeastern Michigan. A collaborative partnership with the University of Michigan Department of Psychiatry, Washtenaw County Government, the county mental health center, and local private health clinics, it was developed to create innovative, best practices in the delivery of integrated health care to Medicaid, Medicare and indigent patients. The Washtenaw Community Health Organization began planning its integrated initiatives in 1998 and launched its first integrated clinic in 2003. Five integrated health clinics have been implemented since 2003. The integrated services that are part of the model are transportable to other health care settings.

Center for Adolescent Health – Adolescent Treatment Initiative
Plymouth, New Hampshire

Abstract
The Center for Adolescent Health - Adolescent Treatment Initiative (CAH-ATI) is a collaborative, interdisciplinary, regional adolescent substance abuse treatment system serving youth and their families in eastern Grafton County, New Hampshire. The CAH-ATI has three elements: 1) ongoing efforts to strengthen regional primary care clinicians' abilities to screen their adolescent patients for psychosocial problems and provide brief interventions and referrals when appropriate; 2) an interdisciplinary specialty adolescent diagnostic clinic, the Center for Adolescent Health; and 3) the implementation of an array of adolescent substance abuse treatment services ranging from psychoeducational programs, pro-social activities, psychopharmacology care, advocacy services and evidence-based individual and family-systems oriented therapies. The CAH-ATI is one of 7 demonstration projects funded by the New Hampshire Charitable Foundations in partnership with New Futures, a nonprofit, nonpartisan advocacy organization working to reduce underage alcohol problems and increase access to treatment in New Hampshire through leadership and policy development. This system brings together and strengthens the many organizations serving youth within eastern Grafton County, including primary health care practices, prevention organizations, CMHCs, schools, a substance abuse counseling organization, a pro-social activities agency and a home-based, family counseling organization. Through collaboration, the system seeks to provide a seamless continuum of high quality, evidence-based adolescent substance abuse screening, assessment and treatment services in a rural region of New Hampshire.

Integrated Service Initiative

Background

Problem

Adolescents with mental health and substance abuse problems are often seen in primary care settings where the problems frequently remain unidentified. When such problems were identified, assessment and treatment services were only sporadically available throughout the region and there was no one place where families could receive a coordinated package of services and supports. Although there were mental health counseling, substance abuse, psychiatric and family medicine and pediatric services available in the region, coordination of services was poor, and evidence-based counseling strategies were not employed. The quality and type of services an adolescent would receive would often depend on what agency or organization the family accessed rather than based on what package of services would be most helpful.

Description of Implementer

The Center for Adolescent Health (CAH) is a specialty adolescent health program in Plymouth, New Hampshire affiliated with Dartmouth-Hitchcock Medical Center. With support through the New Futures Adolescent Treatment Initiative, CAH is developing a seamless system of adolescent substance abuse services in eastern Grafton County, New Hampshire. New Futures is a private, nonprofit, nonpartisan, advocacy organization that strives to reduce underage alcohol problems and increase access to treatment in New Hampshire through leadership and policy development. With financial backing from a private donation to the New Hampshire Charitable Trust, the New Futures Adolescent Treatment Initiative aims to improve the quality and quantity of adolescent alcohol and other drug treatment services throughout New Hampshire. Its strategy is the result of an extensive planning process, including a statewide analysis of adolescent treatment needs; a national review of

selected "best practice" programs; and a national assessment of selected foundations and how they address alcohol and other drug problems, specifically adolescent treatment.

Strategy of the Integrated Services Initiative

An underlying principle of the CAH-ATI approach is to strengthen what is already available in the communities. CAH-ATI strives to build programs through collaboration among the different organizations that already serve youth in the rural area. The CAH-ATI honors the "medical home" and works to strengthen the ability of primary care practices to screen, assess and provide effective brief interventions. The CAH clinic was developed to give professionals a place to refer adolescents once they identify problems. Primary care clinicians otherwise would be hesitant to identify problems that are beyond their capacity to manage. The general adolescent clinic was chosen as a model to reduce the stigma for adolescents referred for further assessment and treatment planning. Although mental health and substance abuse treatment services are offered, adolescents are seen in the general medical setting without the stigma of being seen at a "drug treatment program" or a "mental health center," hindering anyone from knowing whether youth are being seen for a behavioral health issue or a sore throat. CAH-ATI is working to improve the quality and increase the quantity of outpatient substance abuse treatment in the region through commitment to evidence-based models, ongoing training, interdisciplinary assessments and treatment planning.

CAH collaborates with a number of key partners to staff the interdisciplinary clinic that provides biopsychosocial diagnostic, treatment planning and intervention services for youth age eleven through twenty-one who may suffer from any of a wide range of problems such as poor school performance, family conflict, mood issues, chronic physical symptoms, not growing or maturing at the same rate as their peers, acne, attention problems, substance use and abuse or eating disorders.

Key Partners of the Center include:

- **Dartmouth-Hitchcock Clinic/Plymouth Pediatrics and Adolescent Medicine** – A rural health center affiliated with the Dartmouth-Hitchcock Medical Center serving children and adolescents in Plymouth, New Hampshire
- **Horizons Counseling Center** – An outpatient substance abuse treatment provider located in Gilford and Plymouth, New Hampshire
- **Familystrength** – A New Hampshire-wide home-based behavioral health services provider that focuses on family systems development. Familystrength is located in Concord, New Hampshire with multiple regional offices;
- **Genesis Behavioral Health** – A private, non-profit comprehensive, CMHC with offices in Laconia and Plymouth, New Hampshire.
- **Adolescent Drug and Alcohol Prevention Tools, Inc**. – A community-based agency responsible for provision of pro-social activities/experiential learning.

Process for Key Partner Involvement

From earlier efforts to implement periodic surveys of adolescent behavior in area schools, the extent of adolescent alcohol and drug use was well known by health care, school and legal professionals. The CAH Medical Director partnered with an administrative superior court judge and a regional drug prevention organization to secure funding for the CAH-ATI. The Medical Director initially selected clinical partners who, once brought together, could provide the full array of services needed. Ongoing strategic planning has led to refinement of the model over time with modifications of the business agreements to further the mission of the Initiative. Further clinical resources are currently being brought in to the collaborative based on identified clinical priorities. Additional funding through third party reimbursement for services, private donations and additional grants such as funding from Grafton County are being secured to ensure sustainability and growth.

General Description of Implementation Project

CAH-ATI is one of 7 demonstration projects funded by New Futures. The CAH-ATI strategy had 3 main components:

1. Strengthen regional primary care medical clinicians' abilities to screen, further assess and provide brief interventions and appropriate referrals for adolescent psychosocial problems including substance abuse through facilitating quality improvement activities, clinician education, provision of screening and counseling tools, mentorship and technical assistance.
2. Transform the CAH into an interdisciplinary, specialty adolescent clinic for adolescents 11-21 years of age to provide comprehensive assessments and coordinate treatment for a wide array of adolescent health issues through partnering with area behavioral health, substance abuse treatment and pro-social activities organizations. The CAH is designed to both honor and complement the adolescent's medical home.
3. Expand the offering of evidence-based adolescent substance abuse treatment services in eastern Grafton County to include both individual and family-systems focused treatment.

Understanding the Clinical Approach

The CAH-ATI approach is grounded in the biopsychosocial model of care. This model was first articulated by George Engel, M.D in the 1970's, stemming from his integrative work between medicine and psychiatry at the University of Rochester in New York.

The CAH clinical approach is guided by a number of beliefs:

- There are basic values adolescents and families need to embrace to optimize their development. These values are shared with the Community of Caring (i.e., caring, respect, responsibility, trust and family) which has been endorsed by area schools.
- Adolescents deserve respect, choice, honesty, privacy and accurate information.
- Adolescent health and development is optimized through a strengths-based approach.
- All individuals are valuable.
- Adolescents are not little adults and need developmentally appropriate services.
- There are many ways to live life meaningfully.
- Everyone has different gifts and has an obligation to make the most of gifts.
- Everyone has an obligation to care for others, strengthen the community and better the world.
- Everyone makes mistakes and needs forgiveness to move forward in a new direction.
- The "medical home" concept if important. CAH supports primary care clinicians in caring for their adolescent patients. CAH provides consultative care and coordinates this care with the primary care office. CAH does not serve as a primary care clinic for adolescents.
- Adolescents and their families deserve high quality and effective services.
- Services need to serve the adolescent, not another institution. CAH is an independent, private, non-profit entity. By being separate from the court, schools and other institutions and organizations, CAH does not have conflict of interest issues inherent with institution-based services, although collaboration with these agencies is seen as critical.
- Families have the primary responsibility for the welfare of adolescents and CAH works to support families in performing that role.
- Families come in all shapes and sizes and CAH's focus is to optimize family functioning, not making a judgment that a specific configuration is necessarily better than others.
- Privacy is critical when caring for adolescents. Adolescents often only provide sensitive information such as substance use to clinicians when they are comfortable that their privacy

will be respected. Referral to categorical substance abuse treatment requires disclosure of substance use to parents. However, by having a counselor that can address many issues, substance abuse can be addressed comprehensively in the treatment of a variety of problems including family conflict, school underperformance, mood issues and chronic physical symptoms without breeching confidentiality.

- Although substance use may be an acute problem, often psychosocial problems are more chronic and need ongoing monitoring and care.
- Adolescent substance use happens in a context. CAH identifies and addresses contextual factors through the use of a biopsychosocial or ecological model by an interdisciplinary team.
- Solutions need to fit the individual and their family, and the context in which they live.

Strengthening Primary Care

The CAH team includes partners with expertise in supporting practice improvement in primary care. Collaborative care with regional primary care clinicians helps highlight the importance of high quality psychosocial care. CAH assists primary care practices develop policies and practices that facilitate behavioral health screenings in their practices including specific confidentiality policies, developing patient education materials and implementing health screening questionnaires. CAH is providing training, hardware and technical support for clinician use of a screening questionnaire that teens complete on a handheld personal digital assistant (PDA) that has shown great promise in other settings. This 95-question screening instrument enables clinicians to quickly identify and prioritize problems and devote more of the visit to being therapeutic.

CAH Clinical Process

Adolescents are referred to CAH by school staff, courts, area primary care clinicians, mental health professionals, emergency department physicians and families. Individuals may also self-refer to CAH. The program director and adolescent health counselor conduct intake interviews and assist families with completing the intake questionnaire, which can take place at CAH's office, school or over the telephone. During intake, the decisions are made based on the clinical data about what evaluations are needed. Three basic evaluation pathways may be elected:

1. Comprehensive biopsychosocial assessment, interdisciplinary intervention and case management;
2. Adolescent medicine diagnostic and treatment consultation (requires referral from the youth's primary care clinician); or
3. Psychopharmacological consultation and management (requires referral from the youth's primary care clinician).

Appropriate appointments are made and past treatment records are obtained. The adolescent's primary care clinician is identified. If there is none, the family will be assisted in selecting one. Following completion of the initial assessment, cases are staffed at weekly interdisciplinary team meetings for feedback prior to making recommendations for either further clinical evaluation or a specific package of interventions. Once treatment is underway, progress to stated goals is periodically tracked through adolescent and family report and gathering of corroborating data such as communication with guidance counselor, parole officer or urine drug test is undertaken. Adolescents are then followed through graduation from high school or possibly further.

The biopsychosocial assessment is the most common assessment done. This is performed by a master's level adolescent health counselor. If there is substance use involved, this assessment will include the administration of the Global Assessment of Individual Needs or GAIN. The assessment

of non-substance involved teens is completed through a modified HEADSS assessment. If appropriate, a medical assessment may also be requested by the primary care clinician or possible referral to the adolescent medicine specialist or the psychiatrist at the CMHC. Upon completion and review of the assessment findings, the youth and/or family meet with the adolescent health coordinator, program director or adolescent medicine physician and, as needed, clinicians from the partner agencies, to review the findings with the adolescent and family and develop an individualized treatment plan from a menu of available services.

Services available through the collaborative currently include:

- Adolescent health counseling using Motivational Enhancement Therapy /Cognitive Behavioral Therapy (MET/CBT) and the Adolescent Community Reinforcement Approach (ACRA);
- Psychopharmacologic therapies;
- Adolescent Portable Therapy (APT) (from the Vera Institute);
- Medical monitoring from a primary care clinician;
- Community support services for the adolescent and family (e.g., 12-step programs, community therapists, school resources, community service opportunities);
- Pro-social activities/experiential learning; and
- Case management.

Payment and Funding

CAH received a five-year grant from New Futures through the New Hampshire Charitable Foundation as well as county funds to support staffing and services. Medical services are reimbursable through 3rd party payers. CAH is restructuring the collaborative to optimize Medicaid and private insurance reimbursement.

Technology

Dartmouth-Hitchcock utilizes a secure electronic medical record. On-site behavioral health partners (adolescent health counselor, case manger, program director) all have access to the electronic records. Off-site collaborating agencies (Horizons, Familystrength, Genesis and Adolescent Drug and Alcohol Prevention Tools, Inc.) do not have access to the electronic medical record, but share information through written reports, e-mail and verbal communication with the adolescent's permission.

Outcomes

RMC Research Corporation is conducting a 2-year formative evaluation for New Futures Adolescent Treatment Initiative grantees. The aims of the evaluation are to assess community readiness to address adolescent substance abuse; track client-level program indicators at each project site to measure access and retention; and assess client needs and outcomes at treatment entry and varying intervals post treatment using the GAIN. CAH is collecting clinical data in a structured way with relational databases using adolescent and family self report combined with corroborating data from schools, parole and probation officers and drug testing.

Constraints and Limitations

A current constraint is that grant funds support assessment, counseling and treatment of individuals with SUD, and a good fraction of referrals are adolescents who do not use substances, but nonetheless need a comprehensive intervention for other behavioral and emotional problems. Adolescents without drug related-issues are offered assessments provided by CAH, but currently do

not have access to the full array of services available to youth who use substances. CAH-ATI is seeking other funding streams to overcome this barrier.

Barriers and Lessons Learned

CAH-ATI has built a better mousetrap. Although there are glitches, the integration of medical, psychiatric, individual and family counseling services has tremendous power to be therapeutic. By thoughtfully choosing from a menu of high quality services, an effective package of interventions can be efficiently implemented.

It has become clear that true collaboration involves each agency holding each other accountable for providing excellent quality services. CAH believes that collaboration has improved quality in all partners.

There are a few things that, in hindsight, would have been done differently from the beginning. In New Hampshire, different organizations have different abilities to bill 3rd party payers for services by non-licensed professionals. For example, drug treatment programs can bill some private insurances, but not Medicaid, for LADC services. However, a CMHC can hire the same individual and be able to bill for their services. Hence, CAH is restructuring the collaborative so those organizations with the most favorable billing situation are providing specific services. CAH is in the process of supporting Familystrength in hiring a licensed mental health counselor to work out of CAH offices. In addition, Medicaid limits the number of hours billed as an assessment. The GAIN assessment ideally is administered in a single day over a 1-2 hour period. Current Medicaid rules permit one billed hour of assessments per day, so to keep financially afloat, CAH has divided the assessment into two sessions. Fortunately, New Futures is advocating with Medicaid to modify some rules to improve services.

An important lesson is that to effectively collaborate in the CAH-ATI model, each agency needs to make an agency-wide commitment to evidence-based services. The project mandates the use of the GAIN, MET/CBT and ACRA, among others. Some partners went along with using evidence-based treatments in the partnership, but did not embrace the concept throughout their agency. This leads to ongoing conflict and is a real barrier to effective collaboration.

The Future

CAH-ATI is being viewed by the state as a possible model for dissemination. CAH continues to work to optimize business plans and clinical services so when replicated, other similar organizations do not need to make the same mistakes made by CAH. Over time, and with additional support, CAH hopes to demonstrate that this approach works, is relatively inexpensive compared to the cost of the outcomes prevented, and is well received by the medical, mental health and substance abuse treatment communities, schools and the courts.

Cleveland Coalition for Pediatric Mental Health, Cleveland, Ohio

Abstract
With grant funds from the Annie E. Casey and Woodruff Foundations, the Cleveland Coalition for Pediatric Mental Health has developed a web-based resource guide that is currently available to 400 primary care pediatricians and has begun pilot testing the Child Health and Development Interaction System in three local pediatric practices to improve access to mental health care in Cuyahoga County, Ohio.

Background

Service System

In Ohio, the Department of Mental Health and the Department of Alcohol, Drug and Addiction Services are responsible for managing and overseeing state and block grant funds for mental health and SUD treatment services, respectively. In addition, the Department of Job and Family Services - the single state Medicaid agency - delegated authority to the Department of Mental Health and the Department of Alcohol, Drug and Addiction Services to administer Medicaid-covered community mental health and addiction services in the state. All three departments are cabinet-level agencies whose leadership reports to the Governor.

While Medicaid community behavioral health services are managed by the single state Medicaid agency through the Department of Mental Health and the Department of Alcohol, Drug and Addiction Services, services are locally administered by county mental health and addiction boards, which are commonly referred to as alcohol, drug and mental health (ADAMH) boards. The state has approximately fifty ADAMH boards distributed among Ohio's 88 counties. Counties may operate ADAMH boards singly or may combine boards regionally as resources dictate. ADAMH boards have statutory responsibility under Ohio laws to plan and develop mental health and SUD services for county residents. ADAMH boards receive federal block grant and state general revenue allocations directly from the Department of Mental Health and the Department of Alcohol, Drug and Addiction Services. As public entities, many ADAMH boards can levy taxes to generate additional resources. ADAMH boards do not directly provide services but contract with behavioral health services providers that are paid by ADAMH boards on a grant or fee-for-service basis. ADAMH boards' public status also enables boards to draw down federal Medicaid funds to reimburse boards for Medicaid expenditures paid to providers for Medicaid eligible services to Medicaid eligible consumers.

Providers of physician services enter into agreements with the single state Medicaid agency and also contract with managed care organizations as panel providers. Physician offices are not required to contract with ADAMH-funded behavioral health agencies but often refer clients for follow-up care.

Description of Implementer

The Cleveland Coalition for Pediatric Mental Health (CCPMH) is comprised of pediatricians, child and adolescent psychiatrists, child psychologists, administrators from the Cuyahoga County Community Mental Health Board and other community leaders that are interested in improving access to pediatric mental health care in Cuyahoga County, Ohio. Coalition members convened an Advisory Board that regularly meets and discusses ways of building and strengthening the CCPMH.

Goals of the Integrated Services Initiative

Problem

Recent epidemiological research indicates that half of adults with mental illness had symptoms by age fourteen. Mental illness begins in childhood and adolescence, and several recent federal reports

have called upon primary care providers (PCPs) to play a more active role in the identification and treatment of mental health issues. A recent survey of over 130 local pediatricians revealed that while 80% of them felt the identification of childhood mood disorders was their responsibility, less than 20% felt that the treatment should be their responsibility. Given the limited number of mental health professionals, pediatricians are often placed in an untenable position. Having identified children in need of mental health services, they are unable to provide an appropriate intervention.

Goals of Integrated Services Initiative
The initial mission of the CCPMH was to identify ways for pediatricians to better address the needs of patients and families. CCPMH was funded as a planning group charged with compiling a list of available mental health resources. Over time the goals were amplified to:

- Educate and support pediatric primary health care;
- Engage and support parents in mental health prevention and building resiliency;
- Build and strengthen clinical support networks between pediatric primary care and behavioral health providers; and
- Advocate for mental health parity, early identification and evidence-based interventions.

Key Partners
Partners include the Case Western Reserve University School of Medicine, the Cuyahoga County Community Mental Health Board, Northern Ohio Pediatric Society, North Eastern Ohio Society for Child and Adolescent Psychiatry, Cleveland Association of School Psychologists and the Cleveland Psychological Association.

Process for Key Partner Involvement
An Advisory Board of the CCPMH, funded by a grant from the American Academy of Pediatrics, assembled local leaders in pediatric primary and mental health care to engage and support pediatricians to better serve the mental health needs of patients and their families. These Advisory Board meetings are open to all local stakeholders with an interest in improving access to pediatric mental health services.

General Description of Implementation Project
The CCPMH has identified several action steps to achieve its mission. Currently two action steps are underway and represent the integrated services strategies described in this report.

The first action step involves the development of a web-based mental health resource guide to maximize the utilization of currently available mental health resources and empower pediatricians to link children in need with the most appropriate public resource. To date, access to the resource guide is available to any of the 400 local primary care pediatricians who request a password. Because this resource is web based, the individual resources could, eventually, update their own information, allowing the resource guide to remain relevant and accurate.

The second action step involves piloting the use of the Child Health and Development Interaction System (CHADIS). CHADIS is a web-based diagnostic, management and tracking tool designed to assist professionals in addressing parents' concerns about their child's behavior and development efficiently while streamlining other routines of the visit. CHADIS enables parents to complete an online survey of their child's behavior prior to meeting with the pediatrician. The system, developed by Dr. Barbara Howard of Johns Hopkins University, can be customized so that adolescents and family members complete specific mental health screening, assessment and diagnostic tools. CHADIS provides the pediatrician with tentative diagnoses, along with an estimate of severity. By collecting and organizing parental concerns, behavioral issues and other history prior to the actual

visit, CHADIS allows primary care pediatricians more time to address the mental health concerns identified.

Target Populations

The target populations for the CCPMH action steps are the primary care pediatricians of Cuyahoga County and their patients and families. The resource guide is available to all local pediatricians and is designed to empower pediatricians to link children and adolescents in need with the available mental health resources. The CHADIS pilot is currently for patients age 0-8 in three local pediatric primary care practices and is designed to assist local pediatricians in identifying children with psychosocial, emotional and behavioral concerns.

Services

Prior to entering the exam room during a routine office visit, children and their family members complete brief screening questionnaires and other diagnostic tools through the CHADIS website:

1. Parent or teen completes a computerized interview about behavior, health and EPSDT topics online via a secure Internet site from home, work, a library or the waiting room.
2. CHADIS stores all the information collected from interviews and comments from clinicians. This information is available to authorized users from any computer with Internet access.
3. Clinician reviews results of the parent questionnaires, top concerns, provisional diagnoses and health screening answers that are instantly available to them in an electronic worksheet. Clinician may use links to clinical guides for many topics within CHADIS.
4. Clinician selects (and optionally prints) handouts and resources (e.g. books, agencies, therapists) from the CHADIS database of resources categorized by topics relevant to the results on the electronic worksheet. Clinicians can have additional local resources added to this database.
5. Clinician may choose to exchange information with or refer the patient to another provider through CHADIS.
6. Clinician may choose to exchange information with teachers, school psychologists, etc.

CHADIS currently has the following computerized interviews, or questionnaires, available:

- **CHADIS-DSM**: Parent questionnaire for ages 3-12 years resulting in "rule out" Diagnostic and Statistical Manual for Primary Care (DSM-PC) and DSM diagnoses, and prioritized list of parent concerns. Takes 10 to 40 minutes depending upon the number of concerns endorsed.
- **PSC-17: Pediatric Symptom Checklist**, 17-item version for ages 4 - 16 years resulting in self-scored results along three separate subscales (internalizing, attention and externalizing) as well as a total score. Takes 3 minutes for parents to complete.
- **Health Risk Questions**: All currently required EPSDT areas are reviewed including exposure to TB, lead, HIV or immune-suppressed family members, passive smoking and low fluoride.
- **Medical History**: 27 items assessing family history of medical, psychological and social problems.
- **Potential Stressors**: 27 items designed to assess current stressors in the child's family. Items are drawn from the environmental situations and potentially stressful events listed in the DSM-PC, Child and Adolescent Version.
- **McMaster Family Assessment Device (FAD), General Functioning Subscale**: The McMaster FAD is a well-known tool for the assessment of family interaction. The General Functioning Scale provided here includes 12 items assessing overall family functioning.
- **Multidimensional Scale of Perceived Social Support (MSPSS)**: 12 items assessing the respondent's perceived social support from family, friends and significant others.
- **Overall Appraisal of Functioning**: A brief (6 item) questionnaire designed to provide an overall picture of functioning among infants and toddlers.
- **Adjectives to Describe Your Child**: Designed for use with infants and toddlers, this checklist allows the respondent to choose those adjectives that best describe their child.

- **Modified Checklist for Autism in Toddlers (M-CHAT)**: A 23-item screening tool for autism, available for use with toddlers ages 18-36 months.
- **Edinburgh Postnatal Depression Scale**: The widely-used ten-item questionnaire designed to screen for postpartum depression among parents of infants ages 0-6 months.

Understanding the Clinical Approach

CCPMH recognizes that pediatricians are on the front line in their role as PCPs and are often in the best position to detect psychosocial, emotional and behavioral issues and to assist in preventing their exacerbation. CCPMH has elected to pursue the use of CHADIS for several reasons. First, CHADIS is the web based platform for the resource guide, and it contains thousands of national mental health resources (books, videos, websites, etc.). By supplementing this national database with over 160 local programs and providers, and by purchasing access to the resource guide for local pediatricians, CCPMH is empowering local pediatricians to link children in need with the available local resources. Once implemented, the CHADIS program effectively collects parental concerns and relevant history prior to the actual visit. Because it is web-based, CHADIS promotes communication across systems of care (between pediatrician, teacher and mental health provider). Since CHADIS uses standardized screening and diagnostic tools, it is an efficient means of collecting the uniform, standardized data needed to assess evidence-based practices. Although CCPMH does not currently track referrals, once local mental health care providers begin using CHADIS, the monitoring of referrals and follow-ups could be done electronically through CHADIS. Finally, because it is a developmental screening tool, the use of CHADIS is a billable service (CPT 96110). This is important because, once fully implemented, the use of CHADIS should be self-sustaining.

Payment and Funding

The CCPMH received funding from the Annie E. Casey Foundation, the Woodruff Foundation and the American Academy of Pediatrics. These funds enabled CCPMH to 1) survey the local pediatricians for their attitudes and practices, 2) assemble and sustain the Advisory Board, 3) develop the resource guide and 4) purchase the software and licenses for CHADIS.

Providers who utilize CHADIS also bill Medicaid for developmental testing and receive reimbursement for providing the service to Medicaid eligible consumers.

Technology

Because CHADIS is web-based, it allows for the 'virtual integration' of mental and primary care. All consented providers can access the same patient information, thereby breaking down communication barriers. The reports generated by CHADIS can also be copied into an electronic medical record.

Outcomes

Currently, no outcomes data exists on the CCMPH initiative. Surveys of the resource guide users, the CHADIS providers and the CHADIS parents are pending.

Barriers and Lessons Learned

The barriers to the countywide CHADIS implementation are technical, educational, financial and systemic. Technical barriers include providing pediatricians and parents with easy access to computers, breaking down firewalls to allow access to the appropriate internet addresses and developing more sophisticated linkages with electronic medical records (besides cutting and pasting reports). Educational issues include making pediatricians aware of what CHADIS can do for them, educating parents on how to complete the screens and diagnostic tools, training physicians on how to access the CHADIS results and working with pediatricians' staffs to seamlessly integrate CHADIS into their current office procedures. There are financial issues as well, including the funds

that pediatricians need to purchase access to the program, and the capital support the makers of CHADIS need to continuously update, refine and expand the program's capabilities. Once pediatricians are receiving reimbursement for using CHADIS, the system will pay for itself. Finally, system issues derive from the fact that there are 3 distinct health systems in Cuyahoga County, each with its own institutional review board, quality control measures and administrative policies. The implementation of CHADIS on a countywide level would require an unprecedented level of commitment and cooperation between the three major health systems in Cuyahoga County.

The Future

In the future, CCPMH hopes to expand access to the resource guide to include counselors, school psychologists, early intervention specialists and family medicine practitioners. With sufficient funding, CCPMH hopes to expand the pilot to include other practices and other aspects of CHADIS (Edinburgh, ASQ, M-CHAT). Eventually CHADIS could be used to screen and assess the over 350,000 children and adolescents in the Cleveland, Ohio area. If successful, the methods of the CCPMH have the potential for replication across the county.

Colorado Access Integration Model

Abstract
Colorado Access (CoAccess) is a licensed managed care organization which serves Medicaid, Medicare and SCHIP members in Colorado. The health plan implemented a RWJF funded Depression in Primary Care pilot for its Medicaid enrollee population in Denver and surrounding areas in 2004. The care management program screened high risk health plan members for depression using the PHQ-9 and provided members with interventions designed to support guideline concordant depression treatment within primary care practices. Pilot results included significant reductions in the cost of physical health care for patients, making the integration approach economically sustainable.

Background

Service System

The Colorado Department of Health Care Policy and Financing is the state Medicaid agency in Colorado. At the time of the pilot, the Department contracted with managed care organizations statewide to deliver general medical services to both TANF and SSI enrollees on a capitated basis. Mental health services were carved out into separately capitated mental health contracts, overseen by the Division of Mental Health in the Department of Human Services. During the pilot period, the responsibility for oversight of the Medicaid behavioral health program shifted from the Division of Mental Health to the Department of Health Care Policy and Financing. Substance abuse treatment services are not included in the general medical or the mental health capitation.

Description of Implementer

CoAccess is a licensed managed care organization that was formed by Denver area safety net providers to serve publicly insured populations including Medicaid, Medicare and SCHIP. At the time of the pilot, CoAccess contracted with the Department of Health Care Policy and Financing to provide general medical services for Medicaid enrollees in most of the state, including the Denver area. CoAccess also was under a capitated contract to provide mental health services to the Medicaid population in Denver County. In 2005, CoAccess implemented a Medicare Special Needs Plan (SNP) focused on the dually eligible Medicaid/Medicare population.

Goals of the Integrated Services Initiative

Problem

When CoAccess won the contract for the Denver County mental health carve out they had responsibility for both the physical and behavioral health services for the subset of members living in Denver County. With this unique insight into the health care needs of the Medicaid population, the health plan sought to find a way to better serve the "whole person." There was a vague sense that integration between services could be improved, but no clear ideas on what needed to be done. The health plan assigned the responsibility for improving integration to Dr. Marshall Thomas, the Chief Medical Officer and now Vice President of Medical Services.

Goals of Integrated Services Initiative

CoAccess had two goals as a health plan regarding integration of physical and mental health care. First, the plan sought to provide better primary care for patients with severe and persistent mental illness, including improved pharmacy management. Second, the plan sought to improve access to mental health care for those primarily seen in the general medical services system, since analysis by CoAccess identified that even when referrals for mental health services were made by primary care providers (PCPs), members often failed to access the specialty mental health system. In pursuing the

second goal, CoAccess sought funding from the RWJF to implement the Depression in Primary Care pilot.

CoAccess had earlier used funding from the MacArthur Foundation to pilot an initiative to train provider practices to use the PHQ-9 to identify depression and then refer those patients to the health plan's care management program. However, this approach was judged to be too labor intensive to be economically feasible for the plan to sustain. CoAccess was interested in the RWJF grant project because one of the goals was identifying "economically sustainable models" of integration.

Parameters and Constraints

The mental health and general medical territories for CoAccess were not fully aligned for the health plan's business. Various Behavioral Health Management Organizations throughout the state were providing mental health services to the individuals enrolled in CoAccess for general medical services under Medicaid. This added some challenges regarding facilitating effective referrals into mental health treatment for CoAccess enrollees whose need for mental health treatment was identified in the primary care setting.

This lack of alignment required CoAccess to examine the capitation assumptions between the mental health and general medical payments under Medicaid. Though it was a point of some confusion in the system, CoAccess understood that the mental health capitation did not include any funding for primary care, pharmacy or other general medical treatment, even for those services related to the mental health diagnosis. After CoAccess determined that the benefits of improved service integration would likely accrue to the general medical side of the health plan, the plan decided that the case management costs could be borne out of the general medical capitation payment.

CoAccess was able to easily facilitate referrals to the specialty mental health system for those members they served in both the physical and behavioral health plan. However, coordinating specialty mental health care for members whose behavioral health coverage was provided by another health plan was often challenging.

Key Partners

CoAccess had two health plan products involved in the integration initiative: Access Health Plan, which provided general medical services under Medicaid for TANF and SSI enrollees, and Access Behavioral Care, which provided mental health services for Medicaid enrollees. The health plans contracted with the Mental Health Corporation of Denver, the University Hospital of Denver specialized clinics, local FQHCs and the University Hospital primary care clinics to provide primary care and mental health services.

Process for Key Partner Involvement

The integration model was designed to require minimal practice change on the part of service providers, so the focus of planning was within the CoAccess case management and clinical management team. Although there was buy-in for the project at both the board and executive levels, there were still considerable issues of turf and misunderstanding, even within a single organization.

General Description of Implementation Project

CoAccess approached the design of the pilot project with an in-depth analysis of claims data from both the general medical and the mental health plans. The principle focus was on adult populations. The analysis found that while 40% of adults enrolled under Medicaid had received a behavioral health diagnosis, only one third of these were receiving those services in specialty mental health

system, despite the fact that many of the providers in the CoAccess network had co-located mental health and physical health care services.

Enrollees identified as having severe or persistent mental illness showed a high penetration in specialty mental health services and only a slightly higher cost of physical health care than those without SPMI. Enrollees with behavioral health conditions that did not rise to the standard of SPMI tended to have diagnoses of anxiety, substance abuse and depression. CoAccess's analysis found that this population, which was generally seeking services only in primary care settings, had physical health care costs that were 1 to 1 ½ times higher than for enrollees without mental health co-morbidities.

Target Population

CoAccess decided to implement the Depression in Primary Care pilot by incorporating depression management for populations already targeted for case management: enrollees with congestive heart failure, diabetes, high Disability Payment scores (a risk assessment model designed for Medicaid populations), COPD and asthma. Approximately 300 enrollees were served in the pilot. Enrollees were adults, including the elderly, who had moderate to severe chronic physical illness as well as mental illness.

Further analysis of the population showed not only high rates of co-morbid depression, but significant other physical and behavioral health co-morbidities as well. For example, of the 35% of the target population that screened positive for depression, further assessment indicated that 30% also had bipolar disorder.

Over time, CoAccess modified its entire case management system to focus on the top 2-3% of the enrolled population by cost, becoming patient-focused, rather than disease-focused. Screens for mental illness were incorporated into the physical health disease management strategy.

Services

The mental health services available through the network include case management/care coordination, screening, assessment and treatment planning, counseling/psychotherapy, pharmacotherapy and recovery/peer support services. CoAccess pursued evidence-based treatment of depression in primary care and of bipolar disorder, as well as medication management and evidence-based psycho-social services. It incorporated mental health case management into an existing case management/disease management program for targeted physical health care conditions.

Understanding the Clinical Approach

CoAccess developed the integration initiative as a centralized care management model, rather than as a clinical model requiring significant change at the provider level.

Staff Training

CoAccess provided basic education for network providers to assure that they understood the care management approach being adopted by the plan. Providers were not asked to make changes in their practices, though their active cooperation was welcomed if there was interest. The care management staff employed by CoAccess was trained on the new approach to include mental health/depression care as a part of the care management program. CoAccess reports that some care managers found it difficult to put more of a focus on mental health, and there was some turnover in staff as the department adopted the more integrated approach.

Composition of the Clinical Support Team
CoAccess created care management teams that included RNs, social workers, and resource coordinators. Resource coordinators were non-professional staff who provided "practical" outreach for patients. Some had peer counselor backgrounds (from the mental health system), and some were parents who had developed experience as family advocates. The team leader was generally an RN who was responsible for the team's caseload. As a patient's needs changed, often from a medical to a social work focus, a different member of the team might be given the "lead" role. A psychiatrist and a physician were available to support the team's development and monitoring of a patient's treatment plan.

Clinical Protocols and Treatment Guidelines
The CoAccess model is influenced by experience with Assertive Community Treatment and the Wagner chronic care model. It is also influenced heavily by the plan's experience under the prior MacArthur Foundation project. As experience under the Depression in Primary Care pilot grew, CoAccess made further modifications in the model to better focus case management intervention. For example, CoAccess broadened the scope from a narrow focus on depression to a more patient-centered assessment and treatment plan. There is a significant focus on poly-pharmacy management as pharmacy profiles are developed for each patient and are available to be shared with providers and case management staff. The intent is to complement provider activity, provide support for providers and their "problem" patients, rather than to require the provider to change his or her clinical practice.

CoAccess developed a set of tools to support integration, including building their own care management software, and including screens for depression and other mental health problems into the plan's disease management assessment tools.

Care Management
Care management is the focus of the CoAccess integration model. The screening to identify patients for inclusion in care management is conducted by the health plan, and more detailed assessments are then conducted by centralized staff. Much of the interaction with patients is provided by the care management team over the telephone, though home visits are also made if needed. Care management encourages successful referral and follow-up with treatment. The care management team meets weekly to review patient progress. The software system is used to facilitate communication between the physical and mental health care providers and to allow the care management team to monitor the progress of patients in the program.

Family Involvement
The care management approach includes reaching out to "natural supports." If needed, family interventions are initiated to assist in improved medical interventions. Family system issues are addressed if needed.

Organization of Delivery System and Key Partners
Care management team members, including psychiatric and medical supervisors, are employed by CoAccess. Mental health and physical health care services are provided by clinicians under contract with the health plan. CoAccess has received significant cooperation from providers, which have generally appreciated the health plan providing assistance with patients who are often identified by primary care practices as difficult to manage.

Payment and Funding
As a Medicaid provider for both mental health and general medical health care services, CoAccess received two capitation payments for Medicaid enrollees. The RWJF grant provided $700,000 over a

3 ½ year period to support pilot costs that were outside the capitation. Grant funds were used to create the infrastructure to support integrated care management, including software development, and also supported the dedication of staff time for managing the pilot, training providers and staff and supporting additional care management time.

Since the end of the pilot period, CoAccess has withdrawn as a Medicaid managed care contractor for general medical services (Colorado Medicaid no longer has any managed care plans under contract for general medical services). CoAccess still serves Medicaid enrollees for mental health services and continues to enroll SCHIP and Medicare populations. The Medicare product is a SNP that targets dually eligible enrollees. CoAccess is exploring whether the Medicare capitation under the SNP will allow continued support for mental health integration for dually eligible enrollees.

Technology

CoAccess developed software to support the integrated intake and assessment process and serve as the clinical information system for the care management team. Information on the member's utilization history, including case notes across an episode of care and across product lines, are available to support integrated case management. Clinical logic for improved treatment for clinical conditions, including depression and other mental health needs, are incorporated into a separate decision support system for analysis and trending. This includes support for pharmacy management. The automated care management system is available only to the internal case management team. CoAccess credits much of the success of its program to the significant investment the company made in data and information systems that support this and other projects.

Outcomes

CoAccess experienced strong support from provider sites; in fact, some sites became more engaged and supportive over time and CoAccess began to see some change in culture at the provider level. The state Medicaid program seemed supportive of the pilot initially. However, the general relationship between the state and the managed care plans deteriorated, at least in part over serious disagreements over general reimbursement levels. Within the plan, CoAccess was able to demonstrate significant reductions in emergency room and inpatient hospital visits as well and an increase in provider office visits. These shifts in utilization among the members enrolled in the program led to cost savings as well.

Barriers and Lessons Learned

Funding-Related Barriers

Early confusion regarding what services are included in each capitation had to be overcome. The initial organizational bias was that mental health care management and related medical services needed to be paid for out of the mental health carve out. Analysis of the actual data used to set the capitation persuaded CoAccess that care management should be paid for out of the general medical capitation; in fact, the majority of enrollees at risk for mental health care needs were not traditionally being treated in the mental health system. Also, most of the cost savings from successful integration accrued to the general medical side.

Barriers Related to the Integrated Services Approach

Because a major focus of the initiative was to develop an economically sustainable integration model, CoAccess found that the approach to care management needed to transition to one where the care management team became more focused on where interventions produced the most significant results. It required a change in the health plan's internal culture, both to sharpen the focus to assure cost-effectiveness, but also to overcome the organizational "silos" between mental health and general medical product lines.

Barriers Related to the Target Population
CoAccess found the Medicaid population difficult to contact. State-supplied telephone numbers and addresses frequently were not current.

Other Barriers
Dealing with a wide variety of provider models created early barriers to understanding. In general, providers were very supportive of the care management approach, once they understood what the health plan intended. Early on, one group of providers felt "competitive" about the CoAccess model, concerned that the plan's initiative would interfere with their own clinic-based initiatives. However, the group ended up very comfortable with the plan's selection of patients to enroll in the project. For most providers, only a small number of their assigned patients were enrolled (one of the reasons that CoAccess had found a clinic-based approach to integration financially unsustainable).

The Future
As CoAccess moves into serving a Medicare dually eligible population through the SNP product, it is believed that the model that was developed for the Medicaid population would be appropriate to continue with the SNP enrollees. The SNP enrollees who would be targeted for integrated care management are generally the same population that was enrolled under the Medicaid pilot. In addition, the financial model of reimbursement under Medicare is expected to be more generous than the Medicaid capitation due to the risk adjustment process. CoAccess expects that there is significant opportunity to find savings, especially in hospital costs.

Community Care of North Carolina
Mental Health Integration

Abstract
In July 2005, a collaborative approach to mental health and primary care integration was created by the State of North Carolina in four pilot sites. The goal of the pilots is to overcome inadequate access to behavioral health services and manage the behavioral and physical health needs of Medicaid enrollees served in the Medicaid primary care case management program. The four pilot projects are led by the North Carolina Community Care Network Board, comprised of primary care providers. The state Medicaid clinical director, North Carolina's Local Management Entities and other state and local networks complete the integration initiative. The pilot projects, which are located in both urban and rural settings, all serve adult and pediatric populations and utilize the same standardized model components. All four projects are collecting comparable outcome, performance and cost measures. It is expected that the four integration projects will achieve a cost-effective integrated model for Medicaid that can be expanded and replicated statewide.

Background

Service System

The North Carolina Department of Health and Human Services serves as the umbrella agency for several divisions, among them the Division of Medical Assistance which oversees the Medicaid program and North Carolina Health Choice for Children. Service system options for Medicaid enrollees in North Carolina include Community Care of North Carolina (Carolina ACCESS and Community Care). Carolina ACCESS is North Carolina's Primary Care Case Management Program. Community Care was created to build on Carolina ACCESS through local networks comprised of Medicaid providers who have agreed to work together to manage their enrolled population and implement and support evidence-based best practices, care and disease management and quality improvement initiatives.

The Division of Mental Health, Developmental Disabilities and Substance Abuse is also a part of North Carolina's Department of Health and Human Services. Local Management Entities(LMEs), agencies of local government-area authorities or county programs, are responsible for managing, coordinating, facilitating and monitoring the provision of mental health, developmental disabilities and substance abuse services in the areas served. LME responsibilities include offering consumers 24/7/365 access to services, developing and overseeing providers and handling consumer complaints and grievances.

Description of Implementer

Community Care of North Carolina is the implementer of the integration project which takes place in four pilot sites. Community Care providers are also working in concert with their local LMEs. The LMEs are responsible for a broad range of services, including some case management functions, the monitoring of contractors and measurement of quality impact. The integration pilot projects focus mainly on mental health problems and do not directly address substance abuse or the developmentally disabled populations.

Goals of the Integrated Services Initiative

Problem

In 2001 North Carolina's legislature approved a comprehensive reform plan aimed at improving public services for residents dealing with mental health problems, developmental disabilities and substance abuse. Prior to mental health reform, area mental health programs (i.e., precursors to

LMEs) contracted with outside companies and agencies to provide services. Area programs also provided some services using county employees. As a result of reform activities, LMEs are responsible for managing services, instead of directly providing them using their own employees. Some case management services were allowed to be retained by the county to act as a safety net for consumers with the most complex cases.

Goals of the Integrated Services Initiative

Community Care's mental health integration project goals are:

- Collaboration and partnership between Community Care Networks and LMEs;
- Improved access to primary and behavioral health care;
- Increased communication between the primary care physician (PCP) and behavioral health provider;
- Implementation of a standard format for depression screening, assessment and treatment with the PCPs;
- Evaluation of cost-effectiveness of psychiatric telephone consultation with the PCPs; and,
- Creation of a model that is able to:
    - Integrate care of depression at the primary care physician offices
    - Optimally use the National Council for Community Behavioral Health Care Four Quadrant Model
    - Be sustainable and replicable; and
    - Demonstrate effectiveness of consultation/communication.

Parameters and Constraints

The pilot projects are targeted only to Medicaid enrollees who are identified by the state and paid through Medicaid. The state provides $5 per member per month, $2.50 to the primary care practice and $2.50 to the LME. Grant funds are provided to the four pilots for LME telephone support, data management at the local level and care coordination.

Key Partners

- **North Carolina Department of Health and Human Services** provides Medicaid support for the program.
- **State Office of Mental Health** also provides Medicaid support.
- **Office of Rural Health and Community Care** provides oversight and technical assistance.
- **North Carolina Foundation for Advanced Health Programs, Inc** provide**s** non-profit funds.
- **Community Care Network** represented those practices desiring to collaborate toward quality improvement and mental health integration at the practice level and provided local leadership in the development and implementation of the integrated model in concert with the LMEs.
- **Mental Health Medical Directors** were necessary for action at the community level.
- **Mental Health Providers** participated in the community level implementation.
- **LMEs** partnered with the Community Care network.

Process for Key Partner Involvement

Local chapters of the American Academy of Pediatrics and the Academy of Family Practice were extremely supportive of an integrated model to assist in identification of mental health diagnoses. The state medical society and the hospital association endorsed the integration effort in response to the needs of the membership and created integration as a major component of their annual meetings

for a few years. The Community Care network coordinators gave "Lunch & Learn" presentations and evening socials to familiarize all involved parties.

General Description of Integration Project

The mental health integration pilot is a state-level collaboration between the Division of Mental Health; the Division of Medical Assistance; the Office of Rural Health and Community Care (CCNC Program Office); and the North Carolina Foundation for Advanced Health Programs, Inc.

The four pilot projects are led by the Community Care Network Board, comprised of PCPs, which partners directly with the state. The state clinical directors, LMEs and other state and local networks implement the integration initiative at the community level. The networks aim to assist PCPs in identifying and treating people with depression; improve communication between the PCP and behavioral health care providers; implement psychiatric telephonic consultations; ensure that patients can access care in the system where their needs can be met; and adopt uniform process and evaluation measurements for program evaluation.

The initiative began in July 2005 and is funded until July 2007. The four pilots are:

- Access II Care of Western NC (7 county region, including Buncombe)
- Southern Piedmont Community Care Plan (Cabarrus)
- Central Piedmont Access II (Forsyth)
- Partnership for Health Management (Guilford)

The pilots cover approximately 30%of the counties in North Carolina and approximately 20% of the population. Although the scope of the each pilot depends on the individual pilot, each pilot partners with their LME.

Target Populations

The target populations of the Community Care Mental Health Integration initiative are both the adult and pediatric populations. Cohorts are broken out by age (birth to five years and five years and older). The pilot programs serve a mix of urban and rural areas with a service need for mental health, dual-diagnoses and chronic physical illness. Participating individuals have mild to moderate illness and stable symptoms. Individuals are identified and selected for participation in the initiative through utilization of the PHQ-9 tool, provider screening and diagnostic tools.

Services

Services provided by the pilot programs include all Medicaid covered services necessary for delivery of primary care and mental health services.

Understanding the Clinical Approach

The Community Care Mental Health Integration project was created as a hybrid of Wagner's Chronic Care Model with a focus on primary care delivery with social support. The National Council for Community Behavioral Healthcare's Four Quadrant Integration Model also served as a model to integrate behavioral health services at primary care sites.

The Community Care integrated model begins with universal screening with quick access to high quality, efficient and effective behavioral health services. Behavioral health clinicians are conveniently located within primary care facilities.

Behavioral health services are integrated with primary care through screening, assessment, brief supportive counseling, therapy, case management, medication monitoring and coordinated team care.

Communication is a hallmark of the Community Care model with focus given to addressing patient issues in an understandable manner; a personal introduction with the patient, PCP and behavioral health provider; shared health records; frequent updates among providers; and coordinated follow-up care. Joint meetings with all involved staff at each site occur on a weekly basis to discuss an integrated clinical approach for each patient.

Staff Training on the Clinical Approach
Staff training for the model required "changing the culture" of the primary care and behavioral health practices. Clinician training was conducted with the screening tools. Education for PCPs was needed on various mental health topics, and education for behavioral health providers on common medical conditions. Behavioral health providers were educated on learning the primary care practice language and operations of a primary care practice. PCPs were given learning procedures and communication tools with behavioral health providers.

Composition of the Clinical Support Team
The clinical support teams at the four pilot sites include the following members: PCPs, behavioral health practitioners, registered nurses, mental health social workers, licensed practical nurses and case managers.

Clinical Protocols and Treatment Guidelines
McArthur model guidelines are followed at all sites. Secondary screens are also given to all children and adolescents who might be eligible for the integration program. Clinical protocols and treatment guidelines are heavily influenced by the individual network providers contributing to patient treatment.

Care Management
Case managers are provided by Community Care and a PCP in two pilots is paid to follow-up on each integrated case. A primary care fax form has been developed for the care coordinator in each case for any necessary follow-up.

Family Involvement
The Community Care integration model utilizes a "person centered planning" approach. A parent is always involved in the treatment plan in any pediatric case.

Organization of Delivery System and Key Partners
Community Care has a contract with Medicaid, but there is no contractual agreement with the four pilot sites. The PCP is listed as the provider of record for services, with diagnostic responsibility shared between the PCP and psychiatrist. The PCP employs or contracts with clinicians who carry out the treatment services. Primary care services are provided at the PCP site or behavioral health site, depending on the individual case. A one page, single referral form is used for diagnoses and medication, with a care release form.

Payment and Funding
Medicaid funds support the two year start-up effort with additional funds from the North Carolina Foundation.

Technology
Community Care pilots utilize a 24/7 call center, appointment reminder system and consumer support/information system. Electronic medical records are varied among the four sites. Both primary care and behavioral health systems have access to the state Medicaid claims system, a web-based information system.

Outcomes

Accomplishments to this point have included:

- Ten non-profit primary care practices have benefited.
- Eight different counties in North Carolina have been reached.
- Several new behavioral health therapists have been hired and are working in primary care practices.
- A network of consulting psychiatrists has been established.
- Many training events have been completed.
- Standard measurements have been created across all four pilots.
- Data collected from the PHQ-9 supports the project and the need for additional support.

Barriers and Lessons Learned

Funding Related Barriers

The project is currently funded for only two years and is considered in a "start-up" phase. Additional funds will need to be found to continue the project. The fiscal separation of mental health and primary care services has created funding and billing issues.

Service-Related Barrier

North Carolina faces a shortage of behavioral health providers to serve the entire Medicaid population. Provider access is and will continue to be a barrier.

Barriers Related to Integrated Services Approach

Organizational and professional culture differences exist between the PCPs and the behavioral health providers making the paradigm shift. Clinical and fiscal separation of physical and mental health care is a barrier to integration. Legal barriers exist in order to open communication between providers. A lack of evidence-based guidelines exists for integration models. There are state and private insurance policy restrictions. Client cultural differences are apparent among the two populations.

Confidentiality-Related Barrier

The Community Care integration project success or failure will depend on provider and network relationships at a grassroots level. Provider and network relationships depend on the exchange of information. This has been a huge barrier for the project.

Other Barriers

Mental health reform at the state level has been a barrier to the integration models.

The Future

Future plans for the Community Care mental health integration project include securing additional per member per month funding for the networks and addressing the need for additional case managers. The integration model will be replicated in other networks and will become an integral part of the Community Care's efforts to manage the aged, blind and disabled population (the "Chronic Care Project"). Funding sources from Medicaid mental health will need to be identified, along with rural health.

Community Health Center, Inc., Middletown, Connecticut

Abstract
Community Health Center, Inc. is a multi-site FQHC providing services in nine towns and cities throughout central, southeastern and southwestern Connecticut. Currently four of the sites provide co-located primary care and behavioral health services using a model that embeds behavioral health services within the center's operational framework allowing for seamless service delivery. Individuals identified as in need of mental health services are transitioned to behavioral health professionals who provide services onsite at the center. In its integrated services site, the interdisciplinary physical and behavioral health staff meets daily for a "morning huddle" to discuss caseloads and plan service delivery.

Background

Service System

The Department of Mental Health and Addiction Services administers the state's mental health and substance abuse benefit and oversees administration of the federal block grants. In addition the Department of Social Services, the single state Medicaid agency, manages behavioral health rehabilitative services (implemented by the Department of Mental Health and Addiction Services), behavioral health clinic services and the targeted case management benefit. Eligible mental health agencies can become Medicaid providers of Medicaid Rehabilitation Option, clinic and targeted case management services. The Department of Social Services also oversees the state's FQHC benefit and establishes the prospective payment system under which FQHCs receive reimbursement. FQHCs are eligible for cost-based payment of medical, dental and mental health services provided by licensed professionals. Certain services provided under the Medicaid Rehabilitation Option may be provided by non-licensed individuals who work under the supervision of licensed professionals (e.g., community support and assertive community treatment).

Description of Implementer

Community Health Center, Inc. (CHC) was established in 1972 based on the premise that health care is a right and not a privilege. With headquarters in Middletown, Connecticut, CHC provides primary care, dental, mental health and social services throughout central, southeastern and southwestern Connecticut. Of its nine sites, four have been able to implement co-located primary care and behavioral health services.

In 2005, CHC provided services to 43,000 children and adults. Of those, 30,000 received a medical service, 17,000 received a dental service and 2,500 received mental health services. Of the individuals served, 85% earn incomes less than 200% of the poverty level, 20% are uninsured and 59% represent a racial or ethnic group. Of total patients served in 2005, 11,000 are being treated for a major chronic disease and 3,500 are being treated for a psychiatric disorder.

Goals of the Integrated Services Initiative

Problem

CHC has historically focused on collaboration but found that its patients experienced barriers transitioning across services, including across CHC sites. The clinics' populations include those with major chronic diseases (25% of total population and an even higher percentage of its adult population) such as HIV, AIDS, diabetes and depression, as well as individuals who are homeless, which makes the provision of coordinated services essential.

Goals of Integrated Services Initiative
The primary goal of CHC was to co-locate mental health professionals in the same hallway as medical treatment providers to facilitate a "warm handoff" from primary care to behavioral health services. In addition, CHC wanted to create an environment that facilitated communication among the interdisciplinary service team (i.e., physician, registered nurses and therapists). In short, CHC designed its system to enable accessible and seamless services.

General Description of Implementation Project
CHC developed a plan to implement a test site for integrated services using the quality improvement principles of Plan-Do-Study-Act and established goals for the new model. CHC piloted the services model in its New Briton site and co-located primary medical and mental health services under one roof. Two additional sites have also integrated services (Clinton and New London). The new structure places interdisciplinary staff in "pods" (i.e., proximally located and shared work spaces) to facilitate communication. The services are available to all CHC clients, particularly those with limited English proficiency, HIV/AIDS, homeless and those with disabling physical illnesses.

CHC uses Kaiser's Advance Access Model to guarantee that patients receive primary care services the same day or next day upon request. New clients meet with Access to Care Workers who educate clients on how to use CHC services.

Key Partners
CHC employs behavioral health clinicians including psychiatrists, psychologists and therapists who are available forty hours per week. In addition, CHC may engage in contractual relationships with specialty behavioral health clinicians as necessary. In either case, CHC serves as the provider of record and is responsible for billing, documentation and recordkeeping.

Services
During primary medical care visits patients are screened for depression using the PHQ-9. Patients are transitioned to behavioral health services staff via a "warm hand-off" from primary care staff.

Mental health services such as case management, prevention, screening, crisis/emergency, pharmacotherapy and recovery support are provided at CHC by practitioners including adult and child psychiatrists, psychologists, therapists, nurse practitioners and case managers. In one service location, a physician is certified for the administration of Buprenorphine for treatment of substance abuse addiction.

Understanding the Clinical Approach
CHC does not currently utilize a specific clinical approach for behavioral health but does use a planned services model for medical services, which is based on the principles of Wagner's chronic care model. To facilitate communication among practitioners, clinical notes, including mental health case notes, had been arranged sequentially in medical record so that clinicians can have a broad understanding of services and issues. However, the state licensing authority has concerns about co-mingling mental health and primary care records.

CHC also requires that the interdisciplinary staff meet daily in a "morning huddle" to discuss clients and plan service delivery. The physical location of the integrated service team members in "pods" facilitates communication among staff.

Some clients are also assigned a case manager who provides coordination and support, including ensuring that clients access other ancillary services during their tenure as patients.

Payment and Funding
As an FQHC, CHC receives prospective payment for services provided. The federally established payment arrangements enable FQHCs to recoup more of their costs than other non-FQHC clinic providers. Patient revenues (including public payers) account for approximately 64% of annual funds. The center also receives federal community health center and other grants that account for approximately 36% of funding. CHC utilizes its FQHC billing status to receive reimbursement for mental health services provided. Since services provided by non-licensed mental health staff are not billable as mental health encounters, non-licensed staff salaries (e.g., case managers) are built into CHC's overall costs.

Technology
CHC recently implemented an electronic health record, which combines medical and behavioral health services information into a single record.

Outcomes
CHC has been able to identify the prevalence of depression among diabetic clients using the PHQ-9 and plans to conduct a follow-up assessment to compare results. Additionally, CHC has data showing the incidence of perinatal postpartum depression and can track the number of women screened for depression, the number with a positive screen for depression, and the number of women who are actively engaged in depression treatment.

Barriers and Lessons Learned
One barrier is that current regulations prohibit advance practice registered nurses from dispensing Buprenorphine and only one site is certified to administer the treatment. CHC has learned that while "warm handoffs" are effective, some clients need longer-term solutions and need to be part of a sustained recovery effort. The center is mindful that it may need to offer multiple modalities and is learning from peers about how it can position itself to do that.

The Future
As it continues its integrated services strategy, CHC wants to be able to meet the increasing demand for services. CHC also plans to develop an outcomes tracking and reporting process to measure the effectiveness of its integrated services strategy.

Hogg Foundation Integration Grants, Austin, Texas

Abstract
The Hogg Foundation for Mental Health created a grant program through which primary care providers in Texas are implementing collaborative mental health and physical health care. Grantees include urban and rural/frontier clinics. The target populations vary by site and include children and a largely uninsured adult population. The grant project is testing how primary care providers can overcome real world barriers to effective collaborative care models. Grantees anticipate serving approximately 3,500 individuals per year for 3 years. Grantees received direct funding in June 2006, and the Foundation has contracted with experts to provide technical assistance, including training. A formal evaluation is underway.

Background

Service System

The state authority for mental health and substance abuse services is the Texas Department of State Health Services. The Department of State Health Services is a department within an umbrella health and human services agency known as the Texas Health and Human Services Commission. The Texas Health and Human Services Commission serves as the single state Medicaid agency.

Recent changes in Texas' eligibility criteria for public mental health services narrowed the definition of psychiatric diagnoses that qualify for services in that system. For this and other reasons, a signficant number of people with psychiatric diagnoses seek care in primary care settings. In addition, Texas Medicaid has a very restrictive set of eligibilty criteria for adults, which means that Medicaid is frequently not an available funding source for adults who need mental health services.

For those who do have Medicaid coverage, both physical health and behavioral health services are provided through managed care organizations in the State of Texas Access Reform initiative (STAR) in all of the urban areas and their surrounding contiguous counties. Medicaid enrollees in very rural areas have been served in traditional fee-for-service arrangements, but those areas are transitioning to a Primary Care Case Management model for physcial health care. Acute and long term care services for the aged and disabled are also provided through managed care organizations in Harris County/Houston (STAR Plus). SSI eligible adults in Harris County are required to enroll in STAR Plus, including adults with severe mental illnbess. SSI eligible children have the option to enroll in STAR Plus or to remain in fee-for-service. STAR Plus is being expanded to three additional urban areas in the state.

In STAR and STAR Plus, behavioral health services are included in the managed care capitation rate, but most plans sub-capitate behavioral health to separate behavioral health organizations. For those in rural areas in the Primary Care Case Management model, behavioral health services are available on a fee-for-service basis.

In the Dallas service area (Dallas County and the contiguous rural counties), STAR behavioral health funds have been blended with state general revenue and federal funds for mental health and substance abuse services through the NorthSTAR initiative. NorthSTAR is a population-based insurance model. A single behavioral health organization, Value Options, is responsible for providing behavioral health services to persons meeting the state mental health priority population definition who are under 200% of the Federal Poverty Level.

Description of Implementer

The Hogg Foundation for Mental Health (the Foundation) is an administrative unit of The University of Texas at Austin. For over 65 years, the Foundation has accomplished its mandate

through grantmaking to mental health services, research, policy and public education projects in the state of Texas. The Foundation also operates its own programs, including services research, policy analysis and the Regional Foundation Library.

The grant recipients represent a range of primary care organizations, including community-based health centers that operate within a county health system, a FQHC, a nonprofit pediatric group practice that is wholly owned by a children's hospital and a nonprofit primary care clinic. Grantees are: Bluitt-Flowers Health Center and East Dallas Health Center, Parkland Health and Hospital System in Dallas; People's Community Clinic, Austin; Project Vida Health Center, El Paso; Texas Children's Pediatric Associates – Ripley Clinic, Houston; and Valley Primary Care Network, Harlingen.

Goals of Integrated Services Initiative

Problem

Most people seek help for mental health problems in primary care settings. Some do so because they are uninsured or their insurance does not provide adequate coverage of mental health services. For people in rural settings, the closest specialty mental health clinic can be miles away. Cultural beliefs and attitudes toward mental illness lead some people, especially those in ethnic minority groups, to seek help in medical settings. With the recent changes in Texas' eligibility criteria for public mental health services, people whose psychiatric diagnoses are no longer covered must now seek care in other settings, including primary care clinics.

The Foundation believes that effective integration of mental health services into primary care settings offers an opportunity to provide effective care to Texas' most ethnically diverse and geographically dispersed citizens and to address mental health problems before they become more debilitating and costly to treat.

Goals

The ultimate goal of the initiative is to increase access to effective mental health care in Texas. It is hoped that the grant program will generate solutions to the real-world barriers that hinder adoption of collaborative care. With tested solutions to those barriers, the Foundation will work with organizations around the state to promote adoption of the model. The initiative is relatively new, and its goals have not changed to date.

Parameters and Constraints

The Foundation is relatively small and had limited funds for the grant program. Grantmaking within priority areas and through a Request for Proposals process is a new approach for the Foundation. Uncertainty over how the grant programs would turn out led the Foundation to limit the grant period to three years, which they view as a fairly short period of time in which to implement the model and to test solutions to implementation barriers. The Foundation is prohibited from funding for-profit providers, which limits its ability to promote change in the private sector.

Key Partners

Key partners include the five grantee sites, plus a group of psychiatrists at the University of Washington School of Medicine, which is providing training and consultation in collaborative care. Another key partner is the evaluation team, which is led by a Harvard economist and includes a services researcher and psychiatrist from University of Maryland School of Medicine and a health care consultant based in Austin, Texas.

Process for Key Partner Involvement
Grantees were selected through a Request for Proposals process. The training consultants (University of Washington) were selected in consultation with national experts. Some of the grantees (People's, Project Vida, Texas Children's and Valley Primary Care) are also partnering with specialty mental health providers for the initiative. The Foundation uses a combination of conference calls and in-person meetings to involve grantees, consultants and the evaluation team in the grant program. The Foundation plans to launch a web-based discussion forum for grantees, consultants, evaluators and Foundation staff to exchange ideas and information.

General Description of Integration Project
Target Population
Texas Children's exclusively serves children and adolescents. Parkland exclusively serves adults. The other grantee organizations serve children and adults. All primarily serve general uninsured primary care populations, as well as Medicaid enrollees. With the exception of Parkland's Bluitt-Flowers Health Center, which serves a primarily African American population, the grantee organizations' service populations are largely Latino. Grantees are located in both urban and deeply rural areas of Texas. Individuals in the integration project may have both physical problems and mild to moderate mental health conditions.

Services
In addition to full physical health clinic services, the grantees will provide mental health services, including care management/care coordination, screening, assessment and treatment planning, counseling, psychotherapy and pharmacotherapy.

Understanding the Clinical Approach:
Clinical Model used to affect service delivery
The collaborative care model used is similar to those used in IMPACT (the University of Washington Institute for Health Care study), the MacArthur Initiative and the Robert Wood Johnson Incentives grant program - all of which are versions of Wagner's chronic care model.

Staff Training on the Clinical Approach
The Foundation hired Dr. Jurgen Unutzer and his University of Washington colleagues to train the five grantee organizations. Grantees were introduced to the model by Dr. Unutzer at an in-person kick-off meeting in June 2006. Over that summer, Dr. Unutzer and his team conducted conference calls with the individual organizations to help them get started in implementing the model. A separate conference call with the consulting psychiatrists was also conducted. Dr. Unutzer and his colleagues led a day-and-a-half in-person training for all grantees.

Training was provided with a focus on each team member's role in a collaborative care model (e.g., physician, care manager, administrator) and by grantee team. The in-person training will be followed by monthly consultation calls with the sites to troubleshoot and to increase their skills. Grantees also will be able to pose questions and share lessons learned with each other (as well as Foundation staff and the consultants) through a web-based discussion forum. Foundation staff is considering having Dr. Unutzer and colleagues conduct site visits and/or having grantees visit functioning collaborative care sites to augment their training.

Composition of the Clinical Support Team
The primary members of the collaborative care team are the care manager (a BA- or MA-level mental health staff person), the primary care physician (PCP)/pediatrician, the consulting psychiatrist and the administrator/practice manager.

Clinical Protocols and Treatment Guidelines
Each site is implementing clinical protocols. Screening and assessment tools have been selected and are being formally incorporated into practice. Physicians are being encouraged, but not required, to use medication algorithms. Some sites are also instituting protocols for providing evidence-based psychotherapy or behavior training. Site developed protocols are based on the population or conditions targeted at each site (i.e., ADHD in Texas Children's, depression in adults in Parkland).

Some sites are using cognitive behavioral therapy (CBT) or other evidence-based practices as adjuncts to pharmacy management. The Foundation expects that all sites will use medication algorithms developed by the state (i.e., TMAP). The University of Washington is helping in development of a broader algorithm that addresses additional conditions.

Care Management
Care managers work with patients on treatment adherence, educating patients about their treatment and tracking their adherence over the course of treatment. Care managers use a patient registry to assist in identifying patients who are not adhering to treatment. Care managers troubleshoot with patients who are not adhering to treatment. The consulting psychiatrist is also available for consultation to the care manager, physician or patient as needed.

Patients are provided with education about their diagnosis and treatment. When patients are children, care managers provide families additional empowerment training to help them in their interactions with pediatricians and mental health professionals.

Family Involvement
Families are closely involved in the assessment, treatment planning, treatment monitoring and the treatment itself when the patient is a child. Some clinics have procedures for involving families when the patient is an adult, but the model does not explicitly address that issue for adults.

Organization of Delivery System and Key Partners:
Grantee organizations that partner with specialty mental health providers for psychiatric consultation have written agreements with those organizations. Project Vida, Valley Primary Care and People's have partnered with their local CMHCs for such services. Texas Children's Pediatric Associates has a relationship with its parent organization (Texas Children's Hospital) through which they have partnered with a specialty mental health clinic for both psychiatry and psychotherapy support.

The implementers employ the physicians and care managers. With the exception of Parkland, the implementers contract for psychiatric consultation. Most grantees have had to add staff, though some did not intially plan to do so. For the most part, grantees have added care managers, generally Masters prepared. However, one extremely rural site in the Rio Grande Valley is unable to find Masters prepared care managers and is therefore piloting the use of Bachelor's prepared care managers who have a psychology/social work background. The site is concerned that they may face reimbursement challenges under federal guidelines. In all sites except at Parkland, the use of consulting psychiatrists is new.

For all grantee organizations, behavioral health services are provided at the primary care provider (PCP) site.

Payment and Funding
The total grants budget, across all sites over three years, is $2.6 million. Other program costs, including training and evaluation, are in addition to the grant amounts. Grant funds can be used for operational costs for the integration projects, including salaries, data development and patient

services. Most of the funding is coming from the Foundation's grants to the organizations. The Foundation is considering providing limited funding to the organizations at the end of the grant period (e.g., just for care managers' salaries). A funding challenge is that most adults in Texas are not able to get Medicaid, so Medicaid is not expected to be a significant source of funding.

Technology

The Foundation is supporting the development of a web-based patient registry, in which patients with identified mental health needs are tracked. All grantee sites are using the registry. The entire collaborative care team has access to the system, but the care manager has primary responsibility for entering the patient data and using the registry to track appointments and patient progress.

Outcomes

A process and outcome evaluation is being conducted. The evaluation team will use a formative approach to provide feedback to the grantees and Foundation staff throughout the grant period, allowing for mid-course corrections. Domains will include improved mental health status, improved functioning and quality of life, consumer satisfaction, decreased service utilization (within and outside the clinics), treatment costs and cost offsets. Both quantitative and qualitative data will be collected.

Barriers and Lessons Learned

Service-Related Barriers

The initiative is just getting started, but mental health workforce shortages have already been identified as barriers. The rural sites are having trouble hiring care managers and securing adequate psychiatric consultation time. These workforce barriers also reflect reimbursement barriers. The grantee sites are already concerned about and struggling to figure out how to pay for care management and psychiatric consultation.

Confidentiality-Related Barriers

Confidentiality and HIPAA issues have arisen in the context of the patient registry (in terms of sharing registry information between providers and the training consultants).

Horizon Health Services, Buffalo, New York

Abstract
Horizon Health Services is a state-certified provider of substance abuse and mental health services located in Buffalo, New York. Horizon began providing medical services onsite at several of its CMHC locations in 1987 in order to provide onsite access to medical care and facilitate coordination between substance abuse, mental health and medical services clinicians. While financial constraints resulted in the closure of several of Horizon's medical units, three of its locations continue to offer both behavioral health and primary care prevention, treatment and diagnostic services to behavioral health consumers as well as the general public.

Background

Service System

The New York State of Office of Alcoholism and Substance Abuse Services and the State Office of Mental Health provide funding for and certify providers of SUD and mental health prevention and treatment services. The New York State Department of Health serves as the single state Medicaid agency and is responsible for the enrollment of Medicaid providers as well as the certification of medical services. All three agencies are cabinet-level and leadership reports to the Governor.

There is mandatory Medicaid managed care enrollment for all non-SSI individuals on Medicaid. Enrolled individuals are required to select a primary care physician (PCP). Medical services are provided by qualified providers who contract with Medicaid managed care plans and are paid on mostly a fee-for-service basis. Outpatient mental health services are carved-in to the Medicaid managed care benefit. Providers receive fee-for-service payment for services delivered and CMHCs serve as panel providers. SUD outpatient treatment services are carved out and cost-based payment for Medicaid-covered SUD treatment services is made to Article 28 (DOH) providers by the Department of Health. Other free standing providers are paid a fee-for-service set and established rate.

In Erie County, where some of Horizon's CMHCs are located, a partially capitated Medicaid managed care program – Gold Choice – ensures primary care case management services to individuals who are chronically and persistently mentally ill and or in substance abuse treatment, who have historically experienced poor coordination of care. Horizon participates as a panel provider of Gold Choice and receives a capitated reimbursement rate.

Description of Implementer

Horizon Health Services, a certified provider of SUD and mental health services and a Medicaid provider of medical services, operates eight CMHCs located in northern Erie County and Niagara County (Western New York), with a concentration of services in the cities of Buffalo and Niagara Falls. Horizon is also a primary health care clinic but is not a FQHC.

Horizon serves as a panel provider of behavioral health services and contracts with several of the Medicaid managed care plans in the counties, which are responsible for physical and mental health services for non-SSI Medicaid eligible individuals. Horizon does not contract with one of the plans due to low payment rates. Horizon also contracts with Gold Choice to provide primary medical care services to individuals with mental illness and/or chemical dependency.

Goals of the Integrated Services Initiative

Problem

Consumers with behavioral health disorders often have difficulty accessing timely, appropriate and collaborative medical care in the community. PCPs often have limited knowledge and expertise in

behavioral health disorders sometimes leading to medical management of symptoms (e.g., anxiety, depression, pain) that can be contraindicated with consumers' behavioral health treatment plans and goals.

Goals of Integrated Services Initiative
The initial goal was for Horizon to provide medical services in units at eleven of its CMHC sites as well as at the sites of other community mental health providers. Due to significant financial losses, Horizon provides medical services at three of its CMHC locations. Medical units at other non-Horizon community locations closed in 2000.

Current goals of the integrated services initiative are to:
- Provide on-site access to integrated care for individuals with behavioral health disorders;
- Enable coordination between SUD and mental health treatment providers and medical service providers;
- Provide screening and treatment follow-up for medical conditions associated with mental illness;
- Provide medication for mental illness and SUD; and
- Provide specialty services such as HIV testing and outpatient detoxification services to individuals with behavioral health disorders.

Parameters and Constraints
Ideally, Horizon would utilize its medical services provider status to increase services to the general population, which would enable Horizon to conduct early identification of mental health and addiction disorders (estimated at a 20% need across the population each year) as well as assist in obtaining financial integrity for the organization. However, the general population remains a small portion of the medical services business.

Key Partners
Partners include Gold Choice, Planned Parenthood (which provides specialty medical services for women in Horizon medical units) and DePaul, a mental health services agency which provides Horizon use of a medical unit for delivery of treatment services to DePaul consumers with severe and persistent mental illness.

Process for Key Partner Involvement
Integrated services began at Horizon in 1987 following the decision of senior management and the Board. At that time, Horizon was the only CMHC of its kind to attempt to operate a diagnostic and treatment center. The agency went through required local planning forums (Certificate of Need) as the application went through all levels of review.

The Partnership with Gold Choice resulted from emergence of the organization as the partially capitated Medicaid managed care program for the area. In addition, Planned Parenthood's services are necessary for the female SUD population, which further promotes integration and coordination efforts.

General Description of Implementation Project
Horizon has been providing mental health, SUD and primary care services in its CMHC locations throughout Western New York since 1987. Primary care services were offered in eleven sites and now three CMHC sites have medical units. The initiative serves 500 new patients each year and there are approximately 1,500 patients who are active in the practice. The initiative is a voluntary effort of the management and Board of Horizon Health Services and is implemented on a provider system basis.

Target Populations
Populations targeted for the integrated services initiative include adult and elderly consumers who reside in rural or urban areas of the western portion of the state. Consumers may be mild, moderately or severely impaired by mental illness or addiction and participating individuals may be stable or unstable. Other specific populations served under the initiative have HIV/AIDS, are homeless or are survivors of trauma.

Individuals are identified and selected for participation through the behavioral health intake process. If an individual contacts Horizon and does not have an active relationship with a primary care physician and has not had a physical in the past six months, Horizon will offer the individual an appointment in the medical unit. New consumers who present at the medical unit with complaints or symptoms of mental illness are referred to the behavioral health unit to receive mental health or SUD services.

Services
Mental health services provided to the target populations include: case management/care coordination, screening, assessment and treatment planning, counseling/psychotherapy, pharmacotherapy and day treatment. Evidence-based mental health services provided are: Dialectical Behavioral Therapy, Elderly Depression Screening & Treatment, Family Psychoeducation, Illness Self-Management and Recovery, Integrated Co-Occurring Disorder Treatment, Medication Management and Trauma-Focused Cognitive Behavioral Therapy.

Substance abuse treatment services provided to the target population include: primary care prevention, primary care treatment, specialty care, prescription drugs and diagnostic services. Evidence-based SUD services provided are: Adolescent Behavioral Therapy, Individualized Drug Counseling, Motivational Enhancement Therapy, Multidimensional Family Therapy, Narcotic Antagonist Treatment Using Naltrexone Supportive Expressive Psychotherapy, among others.

Understanding the Clinical Approach
Horizon uses a primary care model that was initially designed to screen, treat and manage medical conditions associated with mental illness and addictions. In addition, many consumers have chronic medical conditions such as respiratory disorders, diabetes and hypertension that require a disease management model.

Staff Training on the Clinical Approach
All new staff participate in a corporate and clinical orientation that reviews the philosophy of treatment and recovery and clinical service delivery standards and practices. Staff that are responsible for specific interventions (e.g., HIV testing, acupuncture, etc.) receive specialized and on going training.

Composition of the Clinical Support Team
Medical services staff consists of a medical director, who is a psychiatrist, as well as a director of medical services, who is a family medicine doctor. The team also includes registered nurses, nurse practitioners, licensed practical nurses and credentialed counselors for HIV and acupuncture. Horizon also employs qualified behavioral health practitioners and clinicians who meet state mental health and substance abuse certification requirements. All medical staff participate in continued education as required by New York State for licensure, including in-services and education from pharmacy representatives, DME suppliers and outside practitioners who have expertise in their field.

Clinical Protocols and Treatment Guidelines
Horizon utilizes formal protocols for physical health evaluations, psychiatric services, HIV counseling and testing, Buprenorphine administration and acupuncture. No formal disease management protocol has been developed, as this is individualized by practitioner, based on individual client responses to treatment and restrictions to treatment and prescribing based on the client's health care plan.

Care Management
The medical staff works with the behavioral health clinical and case management staff to increase compliance with medical follow-up, including making and arranging appointments, referrals and transportation for specialty services.

Family Involvement
Currently there is no process in place to ensure family involvement.

Organization of Delivery System and Key Partners
Integrated services are provided by Horizon's employees and contractors. Horizon staff has diagnostic responsibility and are accountable for billing, documentation, supervision and licensure.

Payment and Funding
As a Medicaid provider of substance abuse treatment services, Horizon bills the Department of Health its cost-based rate. In addition, as a panel provider of both mental health and primary care services, Horizon receives fee-schedule rates for consumers enrolled in Medicaid managed care plans. However, Horizon receives a capitation payment from Gold Choice for SPMI consumers who require case management services. Horizon is also a Medicare participating provider and receives other grant funds to support its $630,000 integrated services initiative budget. Horizon's total budget is $15 million.

Since the advent of Medicaid managed care, fewer Medicaid dollars are available. In addition, since Horizon operates as a Medicaid provider of diagnostic and treatment (medical) services and receives a cost-based rate, it is unable to receive Medicaid reimbursement for both a medical service and a substance abuse treatment service on the same day.

Technology
Horizon utilizes an electronic medical record for behavioral health and is considering the purchase of an electronic medical records for medical services.

Outcomes
Currently, no outcomes data exists on the integrated services initiative.

Barriers and Lessons Learned
Funding-Related Barrier
A significant barrier is that Horizon cannot provide a medical service and a chemical dependency service on the same day and get paid for both. In addition, deficit funding rules in the state prohibit the use of mental health surpluses to cover medical unit deficits even though the deficits resulted from the costs associated with providing treatment and follow-up to individuals with SPMI.

Service-Related Barrier
Another barrier is that even with medical and behavioral health staff in the same organization and in the same locations, staff members tend not to communicate consistently.

Barrier Related to Integrated Services Approach
The target population is extremely expensive to serve and the population requires additional supports. Routine office visits take longer to provide. Additionally, it is difficult to find medical staff willing to work in a CMHC setting providing medical services to the target population. The agency experiences a high no-show rate as well as high rates of non-compliance and follow-up with specialists, medication and diagnostic testing.

Confidentiality-Related Barrier
Horizon experiences difficulty coordinating medical care with outside agencies due to HIPAA.

Other Barriers
The software for scheduling, billing and EMR are different for medical and behavioral health which makes coordination and communication more difficult.

The Future
Horizon plans to stabilize financially and build on its addiction medication specialty (Buprenorphine, outpatient detox) and develop more chronic disease management services for obesity, hypertension and diabetes, which are typical problems faced by Horizon's consumers.

Kaiser Permanente Southern California
Depression Care Program

Abstract
In 2001, Kaiser Permanente of Southern California (KPSC) adopted the IMPACT model of collaborative care for depression, developed by Jurgen Unutzer, MD, MPH, at the University of Washington. KPSC participated in an HMO pilot study with Dr. Unutzer, adapting the program through expansion to adults of all ages, expansion of the provider team to include a medical assistant, availability of a depression class, psychiatric supervision by telephone and training of KPSC staff at all 12 regional medical centers. The pilot study compared 300 "post-study patients" to 140 usual care and 140 intervention patients. Results were collected showing fewer care manager contacts post-study than during the IMPACT Study and benefits of the intervention program were comparable. A study of total health care costs showed a savings of 14% per year during the IMPACT study and an additional 9% for one year post study. This led to dissemination of the program at 12 regional medical centers in KPSC and in one additional region which accessed over 3 million KPSC members.

Background

Service System

California's Medicaid (known as "Medi-Cal") program is the largest in the nation, serving 6.5 million individuals and families statewide. Medi-Cal services are provided by the California Department of Health Services on a fee-for-service basis in all California counties. In 22 of the largest counties, one of three Medi-Cal managed care models are in operation, the county organized health system (COHS), geographic managed care (GMC) and two plan models. Each of these models are in operation in Southern California. Orange and Santa Barbara Counties operate under the COHS model and serve all beneficiaries (including seniors and persons with disabilities); San Diego County operates under the GMC model and Kern, Inland Empire (Riverside and San Bernardino Counties) and Los Angeles County operates under the two-plan model. The GMC and two plan models serve children, pregnant women and other non-disabled populations. Seniors and persons with disabilities continue to receive services under the state's fee-for-service program in these counties. CDHS has proposed expanding managed care to additional populations and counties.

Description of Implementer

Kaiser Permanente is America's leading integrated health care organization. Founded in 1945, it is a nonprofit health plan, with headquarters in Oakland, California. Kaiser Permanente serves the health care needs of members in nine states and Washington, DC. As of December, 2005, there were 8.4 million voluntarily enrolled members in Kaiser Permanente.

KPSC had a membership of 3,125,072, as of December 2005, serving the California counties of Coachella Valley, Inland Empire, Kern County, metropolitan Los Angeles/West Los Angeles, Orange County, San Diego County, the Valleys, Tri-Central and western Ventura County.

KPSC is an all inclusive health care system providing mental health, chemical dependency, primary and specialty care, etc. Behavioral health services are a full part of the integrated health care plan. Insured members receive care in adult, pediatrics, ob-gyn, and a variety of medical specialties. The majority of KPSC's revenue is constituted by employer groups, private pay, Medicare and Medicaid funds.

Goals of the Integrated Services Initiative

Problem

The US Preventive Task Force Services recommendations were released with a recommendation for depression screening to occur where treatment pathways exist and are focused where care management needs to be in place, in the primary care setting. Purchasers and accreditation agencies were advocating for effective depression programs in large programs based on evidence-based guidelines. KPSC, as a member of a consortia of large health plan and non-profit agencies, released recommendations that chronically ill patients should be screened and treated for depression.

Goals of Integrated Services Initiative

A strategic plan and goals for the program began in 2001 for KPSC to systematically identify and effectively treat all members with depression using evidence-based guidelines to avoid complications, and to improve their health, productivity and quality of life.

One of the goals is that within six months of a depression diagnosis, 67% of depressed KPSC members will show significant improvement, as reflected by changes in the PHQ-9 or GDS score. Treatment, as appropriate, would occur as an extension of primary care/care management, in conjunction with behavioral health. KPSC would seek to attain/retain the 90th percentile in national measures and reviews. The initial focus will be on, but not limited to, members with cardiovascular disease and integrated care processes across populations.

Parameters and Constraints

The initial focus of the project was mild to moderate depression in adults with co-morbid cardiovascular disease. The project also experienced limits in provider access and follow-up appointments with some resistance to integration and cross-training. The provider scope of practice presented challenges for a licensed social worker and a registered nurse practitioner versus a medical doctor.

Key Partners

- **UCLA – RAND Institute** – Academic institution for research and consulting.
- **Disease Management Association of America (DMAA)** – KPSC attended DMAA's Leadership Forum 2004 and utilized DMAA symposium and journals.
- **Kaiser Permanente** – National Research Division developed evidence-based guidelines and clinical practice guidelines.
- **IMPACT Study –**Dr. Unutzer of the University of Washington, lead researcher of the IMPACT study.

Process for Key Partner Involvement

The process for involvement of key partners included informal discussions of interested parties with mutual interests, face-to-face consultations and stakeholder forums.

General Description of Implementation Project

In 2001, KPSC began the process of implementing a modified version of the IMPACT model of collaborative care for depression, developed by Dr. Jurgen Unutzer at the University of Washington. The implementation is ongoing and expanded to all of the Southern California Region. Participation in the program is strongly encouraged by Regional Leadership, however, not mandated. The 2006 target for initial patient screening with the PQ-9 tool is 40,000 with the scope of the project being the Southern California Kaiser Permanente Regional Membership. The KPSC Depression Care Management Program serves as the lead of the integration initiative.

Target Population
The initiative serves adults with chronic physical illness and non-critical mental health service needs. The geographic area is urban. Target populations are identified by utilizing Kaiser Permanente databases from pharmacy and diagnostic coding identified as CVD patients for screening.

Services
The KP Depression Care Program treatment model is a collaborative stepped care program that utilizes a depression care manager along with the patient and primary care physician (PCP). Patients are offered problem solving treatment or medications as a first step in treatment. Education regarding depression, medication effects and side effects, and behavioral activation are all part of each patient's treatment. The patient is monitored closely using the PHQ-9 scale for depressive symptoms and the treatment plan is evaluated regularly to assure new plans are developed as needed. A relapse prevention plan is developed when the patient is in remission to assure long term care compliance.

Understanding the Clinical Approach
The IMPACT Depression Care Model was used to effect service delivery. IMPACT is the largest randomized controlled treatment trial for late life depression. In the research study, of the 1,800 patients 60 years old and over, half of the enrolled study participants received IMPACT care and the other half received the care that they would usually receive in their primary care clinic (including referral to specialty mental health care). The results showed that the IMPACT model of depression care more than doubled the effectiveness of depression treatment for older adults in primary care settings.

Results of analyses of other data have shown:

- More patients in the intervention group received depression care, as compared to those in usual care;
- Physical functioning steadily declined in usual care patients, while physical functioning improved in the patients receiving IMPACT care;
- As depression decreased, so did arthritis pain and functional limitations; and
- The results were equally effective with the young old, as well as patients over 75.

Data from the survey conducted one year after IMPACT resources were no longer available showed that benefits of the IMPACT intervention persisted after one year.

Staff Training on the Clinical Approach
A two day training program was used to train staff on understanding and using the clinical model. One session was conducted for Care Manager, Level 1 Care, and one session for Level 2 Mental Health Care Managers. In addition, a manual for care has been developed as the focus of the training. There are also monthly follow-up calls for all staff to discuss implementation and consult on cases. National training was also made available through the Hartford Foundation.

Composition of the Clinical Team
Level 1 team members are existing care managers for cardiovascular disease, generally registered nurses. Level 2 team members are mental health providers and registered nurse practitioners who are available to provide care to those who do not respond to the initial treatment, as well as offer problem solving treatment to patients. The patient's PCP is actively involved and kept informed of the patient's progress. In most clinics it is the PCP who makes the initial diagnosis and prescribe the antidepressants, while the Level 1 and 2 team members provide behavioral psychotherapeutic support and follow-up. Where the Level 2 provider is a licensed nurse practitioner, he/she may

provide and monitor initial antidepressant medications per protocol. Psychiatrists are available for consultation and treatment of the most severely depressed, complicated or difficult to treat patients.

Clinical Protocols and Treatment Guidelines
There are specific clinical guidelines written with protocols that are formal and some variations depending on the clinic of implementation. The plan is to keep these evidence-based guidelines in place.

Care Management
A self-management approach using behavioral health activation and problem solving therapy is utilized, along with case management staff and member health education classes. Care managers correspond between primary care and behavioral health with use of registry databases and medication monitoring information.

Family Involvement
Family involvement occurs on a case-by-case basis, if appropriate.

Organization of Delivery System and Key Partners
KPSC is the implementer of the Depression Care Program and listed as the provider of record for services rendered. KPSC also holds full diagnostic responsibility. Each Medical Center has signed a Service Agreement delineating the KPSC Depression Care Program goals and areas of responsibilities. All clinicians are employed by Kaiser Permanente and the IMPACT staffing model is used to deliver the Depression Care services in the primary care outpatient setting. The integrated services are all delivered within the primary care setting.

Payment and Funding
The Depression Care Program is supported by Kaiser Permanente and fund sources may be used for start-up and/or operations. Through an increased identification of newly diagnosed Medicare patients, an increased reimbursement of $11 million was realized by KPSC.

Technology
Electronic medical record, appointment reminder system, consumer/support/information, automated registry and decision support are all technologies used under the initiative to access and expedite service delivery. Level 1 and Level 2 clinicians and coordinating staff have access to information/technology. Other technologies available for the use in the Depression Care Program include the IMPACT website, KP Health Connect, KP Point Database and KP e-referral.

Outcomes
The KPSC Depression Care Program has collected PHQ-9 scores over time, as well as clinical evaluation information for identification/diagnosing of major depression and appropriate Medicare coding, and the use of HEDIS guidelines.

Barriers and Lessons Learned
Regulatory Barriers
The KPSC Depression Care Program has not encountered any regulatory barriers.

Funding-Related Barriers
Funding for the initiative had to be offset by appropriate coding for Medicare reimbursements.

Service-Related Barriers

KPSC experienced some resistance to integration by Population Care Management in each Medical Center as a result of other competing initiatives simultaneously being implemented, increasing the workload on care managers. The lesson learned was to deliver progress reports to senior leadership within each medical center.

Barriers Related to Integrated Services Approach

- The lack of sufficient training of staff indicated the need for early, effective training programs.
- Additional FTE's are needed to implement the program, with additional reimbursement of staff time.
- Staff resistance to using the IMPACT website was shown, as it was perceived to be time-consuming. Website enhancements were made to accommodate Kaiser Permanente documentation and to make it more efficient.
- The integrated services initiative was not an organizational clinical strategic imperative, though it was a clinical strategic tool. This impacts level of prioritization.
- It was difficult to recruit and retain Level 1 and Level 2 staff. On-the-job training of existing staff was necessary to make the initiative successful.
- Staff had apprehensions about suicide risk assessments. The need to provide clear guidelines for appropriate interventions and clear protocols for immediate safety measures was a lesson learned.
- A low response was received to the initial patient mailers of the PHQ-9 questionnaires. KPSC began shared meetings to discuss best practices to overcome barriers to outreach.

Confidentiality-Related Barrier

Medical records staff held initial concerns and reluctance to including mental health documentation within the primary care record, including placement of the PHQ-9 questionnaire in patient's charts. Early involvement, education and training has helped to alleviate concerns of the medical records staff.

Other Barriers

Sufficient staffing is a crucial component of the integrated service initiative. Some labor-management restrictions on hiring place barriers on the program.

The Future

KPSC's ultimate goal is to systematically identify and effectively treat *all members* with depression, using evidence-based guidelines to avoid complications, and to improve their health, productivity and quality of life.

Massachusetts Behavioral Health and Primary Care Integration Projects

Abstract
The State of Massachusetts selected six behavioral health care/physical health care service integration demonstration sites in 2005. Project sites, formed under the auspices of the Medicaid-serving Massachusetts Behavioral Health Partnership, represent partnership proposals between FQHCs, CMHCs and other local Massachusetts networks. Full implementation is anticipated in early 2007, and is expected to target improved service delivery in both primary care and behavioral health specialty care settings, with an emphasis on evidence-based practice and principles of recovery.

Background

Service System

The Department of Mental Health is the State Mental Health Authority in Massachusetts. The Department of Mental Health is one of several Executive Office of Health and Human Services agencies. The Department is separate from the Medicaid agency (also housed within Health and Human Services); however, it has oversight and contract responsibilities for members needing behavioral health services through the Medicaid MassHealth Primary Care Clinician Plan. The Primary Care Clinician plan carves out its behavioral health (mental health and substance abuse) services to the Massachusetts Behavioral Health Partnership.

The authority for the management and delivery of substance abuse services is the Bureau of Substance Abuse Services. The Bureau of Substance Abuse Services is a bureau within the Department of Public Health, which is the Department of Mental Health-sister agency of the Executive Office of Health and Human Services. The Department of Mental Health, the Department of Public Health, and Mass Health/Division of Medical Assistance report to the Assistant Secretary for Health at Health and Human Services. They are not cabinet level agencies or bureaus.

In Massachusetts, MassHealth members have the option of enrolling in four non-profit MCOs, or in the MassHealth operated Primary Care Clinician Plan. Primary Care Clinician Plan enrollees have automatic enrollment in the MassHealth Behavioral Health carve-out. Dual eligibles typically remain in non-managed care. The Primary Care Clinician Plan serves clients across the state; the four MCOs provide primarily regional services, one MCO provides statewide services primarily through CMHCs and one provides some services in other parts of the state.

Because of the Primary Care Clinician Plan carve-out currently managed by the Massachusetts Behavioral Health Partnership, Massachusetts is often considered a "carve-out" state. However, in Massachusetts publicly funded behavioral health services are also provided through: fee-for-service for members in non-managed care; a carve-in arrangement with two MCOs; and partial carve-in with two MCO's that contract with external companies to manage their behavioral health service benefits.

Of note, the Massachusetts Behavioral Health Partnership manages statewide delivery of behavioral health for 14% of the total MassHealth population of over 1 million members. In 2003, the PCC Plan served 382,687 members, of which 128,372 received behavioral health services through the Massachusetts Behavioral Health Partnership. The Massachusetts Behavioral Health Partnership manages 79% of the behavioral health care of the population in the four MCOs and the PCC Plan.

Description of Implementer
The Massachusetts Behavioral Health Partnership (MBHP) has been the vendor responsible for the delivery of managed behavioral health care for the MassHealth Primary Care Clinician Plan since 1996.

The six Massachusetts integration projects were implemented by the MBHP beginning in Fall 2006. Participation by MBHP is not mandatory; however, MBHP receives a performance incentive bonus for serving as the project implementer. Participation by all of the site partners was optional.

At the demonstration site level, all demonstration site Community Health Centers (CHCs) are FQHCs and four have 340 B pharmacies. Of the six CHCs, one CHC also provides mental health services and primary care based Buprenorphine treatment for opioid addiction, and one CHC provides a full range of behavioral health services, e.g. both mental health and substance abuse services. All CMHCs are comprehensive mental health centers (offering a full range of mental health and substance abuse services). Five of the participating CMHCs own and operated Emergency Services Programs contracted through MBHP.

The six integration demonstration projects are taking place in cities across Massachusetts. Projects take place in the following regions:

- Site I: Western (Holyoke)
- Site II: Central (Worchester)
- Site III: MetroWest (Framingham)
- Site IV: Southshore (Quincy)
- Site V: Northshore (Glouchester/Ipswich)
- Site VI: Southeast (Fall River).

Goals of the Integrated Services Initiative
Problem
The Massachusetts Executive Office of Health and Human Services and the Department of Mental Health (EOHHS/DMH) have identified the need to strengthen and to improve the ability of the community-based delivery system to provide effective and quality health care services to publicly-aided patient populations at an affordable price. EOHHS and DMH are both interested in supporting innovative programs and identification of treatment practices for individuals with physical as well as mental health and/or SUD.

There was particular interest on the part of EOHHS and DMH to include essential community providers. CHCs and CMHCs play an integral role in this process. CHCs and CMHCs often work in the same communities, serve similar populations (e.g., low-income, diverse ethnic and immigrant communities, the uninsured) and often share patients. Yet, CHCs and CMHCs vary in the level to which they have created processes to work closely together to coordinate physical and behavioral care for those shared patients, streamline referral processes, reduce redundancies in services offered, and work to assure that clients and patients receive the right service, from the right provider, at the right time. Mental Health and Substance Abuse Corporation of Massachusetts framed the relevant issues and built support in the Administration and partnered with MassLeague. Its members had previously identified the need to bridge behavioral and physical health in the two community based safety net systems, CMHCs and CHCs.

Goals of the Integrated Services Initiative
The initial goals that EOHHS/DMH wanted the proposal to address were:

- Increase the systematic identification and treatment of behavioral health disorders

- Increase the capacity of primary care providers (PCPs) to identify and treat behavioral health disorders
- Increase the number of appropriate referrals to specialty providers
- Institutionalize the use of evidence-based practices in the treatment of behavioral health disorders
- Demonstrate the use of principles of recovery across all aspects of the demonstration project
- Increase system efficiency

In May 2005, MLCHC and MHSACM, with assistance from the UMass Center for Health Policy and Research (CHPR), developed a guidance document for six demonstration project site partners. In addition to addressing EOHHS goal areas, the RFP also asked respondents to:

- Address both regional and organizational needs
- Improve coordination between behavioral health and PCPs (e.g., identify and remove operational barriers to collaboration)
- Foster innovation in the delivery of behavioral health and medical services
- Consistently apply clinical guidelines and/or evidence-based practice in the identification and treatment of behavioral health disorders
- Provide linkages and access to local services
- Use data driven decision support tools
- Use quality improvement principles
- Use a logic model approach to respond to the RFP that includes an evaluation plan

Parameters and Constraints

The following are overarching constraints that affect each of the six integration projects:

- CMHCs are unable to access the uncompensated care pool to treat the uninsured within the CMHC setting.
- DPH and MassHealth regulations require that all mental health care plans be reviewed by multi-disciplinary teams. This requirement must be met for all care plans, regardless of the severity of the client's needs, or case complexity. This requirement represents a financial burden to both CMHCs and CHCs (for those CHCs providing mental health services). This requirement overrides the clinical judgment of the clinician as to when a multi-disciplinary review is needed.
- Disparity exists in how MCOs serving MassHealth administer the Community Support Program (CSP). The CSP program provides short-term services that support mental health, physical health and substance use service integration. CSP services also enhance the patient's likelihood of engaging in behavioral health treatment(s) and services by providing services such as transportation, assistance in applying for entitlements, and some physician-to-clinician communication. The MBHP, the MassHealth carve-out serving the MassHealth Primary Care Clinician Plan, has modified its CSP enrollment criteria to meet the needs of the six demonstration sites. The four MCOs serving MassHealth members have not similarly changed their CSP criteria. MassHealth members under fee-for-service, primarily members who are elderly and/or disabled, and the uninsured are ineligible for CSP services. The four MCOs are currently considering adapting their CSP programs to meet the needs of the demonstration projects.

- There is a lack of site-based infrastructure to support integration, e.g., interoperable health records, other technology for information sharing between participating demonstration sites is being hindered by IT capacity being in various stages of readiness.
- The existence of HIPAA regulations regarding confidentiality and the sharing of health information.
- There is a lack of reimbursement for physician to clinician consultation time.
- There is a lack of reimbursement for clinician to physician consultation time.
- There is a lack of resources, such as staff and time, to support analytic functions and activities.
- There is a need for clarity regarding behavioral health billing issues, e.g., codes for psychiatric consultation services.
- There is a need for physician and clinician training regarding treating clients/patients with behavioral health issues and/or medical co-morbidities.
- Demonstration sites received funding in the amount of $70,000 per site for the first year of the demonstration but funding for future years has not been secured yet.
- There are site-specific barriers regarding how DPH licenses and approves the use of waiting room space for purposes of co-location.

Key Partners

The six demonstration site partners serve as the key partners in the integration initiative:

- Holyoke Health Center and Behavioral Health Network – HCH is a FQHC that provides primary care. BHS is a CMHC.
- Family Health Center and Community Health Link – FHC is a FQHC that provides primary care and behavioral health services (mental health and SUD). CHL is a CMHC.
- Framingham Community Health Center (FCHC), Advocates, Inc., South Middlesex Opportunity Council (SMOC) and Wayside Youth and Family Support Network – FCHS is a FQHC that provides primary care; Advocates, Inc., South Middlesex Opportunity Council (SMOC) and Wayside Youth and Family Support Network are behavioral health organizations providing clinical, residential, and homeless services.
- Manet Community Health Center and South Shore Mental Health – MCHC is a FQHC that provides primary care. SSMH is a CMHC.
- North Shore Community Health, Inc. and Health and Education Services, Inc. – NSCH is a FQHC that provides primary care. HES is a CMHC.
- Health First Health Center and Stanley Street Treatment Center and Resource, Inc. – Health First is a FQHC primary care provider. SSTAR is a FQHC primary care provider and a CMHC.

Process for Key Partner Involvement

MLCHC and MHSACM identified six pairs of CHCs and CHMCs to develop demonstration projects according to the parameters defined in the guidance document. These pilot partners were chosen based on their geographic representation; demonstrated desire and experience in working together to provide care; interest in participation in a demonstration project to improve care coordination between their sites; and, longstanding excellence in caring for MassHealth members and the uninsured.

The prospect of multi-year funding served as an additional incentive for sites to work together to develop and implement demonstration projects.

General Description of Implementation Project
There have been two project phases. In the first phase, responses were submitted in December 2005. Due to lack of funding, limited progress was made in implementing the projects, but strategic alliances were formed and operational barriers were addressed. With the receipt of Year One funding, July 2006 sites were asked to resubmit their proposals. Sites are now receiving feedback on their proposals and will begin full implementation.

Site I – Holyoke Health Center/Behavioral Health Network: Building upon an existing co-location model, this proposal expands recent work conducted as a RWJ Depression Study site. This proposal's primary aim is to increase access to mental health services for the Latino population living in Holyoke. Other aims include improving site based integration, facilitating smooth transitions from medical to behavioral health services, and enhancing the capacity of PCPs to maintain low-mental health need patients with consultation from mental health supports. The use of Community Service Providers (CSPs) as a means to address interim mental health service needs is central to the proposed integration project.

Site II – Family Health Center of Worchester/Community HealthLink: CHL and FHC propose to create a collaborative care model for opiate addiction services. Each site-partner currently provides Suboxone treatment for opiate dependence. While CHCs and CMHCs have been successful providing services within their respective spheres, no site is currently able to offer seamless, comprehensive services to meet these patients' needs. This proposal aims to create an integrated intake and assessment system designed to move patients quickly through the entry process and match them to the full range of services they require using a care coordinator position staffed by a certified mental health provider and using a CSP provider for non-clinical case management services.

Site III – Framingham Community Health Center/Advocates, Inc./Wayside Youth & Family Support Network: This proposal aims to address the unmet need for timely access to integrated behavioral health and primary care services provided to low-income and/or uninsured people. Multiple approaches will be used to achieve this aim. These approaches include:

- Improving integration through developing secure e-mail systems that will support HIPAA compliant cross-provider communication; developing an electronic health record available to both primary care and behavioral health clinicians;
- The use of a bi- or tri-lingual behavioral health navigator; and
- Continued provision of psychopharmacology and psychopharmacology consultation services to shared clients, funded through other grants.

Site IV – Manet Community Health Center/South Shore Mental Health Center: This proposal aims to integrate primary care and behavioral health services for the consumers at the two sites. To meet this aim, the proposal includes the following core components:

- Behavioral health care navigators will be on site at two Manet health care sites on a scheduled basis, functioning as members of the primary care teams providing consultation, brief psychiatric assessment and treatment;
- Utilization of screening tool;
- Implementation of a structured referral process to care at SSMH's outpatient clinics or through home-based treatment;
- Development of an electronically based communication system between the medical and nurse practitioners of SSMH and Manet;
- Embedded behavioral health clinicians;

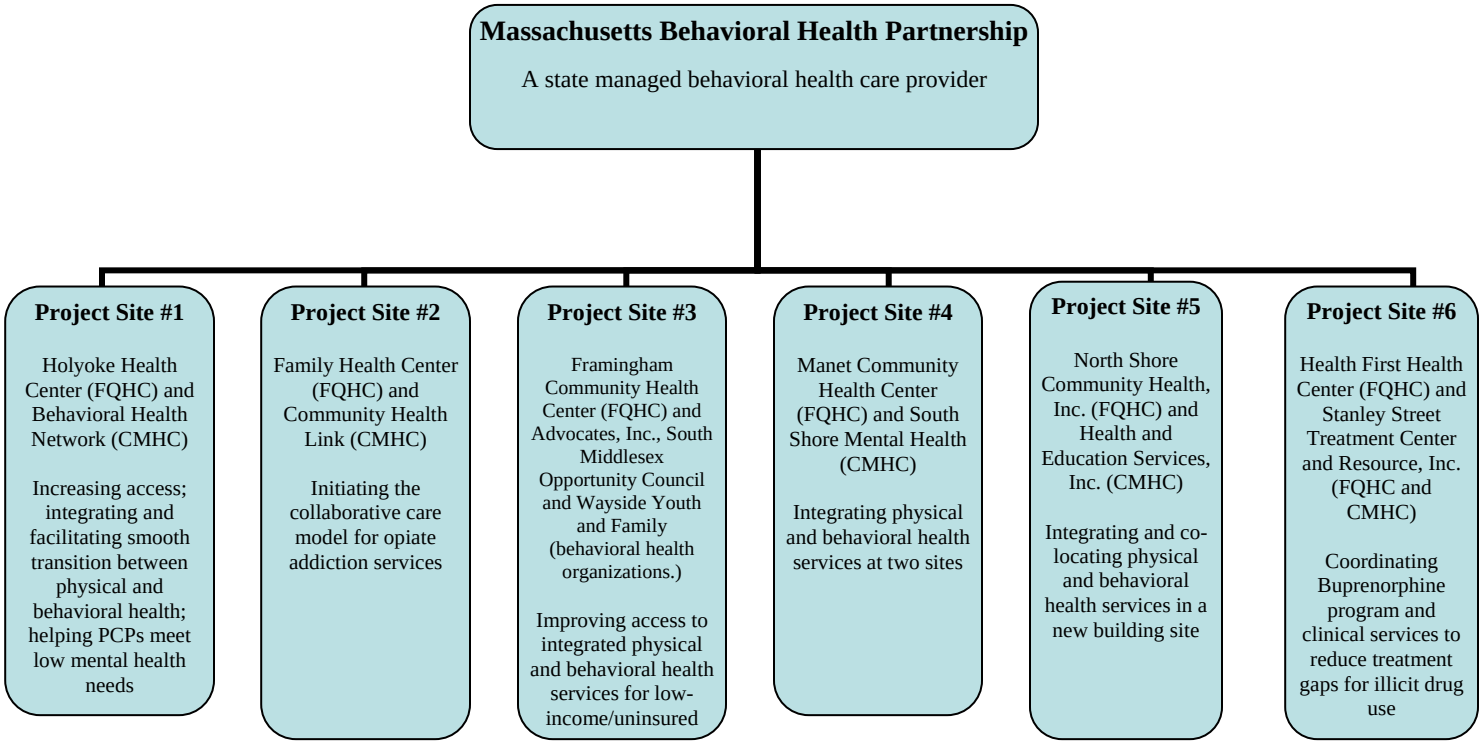
- Care monitoring and chronic disease management for chronic psychiatric conditions that can be effectively managed in the primary care setting, such as less complicated cases of depression;
- Cross-site training emphasizing the importance of care integration; and
- Use of CSP providers for non-clinical case management.

Site V – North Shore Community Health Center/Health and Education: Currently, the site-pairs are working to develop a co-location plan to integrate behavioral and physical health services at a new building that will house both the CHC and CMHC. The co-located model will use funding to hire a project manager to facilitate the development and implementation of administrative and clinical systems and processes to support the operational integration of primary and behavioral health care delivery.

Site VI – Health First Family Health Center/SSTAR: This proposal aims to reduce the treatment gap for illicit drugs and increase access to opioid treatment by implementing a new HFFHC Buprenorphine Program that will coordinate with SSTAR's existing Buprenorphine program and its clinical services. Of note, HFFHC provides primary care services, while SSTAR provides both primary care and behavioral health services. To meet this aim, the proposal includes the following components:

- Patients will receive induction services at SSTAR and then the primary care clinicians will manage addiction at HFFHC as a chronic illness;
- Systematic substance abuse screening of CHC patients at both sites;
- Individual and group counseling, education in relapse prevention, and life skills training for Buprenorphine Program members; and
- Use of CSPs for non-clinical case management services.

Figure 1. Massachusetts Behavioral Health Partnership



Target Population
Target populations for the initiative include adults, male/female, urban/rural, mental health, with service needs of mental health substance abuse treatment, dual-diagnoses and chronic physical illness. The projects will serve all ranges of severity of need, level of symptom stability and the following populations: HIV/AIDS, homeless, trauma-informed and specific cultural groups.

Site I – Targets Latino patients with unmet mental health needs in general and symptoms of depression in particular.

Site II – Targets patients/clients seeking opioid treatment services.

Site III – Targets uninsured primary care patients with unmet behavioral health needs. Also targets all primary care patients regardless of insurance status in order to provide the right care at the right time for behavioral health needs.

Site IV – Targets shared patients with SPMI and chronic health needs. Also targets all primary care patients regardless of insurance status in order to provide the right care at the right time for behavioral health needs.

Site V – How/which populations will be targeted is one focus of the demonstration project.

Site VI – Targets patients/clients seeking opioid treatment services.

Services
Services included in the integration initiative for mental health include case management/care coordination, prevention/early intervention, screening, assessment and treatment planning, counseling/psychotherapy, crisis/emergency services, pharmacotherapy, recovery/peer support services and day treatment.

Substance abuse services cover case management/care coordination, prevention, screening, assessment and treatment planning, psychosocial intervention, pharmacotherapy and patient engagement and retention.

Physical health services include case management/care coordination, primary care treatment, prescription drugs and laboratory services.

Site I – The target population will be any client/patient of BHN or HHC who has both medical and behavioral health needs. HHC currently serves 17,000 patients. BHN serves 11,538 clients.

Site II – The capacity at any one time to treat patients through the Buprenorphine treatment program will be 270. Should regulations be changed that cap the number of patients a physician can treat, this capacity will increase commensurately.

Site III – Targets 60 uninsured clients, many of whom speak Portuguese or Spanish. Targets patients of the Framingham FHC identified by the primary care physician as needing further behavioral health assessment and/or services. This project targets clients in mental health residential care and the homeless shelter.

Site IV – Based on the administration of the CMDQ case finding tool,, 49% of MCHC clients scored affirmatively for the general possibility of psychiatric disorder. MCHC and SSMH share approximately 200 clients with SPMI and chronic health needs.

Site V – With full staffing, NSCH anticipates providing primary care to approximately 9300 patients with encounters totaling approximately 18,000 annually. HES expects to provide behavioral health services to approximately 500 patients associated with the new health center.

Site VI – HealthFirst provides approximately 24,000 dental and primary care visits/year. SSTAR provides 44,000 dental, primary care and WIC visits/year. Both serve a region with a population base of nearly 100,000 individuals that has the most heroin traffic and heroin use in the nation.

Understanding the Clinical Approach
Several models of physical and behavioral health care coordination are being tested in this demonstration project and include:

- Use of Behavioral Health Navigators (BHN) to provide referrals, coordinate care (and support services), and provide follow-up --Sites III and IV;
- Co-location model (CHC and CMHC clinical staff working in shared space) – Sites I and V;
- Operational systems integration between CHCs and CMHCs in the provision of Buprenorphine treatment for opioid dependence – Sites II and VI;
- Expansion of RWJ Depression in Primary Care Project – Site I;
- Sites IV and V also incorporate the NCCBH Four Quadrant Integration Model.

Staff Training on the Clinical Model
Sites have not yet submitted implementation models.

Composition of the Clinical Support Team
Each of the six projects will use a mixture of varying types of clinicians from primary care clinicians (physicians, nurse practitioners, and physician assistants) to behavioral health clinicians (psychiatrists, psychologists, social workers, addiction specialists) to community support providers (usually BA level training or equivalent community expertise).

Clinical Protocols and Treatment Guidelines
Site I – Depression screening using the PHQ-9; referral to a depression care manager for further assessment and referral.

Site II – Buprenorphine intake and assessment system using a care coordinator position staffed by a certified mental health provider.

Site III – 60 uninsured patients have been identified at the Framingham Health Center as needing behavioral health services; primary care patients identified through physician assessment will be referred to a behavioral health navigator.

Site IV – Utilization of screening tools; behavioral health navigators function as members of the primary care teams providing consultation; brief psychiatric assessment and treatment; referral to other behavioral clinicians; using claims, program referral or self-referral, with an additional focus on 200 shared clients with SPMI and chronic medical conditions.

Site V – Process to be developed as core portion of this demonstration project.

Site VI – CAGE-AID to all patients at initial or annual physical; social worker conducts further screening and assessment and referral; coordination of Buprenorphine treatment between treating PCP and clinical staff using structured forms and other communication methods.

Care Management
In general, the demonstration sites are focusing on care integration and the use of Community Support Program staff to provide short-term support individuals in managing physical and behavioral health conditions.

Family Involvement
Family involvement is not currently a prominent component of any of the six demonstration projects.

Organization of Delivery System and Key Partners
Each of the demonstration sites is responsible for its own billing, documentation/recordkeeping, supervision, certification/licensure. These activities take place within their usual day-to-day operations and contract requirements.

Demonstration project grant funds are dispersed by MBHP and the Office of Community Programs at the UM Medical School according to a budget approved by the project.

Diagnostic responsibility is shared in three sites, a FHC at one site, HealthFirst at another, and one site is yet to be determined through their demonstration project.

Each demonstration site employs clinicians who carry out treatment services. Each site will refer applicable patients/clients for CSP services. MBHP contracts with vendors to provide regionally based CSP services. In some cases, the CMHC site partner is also the CSP vendor.

Integrated services are provided at all sites.

Payment and Funding
The total initiative budget includes $70,000 in private grants; Medicaid reimbursement for covered services; the uncompensated care pool as applicable; and the Commonwealth Health Care Plan. Fund sources may be utilized for start-up, capital or operations.

Demonstration sites were asked to submit proposals by December 2005 that would be funded for up to three years. Demonstration sites learned in January/February that funding for the proposals had not yet been secured. Year One funding to support the demonstration projects was not identified until June 2006. Continued funding for Year Two and Year Three has been applied for, with an uncertain outcome.

External grants providing one-time, one-year funds totaling $70,000 per demonstration project ($420,000) are being awarded. These funds do not include the funds for MBHP's performance incentive, or funds for CHPR's team to conduct evaluation activities. The Massachusetts Essential Community Providers Fund has been approached for Year Two and Year Three funding.

The revised 2006 RFP specifies the need to demonstrate ongoing sustainability in such a way that proposed coordination activities between behavioral health and PCPs will go on after grant funding ends.

This project relies on one-year grant funds, third party, contract and private sources. Additional EOHHS support to the project is being provided through a performance incentive to MBHP to serve as project manager, and through the use of the existing EOHHS/UMass contract to retain CHPR's team as the project evaluator.

Technology
Site I – Patient Electronic Care System (PECS) used for patients with depression at the CHC.

Site II – Technology is not a core component of this project.

Site III – CHC and CMHC are developing an electronic health record available to both primary care and behavioral health clinicians.

Site IV – Developing an electronically based communication system between the medical and nurse practitioners at the CHC and CMHC.

Site V – Project seeks to build an integrated, co-located model. Technology is likely to be a part of this project.

Site VI – Technology is not a core component of this project.

Outcomes
The CHPR evaluation team is currently developing cross-site evaluation measures which will include both process and outcome measures.

Barriers and Lessons Learned
Funding-Related Barriers
A pre-implementation barrier is the lack of funding to implement the projects. EOHHS and DMH were unable to secure funding for the project. Funding barriers around project implementation may be discovered as the projects move forward.

Each corporate volunteer to each of these six demonstration projects did so at financial risk based on the belief that funding would ultimately become available. There is also the hope that many of the uninsured will become insured through the newly evolving health care plans of the Insurance Connector Authority, the new Commonwealth Health Care Plan.

The primary lesson learned is that taking steps to improve integration does not necessarily take money. Even without dedicated funding, each demonstration project continued to make progress in implementing its project by working to improve communication and administrative processes and by strengthening their strategic alliances. Sites also worked with MBHP to maximize the CHP program, to increase their understanding of MBHP/MassHealth billing codes and to understand what constitutes a billable psychiatric consultation service. The overall project team comprised of CHPR, MBHP, MHSACM and MLCHC secured external Year One funding.

Service-Related Barriers
A pre-implementation barrier identified is that CMHCs do not receive payment for treating the uninsured. An early lesson learned is that the demonstration projects are serving as a catalyst to change current regulation in this area.

Barriers Related to Integrated Services Approach
At this time, there are no barriers related to each site's chosen integration approach.

The Future
The future plans for the Massachusetts Behavioral Health and Primary Care Integration Projects are to evaluate whether each project is meeting its goals, and whether projects are efficient in their service delivery, sustainable, and replicable.

Results from the six integration projects will be used to:

- Promote adoption of relevant initiative models and lessons learned to other pairs of CHCs-CMHCs in Massachusetts.
- Inform DMH and MassHealth's future contracting with MCOs and MBHP regarding their CSP programs and specific processes to further behavioral health integration.
- Continue to address site-based policies and procedures that serve as a barrier to integration.
- Continue to address state-agency policies and regulations that serve as a barrier to integration.

Rebuilding Lives PACT Team Initiative, Columbus, Ohio

Abstract
The Rebuilding Lives PACT Team Initiative (RLPTI) is a county collaborative of behavioral health, primary care, housing and other supports designed as part of a federal strategy to abolish chronic homelessness in the United States. RLPTI provides services to chronically homeless adults with moderate or severe mental illness and/or SUD. Partners in the initiative include: a non-profit organization dedicated to developing a community response to homelessness; a developer, owner and manager of supportive housing services; a provider of mental health, addictions, pharmacy and clinic services; a network of FQHCs as well as veterans and other entitlement benefits coordinators.

Background

Service System
Same as description for *Cleveland Coalition for Pediatric Mental Health* initiative.

Description of Implementer
The Community Shelter Board is a nonprofit entity created in 1986 to respond to the growing problem of homelessness in Columbus, Ohio and Franklin County. To implement RLPTI, the Community Shelter Board enlisted the participation of several key partners to provide supportive housing, behavioral health and primary care treatment, case management and other support services. The Community Shelter Board is funded by Franklin County, the City of Columbus, the United Way of Central Ohio, the Columbus Foundation, the Ohio Department of Development and others.

Goals of the Integrated Services Initiative

Problem
In August 1997, the Community Shelter Board received a request from the City of Columbus to develop a plan to address the needs of persons who were homeless or at risk of becoming homeless in Franklin County as a result of the Scioto Peninsula development project. With funding from the City of Columbus, the United Way of Central Ohio, and the Franklin County Commission, the Community Shelter Board established the Scioto Peninsula Relocation Task Force. The SPR Task Force studied the problem of homelessness in Columbus and found that 15% of homeless men in Franklin County used 50% of all shelter services. The Task Force's plan to end this cycle of homelessness included creating permanent supportive housing: affordable housing combined with counseling, job training and other services.

In July 1999, the Community Shelter Board launched the *Rebuilding Lives* initiative to implement the recommendations of the Scioto Peninsula Relocation Task Force. The primary goal of the initiative is to replace a patchwork of emergency shelters in the Columbus area with a community-wide approach to providing affordable housing to chronically homeless persons. The approach involves creating a system of partner agencies that together provide 800 units of housing and supportive services that are coordinated, targeted and cost effective.

Goals of the Integrated Services Initiative
Since chronically homeless individuals have the most complex needs and are often difficult to serve, the goal of RLPTI is to implement a multisystem, multi-agency collaboration that is designed to seamlessly coordinate services and access to resources for chronically homeless persons with severe mental disabilities. RLPTI was designed to provide client supportive services using a multi-agency partnership. In addition to administrative, medical and mental health services staff from each of the partner agencies, the RLPTI program relied on Case Managers, Resident Managers, Property

Managers, a Housing Coordinator and Benefits Coordinators, as well as others to implement the program.

Parameters and Constraints
Implementers and partners realized that funding was not permanent and that the project would need to be self-sustaining following the grant period. While behavioral and primary care providers (PCPs) sought Medicaid reimbursement for covered services, many activities (i.e., case management, care coordination and linkage for non-Medicaid eligible clients) are not Medicaid reimbursable and were paid for largely out of grant funds.

Key Partners
In addition to the Community Shelter Board, key partners include:

- **Community Housing Network,** a developer, owner and manager of supportive housing services that serves as the supportive housing provider for the initiative;
- **Southeast, Inc.,** a dually-certified mental health and SUD treatment agency, which is also a full-service pharmacy and offers some primary care services;
- **Columbus Neighborhood Health Centers**, a network of FQHCs responsible for providing primary care and case management services. The centers also serve as the federal grantee of the Healthcare for the Homeless Grantee program;
- **Franklin County Department of Job and Family Services,** the lead agency responsible for assisting RLPTI clients with applying for and receiving financial benefits; and
- **Chalmers P. Wylie Outpatient VA Clinic,** a provider of the VA medical and behavior healthcare program component.

Process for Key Partner Involvement
RLPTI has been able to maintain key partner involvement through the development of the Management Group, consisting of management level representatives from the partner agencies, who meet on a monthly basis to review overall progress, project activities, to set policies and to resolve any issues that may arise. Another level of involvement is through the Administrative Team, consisting of the direct supervisors of the direct service team. This group also meets monthly to discuss training needs, share project service information and to problem solve at the direct service level in a cooperative manner.

General Description of Implementation Project
To achieve the goals of the initiative, partner agencies identified individuals to participate in RLPTI. Individuals eligible for RLPTI are chronically homeless with a severe mental disability as determined by the RLPTI psychiatrist.

Since RLPTI utilizes the Housing First approach, chronically homeless individuals are placed into housing as quickly as possible upon determine of RLPTI eligibility. The Housing First model does not require clients to see a psychiatrist, take prescription medication or abstain from using alcohol or nonprescription medications. Once an individual is housed, an engagement specialist works with the individual to determine the client's goals and needs. When the individual is ready, he/she may begin accessing assistance to obtain entitlement benefits, or behavioral health/primary care services.

Target Populations
The target population of the Rebuilding Lives PACT Team Initiative is chronically homeless individuals with a severe mental disability who reside in Franklin County, Ohio. "Chronically homeless" means an unaccompanied adult who has been continuously homeless for a year or more or four episodes of homelessness in the last three years. Eligible participants are moderately or

severely impaired by mental illness or addiction and participating individuals may be stable or unstable. Of the individuals referred to RLPTI, 43.7% had a primary diagnosis of affective psychoses and 26.2% had a primary diagnosis of schizophrenic disorders. 36%of individuals had a secondary diagnosis of drug dependence. Other primary diagnoses of referred clients include: paranoid states (7.9%), depressive disorder (7.1%), neurotic disorder (5.6%), acute reaction to stress (4.0%), alcohol dependence/alcohol psychoses (2.4%), personality disorders (1.6%) and other (1.6%). None of the individuals referred to RLPTI had a primary diagnosis of drug dependence or nondependent abuse of drugs.

Individuals were initially selected for participation in RLPTI through outreach to homeless shelters and camp sites where homeless individuals had made "residence." RLPTI also received referrals from social and homeless service agencies and RLPTI clients. Most referrals came from the Veterans Administration (17%), Southeast, Inc. project liaison (15%), a women's shelter (13%), self-referred clients (11%) and a men's shelter (7%).

Services

Services provided by partner agencies are intended to ensure that the comprehensive and holistic needs of RLPTI clients are met. Mental health services and supports provided to the target population include: case management/care coordination, screening, assessment and treatment planning, counseling/psychotherapy, crisis emergency services, pharmacotherapy, recovery/peer support services, mobile outreach, expedited benefits linkage, vocational and employment services, life skills development and supportive housing. Evidence-based mental health services provided are: Program of Assertive Community Treatment, Illness-Self Management & Recovery, Integrated Co-Occurring Disorder Treatment, Medication Management, Supported Employment and Housing First.

Substance abuse treatment services provided to the target populations include: case management/care coordination, screening, assessment and treatment planning, counseling/psychotherapy and pharmacotherapy. Evidence-based SUD treatment services provided to the target population are: Motivational Enhancement Therapy and Buprenorphine.

Primary care services are provided to the target population by Columbus Neighborhood Health Centers, an FQHC network, as well as by Southeast, Inc., a behavioral health services agency. Primary care services provided by Columbus Neighborhood Health Centers include medical services provided by physicians, physician assistants and advance practice nurses; laboratory, dental and vision services. In addition, Southeast, Inc. provides nurse practitioner services. Other services provided by Southeast, Inc. include retail pharmacy services.

Understanding the Clinical Approach

RLPTI utilizes four models to implement services: Program of Assertive Community Treatment (PACT), Integrated Dual-Disorder Treatment (IDDT), Housing First and Supported Employment. PACT (or ACT) is a clinical model used for individuals with severe and persistent mental health issues that result in disability in adult functioning (e.g., education, self care and social and interpersonal relationships). The key features of PACT include:

- Medication management
- Individual supportive therapy
- Mobile crisis intervention
- Hospitalization
- Integrated Dual Disorder Treatment
- Skill teaching for ADLs
- Supported employment
- Support for resuming education & employment
- Support for education and family members
- Assistance to obtain legal & advocacy services
- Financial support
- Supported housing
- Money-management services
- Transportation

The PACT team model is designed to provide long-term monitoring and treatment for clients at risk of hospitalization and ensures necessary supports so clients can achieve their highest level of functioning and quality of life in the community.

RLPTI also utilizes Integrated Dual Disorder Treatment (IDDT) model, which enables RLTPI team members to deliver substance abuse and mental illness treatment at the same time. Integrated treatment guiding principles are that:

- Treatment must be provided by the same clinicians within one program;
- Staff must be cross-trained in both substance abuse and mental illness and have access to outside consultation and support;
- Outreach to client must be assertive and find them where they are;
- Services must be client-centered and culturally competent;
- Clients must be closely monitored for medication adherence and substance abuse;
- A complete range of services must be provided including employment, social skills, psycho-education and substance abuse treatment;
- Clients need stable living environments and require a range of options;
- Clients and providers must take a long-term perspective and realize that it may take years for the clients to show improvement;
- Treatment must be stage-wise and based on the client's motivation to change; and
- Optimism and belief in the client's ability to change are key to a strong therapeutic relationship.

In addition, RLPTI operates on the Housing First premise, which means that permanent housing is the primary need for homeless persons. As such, RLPTI-eligible individuals are placed in permanent housing as quickly as possible, supported by services such as case management. Housing First does not require individuals to see a psychiatrist, take prescription medication or abstain from using alcohol or nonprescription medication. Rent expenses are typically paid from an individuals' SSI/SSDI benefits and are based on 30% of income. The acquisition of benefits is an important aspect of the project and is pursued rapidly to enable clients to pay their rent or become eligible for Medicaid to cover case management and medical costs.

The project has been able to expedite receipt of these benefits by having staff trained to assist with gathering client documentation and records and ensuring that all applications are complete and in order. By submitting complete applications to the Social Security Administration and the Bureau of Disability Determination, these agencies are able to process the applications and render decisions in a shorter time frame (one to six months, as opposed to six months to two years).

Finally, RLPTI utilizes Supported Employment to assist clients in locating and retaining employment. The supportive employment case manager is responsible for providing vocational services ranging from vocational assessment to the development of a vocational plan and job development.

Staff Training on the Clinical Approach

RLPTI team members received training on both the PACT and IDDT models. Ongoing training on the models is provided by in-house coaches, trainers and mentors who were previously trained on the models.

Composition of the Clinical Support Team

The RLPTI team is comprised of the following members: team leader, project coordinator, psychiatrist, psychiatric nurse, primary care nurse, case managers, VA clinical case manager, benefits

coordinator, benefits specialist, community living specialists, vocational case manager and housing coordinator.

Clinical Protocols and Treatment Guidelines
Service fidelity is a required component for the implementation of PACT and IDDT. Fidelity to the PACT model requires adherence to the Dartmouth protocol which includes measures such as; team composition, team size, specific staff to client ratios, total caseload, hours of operation and staff scheduling. The IDDT model requires a baseline and then subsequent review of the model's implementation. Findings from the February 2006 review indicated 51% fidelity to the model. Approximately four to five years of operation are needed for a team to meet 100% fidelity. The team has been operating for just over two years.

No fidelity requirements exist for Housing First at this time. The basic tenet for Housing First is a belief that meeting the basic need for the safety and stability provided by housing should be emphasized. Fidelity for supported employment involves caseload sizes, staffing levels, whether specific staff is assigned as employment specialists, the ability to perform rapid job searches and ongoing assessment of the client.

Care Management
Therapeutic alliances and communication among partner agencies helps to ensure clients' adherence to treatment. Five days per week the RLPTI team leader convenes team members in a case review and discussion of each RLPTI participating client. As each client's name is called, team members discuss client updates including progress of current services, additional services needed and resolutions to issues previously raised. Since the majority of team members are physically co-located at Southeast on a daily basis, collaboration and coordination of treatment is more easily facilitated.

Family Involvement
Family involvement is essential to the PACT and IDDT models. Clients may choose to sign a release that enables the clinical and support team to discuss treatment with family members. Family members often participate in treatment planning sessions with the client and team members.

Organization of Delivery System and Key Partners
Mental health and substance abuse treatment services are provided by employees of Southeast, Inc. Services are provided either onsite at Southeast or in the natural setting of the client (e.g., the client's residence). Members of the clinical support team who are Southeast employees include: the PACT team leader, psychiatrist, social work case managers and community living specialist.

Primary care and general case management services are provided by employees of Columbus Neighborhood Health Centers, Inc. Medical and dental services are provided onsite at individual clinic locations, pursuant to FQHC regulations. Case management, coordination and linkage services are provided onsite at Southeast where RLPTI team members share space. Case management services are provided by case management staff, benefits coordinators and a primary health care nurse. Clients who are Veterans may receive services at the VA Outpatient Clinic.

Each agency maintains diagnostic responsibility for clients to whom services are provided. Each agency is also accountable for its own billing, documentation, supervision and licensure.

Supportive housing, resident management services and related services are provided by employees of Community Housing Network. Staff from the VA and the Franklin County Department of Job and Family Services provide case management and entitlement assistance services, respectively.

Payment and Funding

Partner agencies received grant funding to support implementation of RLPTI. A three-year grant by the Health Resources and Services Administration (HRSA) was made to Columbus Neighborhood Health Centers for $990,060 to support the delivery of medical and case management services provided by Columbus Neighborhood Health Centers. Southeast also received a three-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) for $2,027,102 to support the delivery of mental health and substance abuse treatment services for RLPTI consumers. $1,412,938 in Housing and Urban Development (HUD) grant funds were made to Community Housing Network for the development of supportive housing for RLPTI consumers. The VA Clinic also received funds from the department of Veterans Affairs for services the Clinic provides to veterans totaling $443,883. In total, partner organizations received approximately $4,873,983 in federal funds to implement the Rebuilding Lives PACT Team Initiative, $3,017,162 for services provided by Columbus Neighborhood Health Centers and Southeast. Local support is also provided by the Community Shelter Board and its funders, which include the City of Columbus, the Franklin County Board of Commissioners and the United Way of Central Ohio.

A funding sustainability analysis was conducted in 2005 to identify methods that RLPTI partner agencies could continue services delivery beyond the grant periods. The initiative continues to work on financial sustainability. No-cost grant extensions have been used where available.

As a Medicaid provider of community mental health and substance abuse treatment services, Southeast receives Medicaid reimbursement for covered services (e.g., community psychiatric supportive treatment services, counseling and medication management). The Columbus Neighborhood Health Centers also bill Medicaid for reimbursed FQHC encounters (e.g., medical, dental, vision) as well as for Medicaid-reimbursed clinic services (e.g., laboratory and diagnostic services). However, none of the FQHC services are provided by the Columbus Neighborhood Health Centers /RLPTI team.

Technology

The Community Housing Network utilizes the Homeless Management Information System to track client use of supportive housing. Southeast, Inc. uses an electronic medical record and decision support system to measure service utilization and outcomes. The Columbus Neighborhood Health Centers also use an electronic system that provides for the tracking of appointments and services provided. The project also uses the Internet through a Swapdrive program and JABR software to collect project data and create a monthly dashboard report of activities.

Outcomes

Based on an external evaluation of the Rebuilding Lives PAC Team Initiative relative to client service delivery, researchers conclude that as of June 30, 2006:

1. The RLPTI program has successfully provided supportive housing to chronically homeless persons in Franklin County with severe mental disabilities. This has been achieved by providing:
    - Supportive housing to 121 persons who had been previously chronically homeless.
    - Approximately 9 mental health services per client to an average of 73 RLPTI clients per month. A sample of 20 clients reported they had received mental health services more often since obtaining RLPTI supportive housing.
    - Approximately 4 physical health services per client to an average of 64 clients per month. A sample of 20 clients reported they had seen a doctor more often since obtaining RLPTI supportive housing.

2. The supportive services that RLPTI clients received through the PACT Team had a positive impact on helping clients to apply for and receive benefits, achieve and maintain sustained housing, improve their quality of life and function as a member of their community.
    - As of June 2006, all but 10 of 121 RLPTI clients were receiving some type of financial benefits. The numbers of clients receiving benefits had increased by 3% to 8% within the past 12 months. A sample of 20 clients reported they had received help with benefits more often since obtaining RLPTI supportive housing.
    - Twenty-one of the 121 RLPTI clients had sustained housing for at least 24 months.
    - Clients' perceptions of their quality of life improved significantly six months after being admitted to the PACT Team.
    - Service-providers' perceptions of their clients' levels of community functioning improved significantly 12 months after being admitted to the PACT Team.
    - Clients' perceptions of their mental health symptoms did not improve significantly six to 12 months after being admitted to the PACT Team.
3. Obtaining RLPTI supportive housing appears to contribute significantly to an overall reduction (-67%) of the number of infractions of the law committed by persons who were previously chronically homeless with severe mental disabilities. A sample of 20 RLPRI clients reported that they have been arrested less often since obtaining RLPTI supportive housing.
4. RLPTI partner agency staff reported the level of RLPTI integrated service delivery at the client level was high.

Barriers and Lessons Learned

Funding-Related Barriers

A significant barrier is the sustainability of funds to support partner agency activities and services. Strategies employed by the initiative to sustain funding include: improving staff productivity to increase Medicaid reimbursement; billing eligible Columbus Neighborhood Health Centers case management services as CPST service and nursing services to Community Medicaid services; developing a Columbus Neighborhood Health Centers clinic on-site at Southeast, Inc. utilizing FQHC Medicaid as a primary payer; secure ongoing ADAMH funding; secure county agreement to continue Benefits Coordinator position as part of the Ohio Department of Jobs and Family Services ongoing services; secure VA/Veterans Service Commission resources to pay for RLPTI case management, physician and nurse services provided to Veterans by Columbus Neighborhood Health Centers and Southeast, Inc.; and seeking other funding sources.

Service-Related Barriers

Since RLPTI involves use of multiple clinical and service approaches, the team faces challenges with integrating models (i.e., provision of regular access or attention to physical health needs). Another barrier is that use of a community based treatment approach requires travel to/from clients' residences to provide services. Staff productivity becomes problematic since travel time is not reimbursable.

According to Southeast, Inc., clients participating in RLPTI often form friendships and develop a mutual support system which is often manifested by clients coming into the behavioral health services site as a group. The clients' approach to accessing services oftentimes overwhelmed front desk staff who direct multiple individuals to a single team member's office.

Barriers Related to Integrated Services Approach

The RLTPI initiative has not evolved beyond its coordination and linkage functions. Ideally, the services approach would have integrated the delivery of both primary care and behavioral health

services within a single agency. In addition, the initiative views the lack of an integrated physical health record as a barrier. Finally, because the initiative involved integration of services and supports across organization, partners had to overcome issues related to organizational culture and business practices. When appropriate, partners developed policies and protocols to carry out operational aspects of the initiative.

Confidentiality-Related Barriers

Since RLPTI team members are co-located within a single area of the behavioral health services agency, there are some barriers due to proximity of staff within the same office space. However, the initiative has not encountered any confidentiality issues across agencies since members from partner agencies are part of the same "team."

The Future

RLPTI continues to work toward financial sustainability and is leveraging no-cost extensions as those funding sources permit. RLPTI partners are also pursuing alternative financing mechanisms for primary care services, which would enable the behavioral health services provider to become an expansion site of an existing FQHC.

Vermont Depression in Primary Care and Medical Home Project

Abstract
The Office of Vermont Health Access implemented two integration pilots. The Medical Home Project was implemented in 2003 with a grant from the Center for Health Care Strategies to integrate primary care services into community mental health clinic settings. The Depression in Primary Care project was implemented in 2004 with a grant from the RWJF to integrate mental health services into a primary care setting. Based on pilot outcomes, the Medicaid program is developing strategies to support on-going provision of integrated services; this has included authorizing the use of additional Medicaid billing codes to support case management.

Background

Service System

The Office of Vermont Health Access (OVHA) is the single state agency for Medicaid. It is housed within the umbrella Agency for Human Services. The Agency for Human Services also houses the Department of Health, which includes both the Division of Mental Health (since 2004) and the Division for Alcohol and Drug Abuse Programs. OVHA has become a publicly administered managed care program for Medicaid in Vermont under an 1115 waiver and sub-capitates other departments for some services.

Community mental health services and hospital services are "carved out" of the OVHA managed care initiative for those who are severely and persistently mentally ill. This SPMI population is served through CMHCs. OVHA pays a "case rate" to the centers for approximately 3,000 SPMI. There are no private managed care plans under contract with Vermont Medicaid.

Description of Implementer

The Depression in Primary Care pilot was implemented on a voluntary basis in both FQHC and hospital-owned, non-clinic, primary care physician practice settings. The physician practices serve commercial as well as Medicaid and Medicare patients, though they tended to see significant numbers of Medicaid consumers with mental illness diagnoses.

The Medical Home Project (MHP) was implemented in Community Mental Health settings serving SPMI Medicaid as well as non-Medicaid eligible consumers. Payment for SPMI Medicaid consumers is through a set "case rate" per person.

Sites were located in both urban and rural settings.

Goals of the Integrated Services Initiative

Problem

Medicaid consumers who were not identified as SPMI did not have access to mental health services through the community mental health system. Medicaid was concerned that this population was not being effectively treated for mental health issues in primary care settings. This concern increased as Vermont moved from a commercial HMO model to a Primary Care Case Management model; primary care physicians reported uncertainty over how to address conditions including substance abuse, cognitive disorders and depression.

In addition, as Vermont renewed and revised its 1115 waiver, by which OVHA itself became the "managed care plan" for Medicaid enrollees, the Centers for Medicare and Medicaid Services raised questions regarding how the state would assure that those with SPMI, who were to be "carved out" in the proposed arrangement and separately capitated using a tiered monthly case rate to the community mental health agencies, would be assured full access to primary care. Medicaid's own

analysis showed that the SPMI population was dying at a higher rate, and at younger ages, from cardiac and other problems. In addition, there was growing concern that the use of new antipsychotic medications could potentially add to physical health challenges.

Goals of Integrated Services Initiatives

Vermont Medicaid had three goals for the integration pilots:

1. To address access (both access to mental health services for those in primary care/not SPMI, and access to primary care for those with SPMI);
2. To create infrastructure within and across the primary care and mental health systems to support effective integration; and
3. To engage consumers in the design of the integration initiatives.

Parameters and Constraints

Vermont's most challenging constraint was that funding was siloed, resulting in no one agency or provider being responsible for the whole person's health care needs. The Community Rehabilitation and Treatment program is delivered and financed through case rates paid through the Division of Mental Health and local community mental health agencies. The case rates include community and hospital services for psychiatric conditions delivered in any setting. The Medicaid program, administered by OVHA, is responsible for pharmacy and general medical coverage for the target population, and substance abuse services are provided through yet a third funding stream. This can result in conflicts over which state funding stream is responsible for certain services, for example if a consumer was hospitalized with an overdose (needing medical treatment) and then transferred to a psychiatric bed.

Also, under the conditions of the grants, grant funds could not be spent on services that were billable to another program.

Key Partners

Partners in the pilots included OVHA and the Division of Mental Health, the CMHCs, the primary care practices, the Vermont Center for Independent Living, the Vermont Psychiatric Survivors consumer organization, the Vermont Council of Community Health Centers and the Dartmouth Medical Center.

Process for Key Partner Involvement

The OVHA representative met with each of the key partners to describe the vision and seek participation and support. In a small state, the key partners already had significant past working relationships, which facilitated moving the project forward. The key partners had worked together on a standing mental health committee during the move to a Primary Care Case Management approach for Medicaid (prior to the current 1115 waiver approach to managed care).

General Description of Implementation Project

OVHA received two grants that supported two models of integration. The Depression in Primary Care pilot was supported by a grant of $550,000 from the RWJF. The MHP was supported by a grant of $400,000 from the Center for Health Care Services. Grant funds were used to support integration services; treatment services were billed to Medicaid or other available coverage.

Depression in Primary Care – Target Population

The Depression in Primary Care pilot served 2,000 adult and elderly patients who presented at the primary care sites. Most were Medicaid eligible, but the pilot services were not restricted to Medicaid-eligible patients. Persons served had a variety needs, including mental health, substance abuse and chronic physical illnesses. Behavioral health needs identified were from mild to severe,

and with both stable and unstable conditions. People identified with unstable conditions were linked to the CMHC for services.

The National Preventive Task Force two-question depression screen was used to identify individuals for the pilot. Patients were then referred to the care partner for a PHQ-9 assessment. Frequently, however, physicians and office staff knew which patients they thought should be included in the project, without the use of the two-question screen – the "problem patients" for the practice for whom primary care staff believed depression was interfering with medical treatment. The assessment often found patients who either needed services for SPMI or who were experiencing serious mental illness, though not SPMI qualified.

Depression in Primary Care – Services
Services provided under the pilot included Illness Management and Recovery (based on a Dartmouth Psychiatric Resource Center model), psychoeducation and the self-management model called WRAP (Wellness Recovery Action Planning). Evidence-based services included medication management and illness self-management and recovery. Medicaid was available to pay for counseling, medication and other services ordered by the treating physician.

Medical Home Project – Target Population
The MHP served 200 adult and elderly Medicaid-eligible patients who were being treated in a CMHC due to a Severe and Persistent Mental Illness and who were identified by OVHA as having diabetes.

Medical Home Project – Services
Grant funds were used to hire a Registered Nurse (one site), contract with a Registered Nurse employed by a local FQHC (one site) or to train community mental health case management staff to provide primary care case management (one site). OVHA judged the first approach to be the most effective and the latter to be ineffective. The RNs provided direct case management for patients and, over time, became a "coach" and trainer for center staff to help them understand the implications of diabetes and the physical health needs of center patients. Patients in the pilot project were linked to primary care providers (PCPs) for treatment of diabetes and related complications, and continued to receive a full range of mental health services from the center, including illness self-management and recovery.

Understanding the Clinical Approach
OVMH and its partners, including consumers, developed the pilots with consideration of the Wagner Chronic Care Model, with considerable additional emphasis on self-management. The pilots used the model developed by Mary Ellen Copeland to promote consumer-center self-management (WRAP). This model, developed for mental health treatment, was used with good results to promote self-management of physical health conditions, as well. The pilots were also influenced by the CHCS BCAP model (Best Clinical and Administrative Practices) for people with disabilities and Institute for Healthcare Improvement Breakthrough Series regarding quality improvement.

Depression in Primary Care - Staff Training on the Clinical Approach
Primary care practice staff were provided a week long training called "Becoming Recovery Educators," which promotes a peer focused mental health treatment approach.

Medical Home Project - Staff Training on the Clinical Approach
RNs and other staff used to provide integration services received a two-day training using the Stanford model.

Depression in Primary Care - Composition of the Clinical Support Team
Care Partners were supplied by the local CMHC to work in the primary care setting. These care partners had a background in human services and were not licensed to provide psychotherapy or other mental health services. They worked with primary care physicians, office support staff, and consulted with staff psychiatrists at the CMHCs.

Medical Home Project - Composition of the Clinical Support Team
RNs were used as the primary care integration support in two of the three sites. These nurses had physical health care, not mental health, background experience (in primary care, home health or diabetes education).

Clinical Protocols and Treatment Guidelines
Primary care practices and CMHCs used existing clinical treatment protocols. The care partners worked with the primary care staff to facilitate communication with the practice manager, primary care physicians and the psychiatric staff at the CMHC.

Depression in Primary Care - Care Management
Care partners worked with the primary care staff to facilitate communication with the practice manager, primary care physicians and the psychiatric staff at the CMHC. Care partners maintained telephone contact with patients to encourage medical compliance. The most effective pilot sites were those that included the care partner in all staff meetings and where patient records were integrated for physical and behavioral health case management. The integration of care partners into the primary care treatment team were tied to the best outcomes for patients.

Medical Home Project - Care Management
Registered nurses collaborated with other CMHC staff, including the case manager and staff psychiatrist. Services provided by the RNs began as very hands-on interventions with patients, dealing with obesity, unstable diabetes, and encouraging changes in diet and exercise. This included home visits. Over time, as patients in the pilot became more medically stable, the role of these team members evolved to become a coach for center case managers to better understand the medical conditions and needs of patients, so that case managers could include physical health needs in their scope of focus.

Family Involvement
With an adult population, the principle focus was on patient self-management. Family involvement was welcomed where patients supported it.

Organization of Delivery System and Key Partners
Depression in Primary Care
CMHCs used grant funds to hire the care partners that were inserted into the primary care practice settings. Formal contracts were negotiated between the CMHCs and the primary care offices. The CMHCs administered the grant funds locally for the Depression in Primary Care pilot. Additional contracts were negotiated between OVHA and the Veteran's Administration, the Dartmouth Medical School, the Center for Independent Living and Vermont Psychiatric Survivors.

Medical Home Project
Community mental health sites used grant funds to hire or contract with a registered nurse. At one site, grants funds were used to train mental health case managers in primary care case management. Contracts were negotiated between OVHA and the Veteran's Administration, the Dartmouth Medical School, the Center for Independent Living and Vermont Psychiatric Survivors.

Payment and Funding

Depression in Primary Care

The primary care practices and the FQHC receive Medicaid reimbursement for physical health care services and for mental health counseling/psychotherapy. These providers also bill Medicare and commercial insurance plans. Medicare's coverage for mental health is inadequate and the tendency of commercial coverage to have "carve-outs" for mental health complicates the ability of PCPs to find reimbursement for treatment. Grant funds were used for training, evaluation and salaries of care partners.

To support continuation and expansion of integration efforts, Vermont Medicaid has proposed to add billing codes to support case management.

Medical Home Project

CMHCs receive a tiered case rate to serve 3,000 Medicaid eligible consumers with SPMI. The mental health centers are responsible for all hospital and community based mental health services, regardless of site of care. Mental health centers also receive support from the mental health block grant.

To support continuation and expansion of integration efforts, Vermont Medicaid has added billing codes to support primary care case management in community mental health clinic settings.

Technology

Pilot sites made use of automated registries, and a web-based system was used to allow OVHA to upload data on patients included in the pilots. In addition, consumers can access Dartmouth's www.howsyourhealth.com site to complete personalized risk assessments.

Outcomes

Depression in Primary Care

The evaluation is being finalized. The evaluation reviewed standard measures for depression, with a goal of a 10% drop in the average PHQ scores for patients enrolled in the Depression in Primary Care pilot. The actual result over a six month period was a 25% drop.

Medical Home Project

The evaluation is completed. Rates of hospitalization, use of emergency rooms and standard health measures regarding diabetes were evaluated after six months. OVHA reported a three fold increase in office visits for primary care services in the center where the RN was a mental health center employee, with smaller increases reported in the other staffing models. There were increased numbers of patients who had an A1C completed to monitor the patient's diabetic condition. While use of emergency room services and hospital admissions declined, total Medicaid primary care spending on patients with diabetes increased over the short term, especially regarding prescription drugs to treat diabetes and other medical conditions. In general, the sickest patients at the beginning of the pilot saw the most improved results after 6 months, and the OVHA was pleased with results that demonstrated previously unmet physical health care needs were being addressed.

Interestingly, the mental health center which had employed its own RN under the pilot chose to continue the RN on staff after the end of the pilot. The center was convinced that overall results were improving for their patients involved in the pilot, since the improvement in physical health care supported more effective self-management for mental health conditions.

The evaluations underscored the challenge of having such a high rate of dual Medicaid/Medicare coverage for the target populations. In the MHP, 65% of those included in the pilot were dually eligible (with a mean age of 42 years). This complicated funding for services, and may be

complicating future billing for integration-focused case management services. While Medicare has added some billing codes to support psycho-social education, providers are unclear about whether CMHCs are authorized to use them. However, state policy currently requires that Medicare must be billed prior to a Medicaid claim being filed.

Barriers and Lessons Learned

Funding-Related Barriers

As noted above, the siloed nature of state funding for physical, mental health and substance abuse services was a challenge for providers in billing for actual treatment. In addition, there were some technical issues that had to be overcome with the Medicaid claims system edits; prevention type codes could be billed if provided under a psychiatrist's order, but the claims system would not accept these claims from a CMHC.

When the state created their new managed care approach under the renewed 1115 waiver, there was disagreement within the system as to whether the case rate paid to CMHCs should include funding for all mental health related services or for only the non-medical services. The result was that the substance abuse and medical services are billed fee-for-service, outside the case rate. This was done in part to allow Medicaid better access to data to track service utilization.

As noted above, the interaction of Medicare and Medicaid reimbursement policies is a barrier that must be overcome as the OVHA attempts to provide opportunities for service integration beyond the pilot projects. The state must determine how Medicare will react to receiving "primary care" billing codes regarding prevention and case management from community mental health clinics. On the primary care system side, there is anxiety among providers over use over new Medicare codes of "psychosocial" management services provided by psychologists.

OVHA is concerned that the lack of integration options under Medicare may be a barrier to successful expansion of integration within Medicaid. There are no Medicare Advantage or Special Needs Plan options offered in Vermont. In addition, poor availability of Medicare data on the high percentage of dually eligible consumers was a challenge to care management, a situation that is compounded with the introduction of Part D plans.

Service-Related Barriers

The pilot design struggled initially with defining the core competencies needed for the care partners in the Depression in Primary Care pilot. Mental health centers initially had trouble understanding these as care coordinators rather than as treatment professionals. The key skills needed for the care partners were in service coordination and care management, and these are generally not taught to mental health case managers, who were the staff members initially considered by mental health centers to fill the care partner role.

At the same time, the RNs used in the MHP, while well-versed in primary care, were not familiar with group leadership skills. As RNs, they tended to prefer one-on-one involvement with patients. These professionals needed to develop the ability to facilitate groups in CMHCs so that they could become a broader resource in group education. This was accommodated by assigned "co-leads" for groups, with mental health case managers or consumers filling the role.

Model-Related Barriers

The pilots experienced challenges related to cultural differences between primary care and mental health providers and systems. This was important to overcome, since the experience of the pilots was that integration of providers and approaches, rather than simple co-location, was a key to improved results for patients.

Some primary care sites experienced real resistance to acknowledging and incorporating mental health issues from members of the primary care team, an apparent result of the stigma associated with mental illness. There were also some challenges experienced in arranging access to services for the SPMI population when "mainstream" community resources like heath clubs were approached. On the other side, OVHA noted that some community mental health professionals demonstrated discomfort for the medical model of primary care. OVHA stressed the importance of overcoming these cultural differences in creating effective integration models.

State of Washington Medicaid Integration Pilot

Abstract
The Washington Medicaid Integration Partnership (WMIP) was authorized by the Washington state legislature to operate as a pilot in Snohomish County, Washington. Molina Healthcare of Washington, Inc. (Molina) is the HMO that won the contract to implement the pilot. The managed care pilot enrolls SSI clients, including those who are dually eligible for Medicare, into a comprehensive benefit package that includes mental health as well as physical health care services. Molina receives a combined capitation payment for all services, and provides care coordination across all health care needs. Mental health services were included with physical and drug treatment services beginning in October 2005. In October 2006, long term care services were added to the pilot.

To date, 2,700 individuals are enrolled in the integration project. Molina reports that 10% -15% have screened for behavioral health as a primary diagnosis. Overall, 20% - 25%have a mental health component of their care plan. Washington Medicaid will evaluate the pilot after Year Three before deciding whether to continue or expand the model to other geographic areas.

Background

Service System

The Washington Department of Social and Health Services houses the Health and Recovery Services Administration (HRSA), which is the single state Medicaid agency. In 2005, the assistant secretary for HRSA assumed responsibility for mental health and substance abuse treatment services, in addition to physical health care. Aging still functions as a separate division within the Department of Social and Health Services.

Fifty percent of Medicaid clients are served through a mostly mandatory managed care program for TANF and low income children and pregnant women. The integration pilot is one of only two managed care organizations in the state that enrolls SSI clients.

Description of Implementer

Molina is a licensed managed care organization that operates full-risk contracts in multiple states, with a corporate focus on publicly insured populations. In Washington, Molina generally provides medical managed care to TANF and other parent and children populations, including the state-only funded Basic Health Plan.

Goals of Integrated Services Initiative

Problem

The fragmentation of Medicaid benefits into separate budget categories and service programs undermines continuity-of-care and increases total health care costs.

Goals

The vision of the WMIP is that Washington's Medicaid clients will have a system of integrated health care that slows the progression of illness and disability, improves health outcomes and lowers cost of care. Department of Social and Health Services will develop managed care arrangements that integrate the financing and delivery of medical care, mental health services, substance abuse treatment and long-term care.

Strategic Goals

1. Design and demonstrate the value of Medicaid service integration. The WMIP was charged with identifying at least one partner interested in sharing the planning and development costs of a Medicaid integration pilot project.
2. Implement feasible projects and evolve them toward the longer-range vision. Washington Medicaid believes that health care system innovation is possible and worthwhile, though difficult. In particular, HRSA expects to address significant technical complexity and stakeholder concerns. HRSA will evaluate WMIP and other, smaller-scale projects to assess the impact on service quality, client health and safety and cost-effectiveness.
3. Promote Olmstead compliance. Washington Medicaid designed WMIP to be responsive to the Olmstead imperative to provide "community-integrated" health care and support services that are "medically appropriate" for individuals with disabilities. HRSA will design and implement integrated health care models that demonstrate effective accountability for health outcomes.
4. Employ prudent business practices in Medicaid. HRSA views WMIP as an opportunity to serve and protect some of the state's most vulnerable seniors and people with disabilities by managing limited resources according to sound business and professional practices. WMIP will identify health care integration partners to assist in delivering the best consumer benefit and public value for the state's Medicaid expenditures.

Parameters and Constraints

Separate federal waiver authority governs mental health and long term care programs in Washington, and separate state law governs mental health and drug treatment systems and programs. In addition, Washington has to deal with federal constraints under the Balanced Budget Act of 1997 for implementation of managed care programs (e.g., what service costs can be included in MCO rates). State budget provison language limits this project to one county with a maximum enrollment of 6,000 clients.

Key Partners

In addition to Molina, key partners of HRSA included the Snohomish County Health and Human Services agency, Compass Health (the primary provider of mental health services in the county) and the Aging and Disability Services Administration which is responsible for the Long-Term Care portion of the benefits.

Process for Key Partner Involvement

During the planning phase, HRSA held large public forums in Snohomish County, where leaders of Department of Social and Health Services presented the goals of the program and answered questions. The state agency also presented data analysis at a fairly high level on the cross-agency utilization of services by the target population.

HRSA developed an Advisory Committee of local stakeholders, and several meetings of that group were held during the planning phase. The Advisory Committee included provider representatives, county officials and client advocates. Focus groups and one-on-one counseling sessions were held in multiple locations by state staff together with Molina staff to answer questions about the program and talk about enrollment and disenrollment processes.

The pilot project is overseen by an Executive Steering Committee that is responsible to set WMIP policy in order to achieve the project goals.

General Description of Integration Project

The Washington state legislature created the mandate for the Washington Medicaid program to create WMIP. The goal is to incorporate all Medicaid services within a managed care arrangement.

Target Population

WMIP applies to adults age 21 and older, including adults who are Aged, Blind or Disabled enrollees in Snohomish County. Individuals may include those who need mental health and/or substance abuse treatment services, as well as general physical health care services. Individuals with mild, moderate or severe levels of mental health service needs are included in the project.

Services

Services are provided by the clinical providers enrolled in Molina's network. Compass Health provides a broad range of mental health treatment services. There is an additional provider of mental health services, Bridgeways, which provides high intensity services based on a PACT model. Molina Healthcare is responsible to provide a full range of physical, mental health, chemical dependency treatment and long term care services.

Understanding the Clinical Approach

Clinical Model Used to Affect Service Delivery

The model being used in WMIP is a care coordination model, rather than a clinical model of integration. The Washington pilot design was informed by the Wagner chronic care framework as well as by the Prochaska behavioral health change model. The care coordination team performs an initial screening to identify enrollee risks; enrollees are then referred to another team member for more formal assessments as needed. The care coordination team is responsible for addressing all enrollee service needs.

If the enrollee's primary diagnosis is mental health, he or she is assigned to a team that is led by a mental health professional Otherwise, the enrollee is assigned to a primary "medical" care coordination team lead by a nurse, in consultation with the mental health team.

Staff Training on the Clinical Approach

The care coordination teams are trained in Molina Healthcare's processes, available benefits and telephonic motivational interviewing. The entire team was given training specific to mental health diagnostics and treatment modalities. In addition, team members participated in on-site visits to various behavioral health agencies. The team receives on-going training on various issues as the model progresses (i.e., when adding new services such as long term care).

Composition of the Care Coordination Team

A physican (Medical Director) and psychologist (Director of Behavioral Health) are available to consult with all teams. Teams are generally led by RNs who have experience in care coordination and working with chronically ill populations, and they include support staff who provide coordination asssitance. The mental health care coordination team, for enrollees whose primary diagnosis is mental health, is led by a mental health clinician.

Clinical Protocols and Treatment Guidelines

The focus is on care coordination, not a clinical model. The care coordination team receives written care plans from all providers. The Behavorial Health Director reviews cases to evaluate mental health needs. The care coordination RNs use InterQual software and, when needed, consult with the medical director for medical needs. The InterQual software is evidence-based software that is used to assure all needs are being met.

Molina has a formal agreement with Compass Health to assist in the development of the integration model. Molina's leadership met with the Compass team during model development. Compass collaborated with Molina in providing training, and is relied on by Molina as the experts in mental health treatment. In addition, Compass provides a broad range of mental health services, including group and individual treatment, in locations across the county. Services include a mobile outreach unit and a small amount of emergency services. (Most emergency services are still provided by the separately funded Regional Support Network; see Regulatory Barriers, below.) Compass also has an on site pharmacy that specializes in serving those with chronic mental illness.

In addition to the Bridgeways PACT program, evidence-based services include medication management, family psychoeducation and depression treatment for the elderly.

Care Coordination
Individuals are assigned to a care coordination team on the basis of their primary diagnoses. Molina Healthcare uses an internally developed screen for all enrollees and internally developed assessments for those that trip the screen. Each enrollee in care coordination is given a telephone number of a support person that can be contacted directly for assistance. The care coordinators check on enrollees, make appointments, assist in arranging transportation if needed and enourage enrollees to follow through with appointments and treatment. Molina has formal disease management educational materials that are used for those with certain conditions, including COPD, smoking and diabetes.

The HMO staff/care coordination team are available to provide expertise to network providers. Other resources include a formal quality improvement program, HEDIS reporting, provider coaching, sharing pharmacy information with providers, tracking negative outcomes, peer review and provider feedback. Molina does not use provider profiling.

Family Involvement
Caregivers, especially parents, are included in the care coordination process. Caregivers and/or family members are included with the permission of the enrollee.

Organization of Delivery System and Key Partners
Molina has formal contract agreements with all providers. The contracts require cooperation with the care coordination process. In addition, provider manuals explain the care coordination process, and Molina employs field representatives to visit providers to educate them and to solve problems on site. The behavioral health director and medical director also make calls to providers, if needed, to discuss enrollee needs or treatment.

The Washington model is not a co-located service delivery model, though one site has onsite behavioral and physical health care. Each provider in the network is responsible for the enrollee within that practice.

Payment and Funding
The Washington Medicaid program is paying for the integration program through the managed care organization capitation payment. Capitation payments cover both administrative and service costs.

Funding for physical, behavioral and long term care services are integrated into a single capitation, but are drawn from separate funding streams for long term care, mental health, substance abuse and medical services. Molina has no requirements to spend certain amounts on specific services; however, the state tracks spending on behavioral health and physical health care services separately for purposes of the evaluation.

The legislature authorized the pilot, and expansion or termination decisions will be made based on evaluation data.

Technology
Molina offers a 24/7 "Nurse Advice Line" call center for consumers; the advice line reports to the care coordination team each morning on any calls received the night before. In addition, the internal staff on the care coordination team have access to a care coordination system that includes an integrated intake system, electronic medical records, an automated patient registry, an appointment reminder system for enrollees and a decision support system (InterQual) that supports the care coordination team. In addition, special databases track information in some detail for certain diagnostic groups.

Eligibility and prior authorization information is available to network providers on-line. In addition, pharmacy utilization information is available and shared with network providers, but it is not on-line.

Outcomes
A formal evaluation will be conducted on the pilot by the research branch of Department of Social and Health Services. The control group for the evaluation was identified using Kronick grouper scores. In addition, HEDIS and other measures are being taken on an ongoing basis to monitor service delivery. The HEDIS mental health measures will be included in the 2007 reporting requirements for Molina.

In addition, HRSA has received a grant from the Center for Health Care Strategies to perform comparison group consumer satisfaction surveys using the Agency for Health Care Research and Quality (AHRQ)-developed Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey instrument. This is being implemented with Molina conducting the CAHPS survey for enrollees, and the state surveying both disenrollees and the control group.

Barriers and Lessons Learned
Regulatory Barriers
The mental health system operates under a law that specifies that funding for mental health is to be provided through the carved out managed care system which is operated by quasi-governmental entities called Regional Support Networks (RSN). The RSN for Snohomish County filed suit against Department of Social and Health Services to stop the project, citing the Mental Health law that restricts funding to only RSNs. Department of Social and Health Services was successful in fending off the suit, but the lesson learned was that it would have been safer to have had explicit legislative authorization rather than relying on only a provision of the state budget.

Funding Barriers
There are many creative uses of funds already in the system, and it has been very challenging to move money around for new purposes. For example, funds are already blended for long term care and mental health services to be delivered to help keep clients out of institutions, and that funding could not be disentangled for mental health only while Washington Medicaid was waiting for long term care to be added to the pilot.

Another example of the complexity of existing funding streams is that chemical dependence agencies receive a capitation for outpatient services; inpatient services are funded elsewhere. HRSA can't require the chemical dependence agencies to tell HMO enrollees about the full range of treatment services available. In addition, Molina cannot pay for or coordinate state mental health

hospital admissions. The project mangers report significant "turf" issues that have had to be handled, one at a time.

Model-Related Barriers
Some local stakeholders were very defensive of the the old siloed approach of separate service delivery systems and have continuously objected to the pilot's implementation. HRSA reports that it may have been easier from the county's standpoint to have had implementation taking place in several counties at once, to spread out the project impact.

In addition, the prescription drug formulary was an issue early on. Efforts by the state and Compass were needed to persuade Molina to modify its formulary regarding atypical medications.

Population-Related Barriers
Molina reports that new enrollees can be hard to reach and engage by phone. The enrollment files frequently do not have working telephone numbers, addresses are sometimes out of date and the population can be non-responsive to outreach. The health plan has observed some "hopping" by consumers who can move in and out of plan enrollment depending on which providers they want to use, and thus continuity of care for these enrollees is compromised.

Washtenaw Community Health Organization
Ypsilanti, Michigan

Abstract
The Washtenaw Community Health Organization is a service organization that administers primary care, mental health, substance abuse and developmental disability services in southeastern Michigan. A collaborative partnership with the University of Michigan Department of Psychiatry, Washtenaw County Government, the county mental health center and local private health clinics, the WCHO was developed to create innovative best practices in the delivery of integrated health care to Medicaid, Medicare and indigent patients. The WCHO began planning its integrated initiatives in 1998 and launched its first integrated clinic in 2003. Five integrated health clinics have been implemented since 2003. The integrated services that are part of the model are transportable to other health care settings.

Background

Service System

The Michigan Department of Community Health MDCH was created in 1996, combining services and funding for public health, mental health, substance abuse and Medicaid. The Department serves as the single state Medicaid agency and is responsible for the enrollment of Medicaid providers. The Department is a cabinet-level agency whose leadership reports to the Governor.

There has been statewide mandatory Medicaid managed care enrollment in Michigan for nearly all populations since 1996. The major exception is the dual eligibles population (Medicaid/Medicare), where participation in managed care is voluntary. Medical services are provided by qualified, accredited providers, who contract with Medicaid managed care organizations and are paid on a fee-for-service or capitated basis. In Washtenaw County, one managed care organization, M-CARE, manages 75%-85% of the Medicaid patients.

Michigan has both a carved-in and carved-out system for mental health services. The managed care organizations in Michigan manage 20 outpatient mental health visits in a carved-in payment system. Public mental health services and substance abuse specialty services are carved out and administered by 18 regional PIHPs (Prepaid Inpatient Health Plans). The Washtenaw Community Health Organization (WCHO) is the PIHP for the Southeastern Region, comprised of four counties, and manages approximately $85 million in Medicaid services.

Description of Implementer

The WCHO was created in 1998 by the University of Michigan Health System, Washtenaw County Government and the local community mental health program to provide an integrated medical home for Medicaid and indigent consumers. The development of the WCHO required the transformation of a traditional CMHC and accommodations from an academic medical center to create an organized and integrated health care service delivery network with policy and governance responsibility for primary care, mental health and substance abuse services in one community board.

In May 2000, the Michigan Mental Health Code (MCL, PA 258 of 1974) was amended to allow the Washtenaw County Board of Commissioners and the University of Michigan Health Systems to jointly create and operate a Community Mental Health Services Board. In July of 2000, the then existing Community Mental Health Services Board discontinued operation and the WCHO was created, with a new joint policy-making board comprised of six (6) members appointed by the University of Michigan Board of Regents, six (6) members appointed by the Washtenaw County Board of Commissioners and staff with broader responsibilities. With a newly-appointed Executive

Director and board composed of primary and secondary consumers as well as community members representing both the County and the University, the agency began to function as a substance abuse coordinating agency and a CMHC, with the newly-defined charge of primary health care policy oversight.

Goals of the Integrated Services Initiative

Problem

Research has shown that seriously mentally ill individuals comprise a vulnerable population with a higher-than-average prevalence of smoking, poor nutrition, diabetes and infectious diseases. Although most consumers have a primary care physician of record, many do not receive regular preventative care or effective disease management for diabetes, heart disease, or other chronic diseases. For those who do not have a primary care physician, emergency room utilization is reported to be significantly higher than the general population.

In the previous decades, public mental health consumers were considered "clients for life" with little hope for recovery or full participation in community life. Indeed there was not an open "back door" for consumers to exit the public system and receive ongoing care in the community. By history and design, the public mental health system had become increasingly isolated from other systems of care. As consumers and providers embraced the concepts of recovery, community inclusion, improved health and self determination, new options for care were needed.

Goals of Integrated Services Initiative

Strategic planning commenced in 1995 in response to the State of Michigan's attempt to privatize the public mental health system. The WCHO was created as a joint entity between Washtenaw County Government and the University of Michigan Health System (UMHS) with the charge to create an integrated system of care, positioning the local safety net to provide services in the event of privatization. This initial partnership established the vision of an integrated program, including the potential for various community partners, to create integrated care in the community, building on the strengths of each entity.

The initial goal was to re-integrate the bifurcated health care funding directed from the State of Michigan into a single policymaking Board that could influence how the funds were spent and improve the health outcomes for indigent and Medicaid consumers within the UMHS. The goals expanded beyond the UMHS partnership in 2003 to include local primary care clinics and the location of small teams of mental health professionals in local safety net medical practices. This goal expanded to one of creating an integrated "medical home for every consumer," with a focus on adapting disease management protocols for the seriously mentally ill population.

In the process of WCHO full implementation, an electronic health record called "Encompass" was initiated to further the standardization of care, ensure adherence to regulatory compliance requirements, support clinical practice, and create the ability to mine data for outcomes. With the expansion into primary care integration, an outpatient primary care module was developed in Encompass to be used in two of four primary care sites, thus creating a truly integrated medical record available to consumers. Goals for 2006-08 include "Phase II" for outreach to primary care practices not included in the formal partnership network and the development of a hospital medical module for Encompass to be able to capture the whole continuum of care.

Parameters and Constraints

The scope and direction of the project is to enhance the capability of the primary care providers (PCP) to offer mental health care as a part of total medical care, as opposed to side-by-side, separate care. The constraint is the strong generalist-specialist paradigm within the medical field.

There are also funding constraints and requirements, creating administrative and reporting complexities with each governmental body. WCHO is required to budget and maintain three separate funding streams (mental health, substance abuse, and primary care). At the end of each fiscal year, WCHO is required to return any unspent state funding, even if losses are incurred in another category of funding. This limits the flexibility needed to be completely effective within the model. Separate billing codes and practices also restrict reimbursement for these services.

Key Partners

Local primary care safety-net clinics were selected that provided a welcoming atmosphere to consumers and clinics expressing an interest in becoming a partner in creating a medical home.

- Packard Community Clinic is a private, non-profit primary care clinic and safety net provider. Packard Clinic is the host setting for a part time adult psychiatrist and full time MSW on-site, entry to SMI patients and partner in Encompass implementation.
- Neighborhood Health Clinic is an outpatient safety net primary care clinic. Neighborhood Clinic is the host setting for a part time psychiatrist and full time MSW on site.
- Corner Health Center is a private non-profit safety net primary care clinic, serving ages 12-20 and their children. Corner is the host setting for a part time child psychiatrist and full time MSW on site
- Ypsilanti Family Practice is an outpatient service and training clinic for UMHS, including both a pediatric and family medicine program. It is the host setting for a child psychiatrist and adult psychiatrist for consultation.
- Delonis Homeless Shelter is a community, non-profit homeless shelter. It is not an FQHC. Delonis is the host for the county mental health outreach team and a partner in the Encompass implementation.
- University of Michigan is a public university and medical center. The University is the founding parent organization, provides collaboration via research and joint programs, training, knowledge development and interest in evidence-based practice.

The University of Michigan School of Nursing is another key partner in collaborating to provide a part time clinical Nurse Practitioner to work within Community Support and Treatment Services, providing basic medical care for consumers unable to establish a relationship with local primary care.

Process for Key Partner Involvement

Involvement of the key partners in the integration initiative began with vision discussions at all levels through a Steering Committee. Focus groups, further data collection, involvement with the local chapter of National Alliance on Mental Illness and discussions with consumers added to the dialogue and planning.

In the cases of the primary care partnerships, initial discussions flowed from stakeholders to all staff directly involved in the form of a retreat, in which each individual from the front desk receptionist staff to the primary care physician, were able to voice their hopes, as well as any concerns, before the project commenced. These were recorded and prioritized for the Steering Committee. In addition, each project has an active project manager, who meets monthly with the larger collaborative Steering Committee at each host setting. Data is collected at each site on both client and provider satisfaction. An annual report is issued on each site, with an annual meeting of all stakeholders to review progress.

The framework of the process is documented in a manual entitled: "Raising the Bar," available from the National Council for Community Behavioral Healthcare.

General Description of Implementation Project

Community Support and Treatment Services (CSTS), the community mental health agency in Ypsilanti, Michigan, has served as implementer of the integration initiative since 1995. It is not mandatory that the CSTS participate in the initiative. WCHO maintains a contract with CSTS. The project covers approximately 22,700 "safety net" individuals within Washtenaw County. It is estimated there are approximately 37,000 citizens in Washtenaw County that are uninsured, about 11% of the population. In the current primary care partnerships, the WCHO penetration rate is approximately 5.5% at this time.

Target Populations

The project serves an urban population of all age groups, gender, service needs, severity of need, and includes the homeless, trauma-informed, and family-focused programs with varying levels of symptom stability.

There are two focused target populations. The first are stable SPMI consumers in the public sector, who could well be served in a primary care clinic as a medical home, if that clinic has support from mental health professionals, offering consumers a less stigmatizing choice of care locale as well as an open 'back door' to the county mental health system. The second group is comprised of those consumers identified by the host primary care provider in need of mental health consultation. The option for mental health consultations is unlimited, in an effort to have the mental health team recognized as an integral part of the clinic and to make sure opportunities to transfer knowledge to the primary care practitioner are not lost. The project initiative has demonstrated that over time, as primary care practitioners become more comfortable and knowledgeable, they refer only the most complex patients for consultation. The goal is to be inclusive, as safety net primary care clinics accept all consumers.

Individuals are accepted and selected for participation in the initiative through referral by their primary care physician, and also must be an active patient in the primary care clinic. Consumers from the public community mental health system mainstreaming to primary care must establish that they have not been hospitalized within the previous 12 months, have a stable living situation, understand their need for mental health treatment and are medication adherent.

Services

Mental health services provided by CSTS to the public mental health population include: case management/care coordination, prevention/early intervention, screening, assessment and treatment planning, counseling/psychotherapy, crisis/emergency services, pharmacotherapy, and recovery/peer support services. Evidence-based mental health treatment services are: Assertive Community Treatment, Dialectical Behavior Therapy, Family Psychoeducation, Illness Self-Management and Recovery, Integrated Co-Occurring Disorder Treatment, Medication Management, Parent Training and Trauma-Focused Cognitive Behavioral Therapy.

Substance abuse treatment services provided by CSTS and a network of providers to the target population include: case management/care coordination, prevention, screening, initial brief intervention, assessment and treatment planning, psychosocial intervention, pharmacotherapy, patient engagement and retention and recovery/chronic care management. Evidence-based substance abuse treatment services are: Motivational Enhancement Therapy, Multisystemic Therapy and Supportive Expressive Psychotherapy. At CSTS, the following evidence-based services are practiced: Assertive Community Treatment, Dialectical Behavior Therapy, Co-Occurring, Parent Training, Multi-Family Groups, and Motivationally Enhanced Substance Use Services.

Primary care services provided to the population include: case management/care coordination, primary care prevention, primary care treatment, prescription drugs, laboratory and diagnostics. Evidence-based primary care services provided by UMHS to the target population include medical management and disease management services. In primary care partnership sites, CSTS provides an on- site psychiatrist for psychiatric evaluation, consultation and medical management, as needed. An MSW social worker is also available on site to provide a psychosocial evaluation, brief therapy, consultation and case management, as needed. Additional services range from medication management, crisis intervention to individual therapy or referral for community services, eviction prevention, food bank access and other social community needs. The primary care mental health team has access to Evidence-Based Practices professional training and referral to the CSTS programs, should the patient meet criteria.

Understanding the Clinical Approach

WCHO uses Wagner's Chronic Care Model as the underlying approach to their integration model, in addition to the Program of Assertive Community Treatment (PACT/ACT), PORT outreach to homeless, the McFarland model for multi-family groups, and the Minkoff and Drake models for co-occurring treatment using motivational enhanced interviewing. Continuous case management teams use wrap around capability for consumers in crisis.

Staff Training on the Clinical Approach

When possible, national experts have addressed staff on the various clinical models to provide training and motivation. The experts have included: William McFarlane, Robert Drake, Kenneth Minkoff, Mei Lee and Marsha Linehan. This training has been followed by individual professional development plans that often include a recommendation for further training and education, i.e., a number of the bachelor level case managers have earned a CAC in order to provide enhanced substance abuse services. In addition, project staff participate in the University of Michigan "grand rounds" and local experts are tapped for WCHO/CSTS "grand rounds" educational programs.

A major leadership development project is available to both organizations (WCHO/CSTS) that helps individuals understand the role of change and change management in the public mental health system. This leadership development/change management system has served as a motivator in moving the project forward at a more rapid pace than is usually seen in the public mental health system and allowed the project to drastically reduce the traditional implementation time in the public system.

Lastly, a competency evaluation is included in each direct care staff's annual evaluation.

Composition of the Clinical Support Team

Medical services staff consists of a medical director, who is a psychiatrist, as well as a director of medical services. The team also includes additional psychiatrists, physicians, pediatricians, licensed MSWs, registered nurses and nurse practitioners.

Clinical Protocols and Treatment Guidelines

Treatment services are planned based on an evaluation and collaboration with all providers. Standard protocols are used, unless otherwise warranted, and, when possible, evidence-based practices are sought. Care is continually evaluated in patient 'rounds' or in case discussions.

WCHO is planning to imbed decision support processes within the electronic medical record system. This would include the evidence-based practice protocols for evidence-based services. The first project, funded by the Flinn Foundation in Michigan, will embed medication algorithms for psychiatrists in the medical records. The project will then progress to the Integrated Dual Disorders

Treatment (IDDT) model, family psycho-education and other current, national recognized evidence-based practices.

Care Management
The WCHO project tracks high utilization patterns and brings these cases to the treatment team for increased support. Unstable clients are monitored closely for medication adherence via frequent appointments and follow-up with a social worker. The project is in the process of finalizing a diabetes registry that will aid in assisting to identify clients at risk in order to provide additional education and support, hopefully leading to self-management of their illness for some percentage of the population.

Family Involvement
A person-centered planning process is utilized in Michigan to allow the consumer to designate whomever they wish to be involved in their plan of care. Family-focused treatment is an option in primary care sites, if it makes clinical sense. WCHO has a close alliance with the local National Association of Mental Illness, whose members co-lead multi-family groups.

Organization of Delivery System and Key Partners
WCHO has a service provider contract with CSTS and a memorandum of understanding with each primary care host site. A formal contract exists between CSTS and each primary care clinic.

In the primary care setting, the primary care clinic is the holder of record for services delivered and all record entries are made in the primary care record. The Encompass electronic medical record includes mental health, substance abuse and primary care components, essential for all parts of the record. The WCHO has access to information in compliance with State and federal privacy standards. WCHO is also the holder of the mental health and substance abuse records contracted outside of the mental health system. CSTS is responsible for documentation, billing and supervision. Diagnostic responsibility is shared between the primary care clinics, CSTS and the University of Michigan, Department of Psychiatry.

Staff supervisions is a shared responsibility, but is primarily provided by the primary care organization. Behavioral health staff in the primary care settings are employed by the public mental health system and assigned to the primary care sites. Integrated services are provided in the host primary care clinics, except for a nurse practitioner practicing at CSTS.

Payment and Funding
The integrated service initiative operates as a braided system of funding with revenue received from Medicaid, Medicare, local tax dollars, mental health block grant funds, substance abuse block grant funds, private funds and state general funds. The total annual budget is $127 million - fund sources may be used for start-up and/or operations activity. Since implementation of the initiative, new fund sources have been added including a local indigent health plan, the Adult Benefit Waiver in Michigan, private insurance sources and a system for reimbursement funding from a local primary care managed care organization should be completed by the end of 2006. All funding flows through the WCHO.

All systems of funding are expected to be ongoing, as WCHO continues to be committed to the service and are in the process of receiving permission from the State of Michigan to continue to use funds for this project from adult benefit waiver funds, Medicaid, capitated funds from a local health plan, and savings realized by mainstreaming consumers from a more expensive public sector program to a less expensive primary care setting.

Technology
The integrated service project utilizes a 24/7 call center, appointment reminder call system, consumer support/information, electronic health records, integrated intake and decision support through Care Web, Encompass and a Data Warehouse.

- Care Web – an integrated medical record at UMHS with mental health information added; available to all PCP's and community mental health psychiatrists and nurse practitioners; with affirmative participation by consumers.
- Encompass – a new community mental health electronic record with full web-based management system for providers to see authorizations and provide claims electronically.
- Data Warehouse – an integrated data set that includes mental health, substance abuse and primary care utilization data. Information is "refreshed" on a daily basis.

All mental health documentation is completed on Encompass. Access to the system is granted on a need-to-know basis, in compliance with HIPAA. Since Encompass is a web-based system, access, if granted, is available wherever staff can access the internet. The primary health care section of the electronic health record is expected to be available by the end of 2006.

Outcomes
Currently, the WCHO integrated project tracks and measures the following:

- Consumer and provider satisfaction surveys
- Utilization rates
- Scheduled appointments
- Client diagnostic patterns
- Payer mix
- Return on investment analysis
- Cost offsets
- Costs per enrollee per year
- Consumer outcomes in inpatient utilization, crisis residential and substance use.

In 2006-07, WCHO will add Quality of Life inventory and depression screening, plus a registry for diabetes disease management.

Evaluation of the project has demonstrated a slight increase in physical health care and medical costs, with a marked decrease in mental health only diagnoses and treatment. Access to the Care Web system by psychiatrists and physicians averages over 130 times a month per clinician. Treatment outcomes data reports from one WCHO program reports a drop in unemployment, homeless and legal issues with 43% identified as having a co-occurring disorder.

Barriers and Lessons Learned
Regulatory Barriers
The 42 CFR determines privacy and confidentiality rules for substance abuse care recipients. This created a number of significant hurdles, as the standards exceed even the strictest mental health privacy rules. After a year in consultation with SAMHSA and a number of attorneys, WCHO finally received an approval of an integrated confidentiality policy that was deemed sufficient.

Funding-Related Barriers

- Bifurcated and fragmented billing requirements between medical and mental health care are a significant barrier for the project, including the impact of lack of parity in which Medicare reimburses 80%+ of an outpatient medical visit, but only 50% of an outpatient mental health visit.

- The project is able to serve Medicaid, Medicare and indigent individuals, but not those with third party resources at this time, due to barriers of closed panels in some cases (managed care organizations) and the accreditation standards in other cases (Blue Cross/Blue Shield).
- The Medicare behavioral health CPT 96151 series is not billable in primary care in Michigan.
- Mental health services are tied to specialty clinic accreditation by Blue Cross/Blue Shield in Michigan and other private payers.
- Current rules do not permit two services in the same day. This provides a strong barrier to integration of care.

Lessons Learned – Strong advocacy at the national and state level is needed to resolve these issues.

Service-Related Barrier
Multiple forms of medical records create a significant challenge for the project. Two of the primary care clinics are on paper records; one is on a separate electronic health record and two are now on the Encompass system. Services need to be realigned to fit the resources.

Barrier Related to Integrated Services Approach
The WCHO integration project embeds mental health staff in local primary care clinics, adapting to the host setting protocols and work processes. Although this model has been successful, it created the unintended consequence of variability in work processes and forms. The individualized approach means each clinic has a core of mental health operations that are similar, but also different in record keeping and emphasis. While this approach makes the project more aligned to meet the needs at each site, it makes outcome data more difficult to mine and compare across the five settings.

Lesson Learned – The decision to be "clinic-centered" in the WCHO approach presents a challenge to devise creative methods to collect comparable data across all clinics.

Confidentiality-Related Barrier
HIPAA rules and regulations have created definite challenges in sharing patient data and information across providers in all systems. In addition, incorporating the 42 CFR for substance abuse privacy and confidentiality into the system and the state mental health recipient rights code have created additional administrative challenges and need to be streamlined into an integrated system.

Other Barriers
WCHO recognizes that primary care and mental health practice are founded in different cultures, represented by the medical model (primary care) and client self-determination (community mental health). The integrated model is creating a "third culture" that attempts to draw the best from both models. Mental health practices now are discussing integrating disease management into mental health care, as mental illness is recognized as a chronic disease that needs disease management protocols. This is a common language for both primary care and mental health. While mental health practices adapt to this new culture, the WCHO model seeks to introduce teaming and case conferences into already stretched primary care practices. WCHO views this as an evolving process, as the individuals encounter issues and seek new ways to address them together in an integrated practice.

The Future
The vision of integrated health at WCHO is one of continued growth, as data shows that clinic partnerships are financially sustainable in three years. Current program development includes the following:

(1) WCHO is planning a Phase II outreach program to the remaining primary care clinics to support consumers, to reach a wider number of clinics for care.
(2) Data shows that some 30% of consumers are impacted by diabetes or metabolic syndrome, thus the WCHO is developing a diabetes disease management protocol, adapted for the unique integrated population, in collaboration with primary care partners.
(3) Funds have been secured to expand CSTS nurse practitioner capacity to nearly full time to provide basic medical services to consumers unable to connect to local primary care.
(4) An electronic medical health record will soon "go live" in Encompass, with a hospital medical record to follow.

By virtue of an extensive data infrastructure, multiple funding sources for inpatient and outpatient mental health, substance abuse and primary medical care for some 56,320 covered Medicaid lives in a four county region in Michigan, the WCHO is uniquely positioned to model an efficient and effective future system of care.

WCHO plans to host a national conference in 2007 to gather key players in the integrated health network across the nation, to start working on an evidence-based practice tool kit and program description.

WCHO continues to participate in the national dialogue on integrated care through writing papers, attending conferences, and giving presentations on the model.

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Appendix 1
Integration Initiatives Summary

Name of Program/Location	Implementer	Target Population	Model/Approach	Funding Source(s)	Goals	Outcomes
Center for Adolescent Health – Adolescent Treatment Initiative Eastern Grafton County, New Hampshire	The Center for Adolescent Health, a specialty adolescent health program affiliated with Dartmouth-Hitchcock Medical Center	Adolescents	Collaborating partners staff an interdisciplinary clinic that provides biopsychosocial, diagnostic, treatment planning and intervention services, as well as general medical services. Support provided to area PCPs so they can screen, assess and provide brief interventions. Grounded in Dr. Engel's biopyschosocial model.	Grants, county funds and 3rd party reimbursement	Provide a seamless continuum of high-quality, evidenced based adolescent substance abuse screening, assessment and treatment.	In the process of conducting a two-year evaluation. Will assess community readiness to address adolescent substance abuse; measure access and retention; and assess client needs and outcomes.
Cleveland Coalition for Pediatric Mental Health Cuyahoga County, Ohio	A coalition of local pediatricians, child psychiatrists, child psychologists, county mental health board administrators and other community leaders	Pediatricians, and their adolescent patients and families	Piloting use of the Child Health and Development Interaction System (CHADIS), a web-based diagnostic, management and tracking tool. Also developed a web-based mental health resource guide to maximize available mental health resources and help pediatricians link adolescent patients to appropriate resources.	Grants and 3rd party reimbursement (providers who use CHADIS can bill Medicaid for developmental testing)	1) Educate/support pediatricians; 2) Engage/support parents; 3) Build/ strengthen networks between pediatricians and behavioral health providers; 4) Advocate on mental health issues.	Surveys of resource guide and CHADIS users is pending.

Name of Program/Location	Implementer	Target Population	Model/Approach	Funding Source(s)	Goals	Outcomes
Colorado Access Integration Model Denver, Colorado and surrounding areas	Colorado Access, a managed care organization formed by Denver area safety-net providers to serve publicly insured populations	Adult Medicaid enrollees, focusing on the most costly 2-3%	A RWJ Depression in Primary Care pilot. Screened high risk health plan members for depression using the PHQ-9, provided evidence-based treatment of depression and bipolar disorder in primary care and created care management teams. A centralized care management model based in part on the Assertive Community Treatment and Wagner chronic care models.	Grants and Medicaid managed care capitation payments	1) Provide better primary care for SPMI patients, including pharmacy management; 2) Improve access to mental health care for those who primarily seek care in the primary care setting.	Significant reduction in physical health care costs for high risk plan members, making it an economically sustainable model of integration
Community Care of North Carolina Mental Health Integration North Carolina	Community Care of North Carolina, the state's PCCM program	Adolescents and adults in the Medicaid PCCM program	Behavioral health providers are located in primary care facilities and universal screening tools are used. Provides support to improve communication between PCPs and behavioral health care providers. There is a mental health focus. Based on the Wagner chronic care model (with focus on primary care delivery and social support) and the NCCBH four quadrant integration model.	Medicaid and grant funding	There are many stated goals, but the primary goal is to overcome inadequate access to behavioral health services and manage both the behavioral and physical health needs of Medicaid enrollees served in the state's PCCM program.	Standard measurements across the pilot sites have been created. Data collected from the PHQ-9 supports the project and the need for additional support.

Name of Program/Location	Implementer	Target Population	Model/Approach	Funding Source(s)	Goals	Outcomes
Community Health Center, Inc. Central and Southern Connecticut	Community Health Center, Inc., a multi-site FQHC	Adolescents and adults	Co-located primary care and behavioral health services; "morning huddles" with interdisciplinary physical and behavioral health teams; "pod" worksites to facilitate communication among interdisciplinary staff.	3rd party reimbursement and grants	Co-locate mental health professionals with medical treatment providers to facilitate seamless service delivery (i.e., "warm handoff" from primary care to behavioral health services).	The prevalence of depression among diabetics and postpartum women patients has been identified.
Hogg Foundation Integration Grants Austin, Texas	The Hogg Foundation for Mental Health	Grant recipients, including community based health centers, a FQHC, a pediatric group practice and other primary care providers	Grant program to support primary care providers in implementing the collaborative care model for mental health and physical health care. Based on variations of Wagner's chronic are model.	Hogg foundation grants	Increase access to effective mental health care and promote the adoption of collaborative care by reducing real world barriers to successful implementation.	In the process of conducting a process and outcome evaluation. Quantitative and qualitative data will be collected in the domains of mental health status, treatment costs, customer satisfaction, decreased service use, etc.
Horizon Health Services Western New York	Horizon Health Services, a state-certified provider of substance abuse and mental health services that operates 8 CMHCs	Adults and the elderly with mild to severe mental illness or addiction	Co-location of medical health services and behavioral health services. Based on a primary care model designed to screen, treat and manage medical conditions associated with mental illness and addictions.	3rd party reimbursement, primarily Medicaid and Medicare	Provide onsite access to medical care and facilitate coordination between substance abuse, mental health and medical services providers.	Outcomes data does not currently exist.

Name of Program/Location	Implementer	Target Population	Model/Approach	Funding Source(s)	Goals	Outcomes
Kaiser Permanente Southern California Depression Care Program Southern California	Kaiser Permanente of Southern California, an integrated health system	Adults with chronic illness and non-critical mental health needs	Adopted IMPACT model of collaborative care for depression that utilizes a depression care manager along with the patient and primary care physician.	Kaiser Permanente and Medicare	Identify and effectively treat all members with a chronic illness and depression using evidence-based guidelines.	67% of depressed KPSC members showed significant improvement in PHQ-9 or GDS scores; savings of 14% per year achieved during the IMPACT study and an additional 9% for one year post-study.
Massachusetts Behavioral Health and Primary Care Integration Projects Massachusetts	Massachusetts Behavioral Health Partnership, a state Medicaid managed behavioral health provider	Adults with chronic physical illness and mental health and/or substance abuse needs	Six demonstration sites created out of partnerships between FQHCs and CMHCs to integrate behavioral health care and physical health care services. There is an emphasis on evidence-based practices and improving service delivery.	Grants, Medicaid, uncompensated care pool and the Commonwealth Health Plan	There are many stated goals, including improving the identification and treatment of behavioral health disorders, increasing efficiency and institutionalizing use of evidence based practices.	In the process of developing cross-site evaluation measures which will include both process and outcomes measures.
Rebuilding Lives PACT Team Initiative Columbus, Ohio	The Community Shelter Board, a non-profit entity created to respond to the problem of homelessness in Columbus, Ohio	Chronically homeless individuals with a severe mental disability	Several models in use including: ACT, IDDT, Housing First and Supported Employment.	Grants, Medicaid reimbursement	Implement a multi-system, multi-agency collaboration designed to seamlessly coordinate services and access to resources for chronically homeless with severe mental disabilities.	External evaluation indicated a 67% reduction in legal infractions. Clients reported receiving mental health services more often and having a better quality of life since receiving supportive housing.

Name of Program/Location	Implementer	Target Population	Model/Approach	Funding Source(s)	Goals	Outcomes
Vermont Depression in Primary Care and Medical Home Project Vermont	The Office of Vermont Health Access, the single state agency for Medicaid	Adults and the elderly (Depression in Primary Care); Adult and elderly Medicaid-eligible patients with SPMI and diabetes (the Medical Home Project)	Created two separate integration projects: The Depression in Primary Care project integrated mental health services into a primary care setting by utilizing "care partners" supplied by CMHCs; the Medical Home Project integrated primary care services in CMHC settings by using RNs. Pilots developed with consideration of the Wagner chronic care model.	Grants and 3rd party reimbursement	Increase access, support effective integration of primary care and mental health systems and engage consumers in the design of the integration initiatives.	The Depression in Primary Care project experienced a 25% drop in average PHQ-9 scores; the Medical Home Project experienced a decline in ER use and inpatient admissions, but an increase in primary care spending.
State of Washington Medicaid Integration Pilot Snohomish County, Washington	Molina Healthcare, a Medicaid managed care organization	SSI individuals	Provision of a comprehensive benefit package that includes mental health as well as physical health care services. A care coordination team performs initial screening to identify enrollee risks. Informed by the Wagner chronic care model and the Prochaska behavioral health change model.	Medicaid managed care capitation payments	Create a system of integrated health care that slows the progression of illness and disability, improves health outcomes and lowers cost of care while demonstrating the value of Medicaid service integration.	Formal evaluations will be conducted in the future.

Name of Program/Location	Implementer	Target Population	Model/Approach	Funding Source(s)	Goals	Outcomes
Washtenaw Community Health Organization Ypsilanti, Michigan	The Washtenaw Community Health Organization, a collaborative partnership with the University of Michigan Department of Psychiatry, county government, county mental health centers and private health clinics	Stable SPMI consumers and consumers identified to be in need of mental health consultation	Integration of bifurcated health care funding into a single policy making board. Six integrated clinics have been launched since 2003. The Wagner chronic care model is used as an underlying approach to integration, with other models also used.	Medicaid, Medicare and other 3rd party reimbursement, local taxes, grant funds, private funds and state general funds	Create innovative best practices in the delivery of integrated health care with a medical home to Medicaid, Medicare and indigent patients	Slight increase in physical health care and medical costs, with a marked decrease in mental health only diagnoses and treatment. Drop in unemployment, homelessness and legal issues reported at one site.

Appendix 2
Program Contacts

Initiative/Program	Contacts
The Center For Adolescent Health 71 Highland St. Plymouth, New Hampshire 03264 http://www.ppam.yourmd.com/	Viking Hedberg, MD, MPH Medical Director viking.a.hedberg@hitchcock.org Patricia A. O'Riordan, MA Program Director patricia.a.o'riordan@hitchcock.org (603) 536-5384
Cleveland Coalition for Pediatric Mental Health Cleveland, Ohio http://www.clevelandpedsmentalhealth.org/	Andrew Garner, MD, Ph.D info@clevelandpedsmentalhealth.org (440) 808-9228
Colorado Access P.O. Box 17580 Denver, Colorado 80217-0960 https://www.coaccess.com/public/index.jsp	Marshall Thomas, MD Vice President of Medical Services marshall.thomas@coaccess.com (303) 315-9148
Community Care of North Carolina P.O. Box 10245 Raleigh, North Carolina 27606 http://www.communitycarenc.com/	Denise Levis Hewson, RN, BSN, MSPH Senior Consultant and Director of Quality Improvement denise.levis@ncmail.net (919) 715-1088
Community Health Center, Inc. 635 Main St. Middletown, Connecticut 06457 http://www.chc1.com/	Margaret Flinter, RNC Vice President, Clinical Director FlinteM@chc1.com (860) 347-6971
Hogg Foundation Integration Grants Hogg Foundation for Mental Health P.O. Box 7988 Austin, TX 78713 http://www.hogg.utexas.edu/	Laurie Alexander Program Officer la333@austin.utexas.edu (512) 471-9608
Horizon Health Services 3020 Bailey Ave Buffalo, New York 14215 http://www.horizon-health.org/	Anne Constantino Chief Executive Officer adc@horizon-health.org (716) 831-1800

Initiative/Program	Contacts
Kaiser Permanente Southern California Depression Care Program 393 E. Walnut Street, 2nd Floor Pasadena, California 91188	Rogena Burrus, MSN, FNP-C Senior Project Manager Behavioral Health Care Services Regional Depression Senior Consultant rogena.x.burrus@kp.org (626) 405-5471 Rita Haverkamp, CNS KP San Diego Medical Center rita.m.haverkamp@kp.org (619) 589-3313 Mark Dreskin, MD Regional Depression Clinical Leader Baldwin Park Medical Center mark.dreskin@kp.org (626) 527-1288 Gabrielle Beaubrun, MD Regional Depression Clinical Leader South Bay Medical Center gabrielle.f.beaubrun@kp.org (310) 517-3764
Massachusetts Behavioral Health and Primary Care Integration Projects Mental Health and Substance Abuse Corporations of Massachusetts, Inc. 251 West Central Street, Suite 21 Natick, MA 01760 http://www.mhsacm.org/index.shtml	Elizabeth Funk President and Chief Executive Officer bfunk@mhsachm.org (508) 647-8385 Debra Hurwitz, MBA, BSN, RN Director, State Health Policy Analysis University of Massachusetts Center for Health Policy & Research debrahurwitz@umassmed.edu (508) 856 4270 Nancy Paull, MS, LADC1 President and Chief Executive Officer SSTAR npaull@sstar.org (508) 679-5222 John Strauss Medical Director MBHP john.strauss@valueoptions.com. (800) 495-0086

Initiative/Program	Contacts
Rebuilding Lives PACT Team Initiative Community Shelter Board 115 W. Main St., LL Columbus, OH 43215 www.csb.org	Barbara Poppe Executive Director bpoppe@csb.org (614) 221-9195
Vermont Depression in Primary Care and Medical Home Project Office of Vermont Health Access 312 Hurricane Lane, Suite 201 Williston, Vermont 05495	Liz Reardon Managed Care Director lizr@path.state.vt.us (802) 879-5938
Washington Medicaid Integration Pilot	Alice Lind Office Chief HRSA P.O. Box 45530 Olympia, WA 98504 lindar@dshs.wa.gov (360) 725-1629 Jan Cunningham, LICSW Government Contracts Manager Molina Healthcare jan.cunningham@molinahealthcare.com (425) 424-7119
Washtenaw Community Health Organization 555 Towner St. Ypsilanti, Michigan 48197 http://www.ewashtenaw.org/government/departments/wcho	Virginia Koster, LMSW, ACSW Manager of Integrated Initiatives kosterv@ewashtenaw.org (734) 544-3082 Kathleen M. Reynolds, LMSW, ACSW Executive Director reynoldk@ewashtenaw.org (734) 544-6813

About Health Management Associates

Health Management Associates is a national research and consulting firm specializing in complex health care program and policy issues. Founded in 1985, in Lansing, Michigan, Health Management Associates provides leadership, experience, and technical expertise to local, state, and federal governmental agencies, regional and national foundations, multi-state health system organizations and single site health care providers, as well as employers and other purchasers in the public and private sectors.

REPORT BY:

Barbara Coulter Edwards – Principal, Columbus, Ohio
bedwards@healthmanagement.com

Barbara Coulter Edwards has over 25 years of public and private sector experience in health care financing, and is a nationally recognized expert in Medicaid policy, including managed care, cost containment, long term care, and state and federal reform. Ms. Edwards is a frequent national presenter on Medicaid trends, Medicare Part D, and state health policy challenges. She has extensive experience in leading strategic planning and organizational change initiatives in public agencies. Prior to joining HMA, Ms. Edwards served 8 years as director of Ohio's $12 billion Medicaid program. She served on the federal State Pharmacy Assistance Program Transition Commission regarding implementation of Medicare Part D, served on the National Quality Forum Steering Committee which recommended standards for nursing home care, and was vice chair of the National Association of State Medicaid Directors. Ms. Edwards has testified before both the U.S. Senate Finance Committee and the U.S. House Energy and Commerce Committee regarding state Medicaid and SCHIP programs.

Susan P. Garcia – Senior Consultant, Columbus, Ohio
sgarcia@healthmanagement.com

Ms. Garcia has experience with federal, state and local health policy issues and analysis, managed care, public health, association management and foundation development. Her broad range of experience in state government and in health care associations from the federal, state and local level have given her a unique perspective on both public and private health care delivery system operations and issues, thus enabling her to assist state and local programs, national and state associations and community based programs.

Alicia D. Smith – Senior Consultant, Columbus, Ohio
asmith@healthmanagement.com

Alicia Smith has over 10 years of experience in Medicaid and behavioral health policy, financing and reimbursement matters. Prior to joining HMA, Ms. Smith operated a behavioral health consulting firm assisting state and local mental health authorities and providers with the development of needs assessments and resource inventories, strategic assessments as well as coverage and reimbursement policies. As Deputy Director of Resources For Recovery, a national grant program of The Robert Wood Johnson Foundation, Ms. Smith assisted states with identifying and implementing strategies for the expansion of alcohol and other drug treatment access and resources. Ms. Smith also worked as Medicaid health services administrator for the Ohio Medicaid program. Ms. Smith serves as a member of the Board of Trustees of Community Housing Network and also serves as a member of the Rebuilding Lives Update Strategy Committee to plan and address the needs of homeless families, children and adults.

HEALTH MANAGEMENT ASSOCIATES LOCATIONS

Lansing, MI - Corporate Office
120 North Washington Square
Suite 705
Lansing, MI 48933
Telephone: 517-482-9236
Fax: 517-482-0920
Email: info@healthmanagement.com
Map: Mapquest

Austin, TX
Bank of America Center
515 Congress Avenue
Suite 1760
Austin, Texas 78701
Phone: (512) 473-2626
Fax: (512) 473-2642
Email: info@healthmanagement.com
Map: Mapquest

Columbus, OH
37 West Broad Street
Suite 1150
Columbus, Ohio 43215
Phone: 614-224-2500
Fax: (614) 221-1437
Email: info@healthmanagement.com
Map: Mapquest

Indianapolis, IN
8888 Keystone Crossing
Suite 1300
Indianapolis, Indiana 46240
Telephone: (317) 575-4080
Fax: (317) 575-4180
Email: info@healthmanagement.com
Map: Mapquest

Tallahassee, FL
301 South Bronough Street
Suite 500
Tallahassee, FL 32301
Telephone: 850-222-0310
Fax: 850-222-0318
Email: info@healthmanagement.com
Map: Mapquest

Washington, DC
2100 M Street
Suite 605
Washington, DC 20037
Telephone: 202-785-3669
Fax: 202-833-8932
Email: info@healthmanagement.com
Map: Mapquest

Chicago, IL
180 North LaSalle Street
Suite 2305
Chicago, IL 60601
Telephone: 312-641-5007
Fax: 312-641-6678
Email: info@healthmanagement.com
Map: Mapquest

Long Beach, CA
100 Oceangate
Suite 1200
Long Beach, CA 90802
Telephone: (562) 628-5564 or (562) 628-5567
Fax: (562) 628-5566
Email: info@healthmanagement.com
Map: Mapquest