

**Healthcare Integration Committee**  
**April 16, 2015**  
 Double Tree  
 2800 Via Cabrillo Marina  
 San Pedro, CA 90731  
**Madeo Room**  
**8:30 a.m. to 12:00 p.m.**

<b>Time</b>	<b>Topic</b>	<b>Presenter or Facilitator</b>	<b>Tab</b>
8:30 a.m.	Planning Council Member Issue Requests		
8:35 a.m.	Welcome and Introductions	Steven Grolnic-McClurg, LCSW, Chairperson	
8:40 a.m.	Review and Approve January Meeting Highlights		
8:45 a.m.	Presentation: California Health Care Foundation	Catherine Teare, Associate Director, California Health Care Foundation	A
9:40 a.m.	Questions/Comments		
10:30 a.m.	Break		
10:45 a.m.	Work Plan Review and Update		B
11:25 a.m.	Committee Discussion		
11:40 a.m.	Public Comment		
11:50 a.m.	Next Steps/Develop Agenda for Next Meeting	Steven Grolnic-McClurg, LCSW, Chairperson	
11:55 a.m.	Wrap up: Report Out/ Evaluate Meeting	Steven Grolnic-McClurg, LCSW, Chairperson	
12:00 p.m.	Adjourn Committee		

**The scheduled times on the agenda are estimates and subject to change.**

**Committee Members:**

**Chair:** Steven-Grolnic McClurg

**Chair-Elect:** Terry Lewis

**Members:**

Dale Mueller

Josephine Black

Cindy Claflin

Joseph Robinson

Deborah Pitts

Jeff Riel

Robbie Powelson

Cheryl Treadwell

Daphyne Watson

Melen Vue

**Staff:**

**Tracy Thompson**

# HEALTHCARE INTEGRATION COMMITTEE CHARTER

ADOPTED 10/17/12

## OVERVIEW

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The California Mental Health Planning Council (CMHPC) is mandated by federal and state statute to advocate for children with serious emotional disturbances and adults and older adults with serious mental illness, to provide oversight and accountability for the public mental health system, and to advise the Governor and the Legislature on priority issues and participate in statewide planning.

## PURPOSE

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The purpose of the Healthcare Integration Committee (HCI) is to develop a framework for tracking, addressing, and responding to the multitude of issues resulting from Federal Healthcare Reform that impacts California's mental health system.

The HCI promotes the inclusion of five core elements from the Mental Health Services Act to guide all mental health work:

- Promoting Consumer and Family oriented services at all Levels
- Ensuring Cultural Competence
- Increasing Community Collaboration
- Promoting Recovery/wellness/resilience orientation
- Providing Integrated service experiences for clients and families

## MEMBERSHIP

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The Committee membership is listed below.

The Chairperson and Vice-Chair will be appointed by the CMHPC Leadership. In the Chairperson's absence the Vice Chair will serve as the Chairperson. Terms will begin with the first meeting of the calendar year, and end with the last meeting of the calendar year.

## MEETING TIMES

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The Committee meets four times a year, rotating locations in conjunction with the standing meeting times of the plenary and other committees. The Committee meets on Thursday from 8:30 AM to 12:00 PM.

Regular attendance of committee members is expected in order for the Committee to function effectively. If a committee has difficulty achieving a quorum due to the continued absence of a committee member, the committee chairperson will discuss with the member the reasons for his or her absence. If the problem persists, the committee chair can request that the Executive Committee remove the member from the committee.

The Chair and Vice Chair hold meetings as needed to plan for the full Committee meetings.

## ROLES AND RESPONSIBILITIES

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Members are expected to serve as advocates for the Committee's charge, and as such, could include, but are not limited to:

- Attend meetings. Speaking on behalf as requested.
- Speak at relevant conferences and summits when requested by the Committee leadership
- Develop products such as white papers, opinion papers, and other documents
- Distribute the Committee's white papers and opinion papers to their represented communities and organizations
- Assist in identifying speakers for presentations

Materials will be distributed as far in advance as possible in order to allow time for review before the meetings. Members are expected to come prepared in order to ensure effective meeting outcomes.

## GENERAL PRINCIPLES OF COLLABORATION

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The following general operating principles are proposed to guide the Committee's deliberations:

- The Committee's mission will be best achieved by relationships among the members characterized by mutual trust, responsiveness, flexibility, and open communication.
- It is the responsibility of all members to work toward the Committee's common goals.
- To that end, members will:
  - Commit to expending the time, energy and organizational resources necessary to carry out the Committee's mission
  - Be prepared to listen intently to the concerns of others and identify the interests represented
  - Ask questions and seek clarification to ensure they fully understand other's interests, concerns and comments
  - Regard disagreements as problems to be solved rather than battles to be won
  - Be prepared to "think outside the box" and develop creative solutions to address the many interests that will be raised throughout the Committee's deliberations

## MEETING PROTOCOLS

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The Committee’s decisions and activities will be captured in a highlights document, briefly summarizing the discussion and outlining key outcomes during the meeting. The meeting highlights will be distributed to the Committee within one month following the meeting. Members will review and approve the previous meeting’s highlights via email.

#### DECISION-MAKING

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Council and non-council members of the Committee will work to find common ground on issues and strive to seek consensus on all key issues. Every effort will be made to reach consensus, and opposing views will be explained. In situations where there are strongly divergent views, members may choose to present multiple recommendations on the same topic. If the Committee is unable to reach consensus on key issues, decisions will be made by majority vote using the gradients of agreement. Minority views will be included in the meeting highlights.

#### MEDIA INQUIRIES

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In the event the Committee is contacted by the press, the Chairperson will refer the request to the CMHPC’s Executive Officer.

#### SUPPORT

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Tracy Thompson, Associate Governmental Program Analyst, [tracy.thompson@cmhpc.ca.gov](mailto:tracy.thompson@cmhpc.ca.gov)

Healthcare Integration Committee Membership

NAME
Steven Grolnic-McClurg, LCSW, Chairperson
Josephine Black
Cindy Clafin
Dale Mueller , EdD, RN
Terry Lewis
Deborah B. Pitts, PhD
Robbie Powelson
Jeff Riel
Joseph Robinson, LCSW, CADC II
Cheryl Treadwell
Daphyne Watson
Melen Vue

Updated: 03/23/15

California Mental Health Planning Council  
HEALTHCARE INTEGRATION COMMITTEE  
**External Roster**

HCR Chair and Chair-Elect

<p><b>Steven Grolnic-McClurg, LCSW, Chair</b> E-mail: SGrolnic-McClurg@ci.berkeley.ca.us P: 510-898-1624</p>	<p><b>Terry Lewis</b> E-mail: tlewis@dmh.lacounty.gov P: 818-425-8021</p>
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Committee Members:

<p><b>Josephine Black</b> E-mail: jblack32@cox.net P: 805-684-4934 C: 805-895-3108</p>	<p><b>Cindy Claflin</b> E-mail: cclaflin@uacf4hope.org P: 916-203-3449 C: 916-230-3449</p>
<p><b>Deborah B. Pitts, PhD, OTR/L, BCMH, CPRP</b> Email: pittsd@usc.edu P: 626-799-9734</p>	<p><b>Dale Mueller</b> E-mail: dmueller@earthlink.net P: 909-920-5854</p>
<p><b>Robert Powelson</b> E-mail: <a href="mailto:robbiepowelson@gmail.com">robbiepowelson@gmail.com</a> P: 415-924-2826</p>	<p><b>Joseph Robinson</b> E-mail: joseph@casra.org P: 415-572-5173 C: 925-229-2300</p>
<p><b>Cheryl Treadwell</b> E-mail: cheryl.treadwell@dss.ca.gov P: 916-651-6020</p>	<p><b>Jeff Riel</b> E-Mail: JRiel@DOR.ca.gov P: 916-558-5421</p>
<p><b>Daphyne Watson</b> E-mail: <a href="mailto:dwatson@mhasd.org">dwatson@mhasd.org</a> P: 619-942-6588</p>	<p><b>Melen Vue</b> melen@namica.org P: 916- 862-2078</p>

**Staff**

**Tracy Thompson**  
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Sacramento, CA 95899-7413  
[tracy.thompson@cmhpc.ca.gov](mailto:tracy.thompson@cmhpc.ca.gov)

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL  
Healthcare Integration Committee  
Meeting Highlights  
Crowne Plaza San Diego  
January 15, 2015  
8:30 A.M. to 12:00 P.M.

**Committee Members Present:**

Steven Grolnic-McClurg, Chair  
Cindy Claflin, Vice-Chair  
Terry Lewis  
Deborah Pitts, PhD  
Joseph Robinson  
Jeff Riel  
Cheryl Treadwell  
Daphyne Watson  
Josephine Black  
Robbie Powelson  
Dale Mueller

**Staff Present**

Tracy Thompson

**Others Present**

Dr. Peter Currie, Clinical Director of Behavioral Health Inland Empire Health Plan (IEHP)

**Welcome and Introductions**

We have been tracking and understanding the changing landscape of the public mental health system and have been increasingly interested in the new partnerships with the health plans. There is a new mandate for the health plans to provide mild to moderate mental health treatment to Medi-Cal beneficiaries. There is a lot of work that needs to be done in this arena and we hope to support the health plans in providing that.

**Presentation: Behavioral Health Inland Empire Health Plan**

Dr. Peter Currie, Clinical Director of Behavioral Health Inland Empire Health Plan (IEHP), provided a presentation on the plan's experience with integration. The Behavioral Health Inland Empire Health Plan is a non-profit public health plan, serving low-income families and individuals in two of the largest counties in the country – San Bernardino and Riverside Counties. Today IEHP serves over 1,000,000 members in government-sponsored programs compared to 400,000 in 2009. With Health Care Reform and the Cal Medi Connect, IEHP is projected to grow to well over 1,300,000 members by 2015.

IEHP integrated healthcare because Physical Health and Behavioral Health (BH) care were separate and disconnected. Outpatient Mental Health Services were under-utilized and substance abuse treatment was nil. IEHP had no influence over the BH Network.

The BH integration plan is a fully integrated BH program where everything is “In House.” The coordination of physical and mental health benefits has been streamlined and there is one fully integrated system of care. Directly Contracted BH Network – Identify and Support Best Practices which eliminates reliance on vendors (MBHOs) for all BH expertise.

The BH Integration plan was launched February 1, 2010 with a “No Gate Keeper” model:

- PCP referral not required
- One phone # access at IEHP for physical and mental healthcare
- BH Call Center: Triage and referral by Licensed BH Care Managers
- Higher than average rate of pay for the initial assessment:
  - Incentivize prompt Access
  - Payment triggered by Coordination of Care Report Web Form – eliminating the “Black Hole”
- Added new BH services: Intensive Outpatient Programs (IOP)
- Direct Partnership with County Mental Health Departments

BH Integration results:

- Increased access to BH services 150% – Cost Neutral to Plan
  - Improved coordination of physical and behavioral healthcare:
  - BH providers must submit Tx Plan (COC) Web Forms
  - 78 % of COCs passed on to the member’s PCP (with release)
  - 75 % of PCPs used web portal to access these BH Tx reports
- Medical Cost-Offsets from BH services for high-risk/high-cost populations – Dual Eligible's & SPDs
- Infusing BH expertise within IEHP to respond to crisis calls
- Met 100% of the NCQA requirements for BH in 2012 Audit
- IEHP’s BH network - Private Sector, FQHCs, MHP & CBOs

There has also been successful Collaboration with the IEHP and County MH:

- Eating Disorder Complex Care Management
- Care Integration Collaborative: Co-Location of Mental Health, Substance Abuse and Primary Care
- Medi Cal Expansion “Warm Hand Off” Referrals between County Specialty Mental Health & Health Plan

- Adding County Mental Health Providers to the IEHP BH Network for the Cal Medi Connect Pilot
- Autism Collaborative with a Mission to develop an Inland Empire ASD Center of Excellence

#### Integration in California: Agenda for 2015

- The Impact of the ACA on California
  - From Silos to Accountable Organizations
  - New Benefits require expanded Health Plan responsibility
  - Debate over transition from “Carve-Out” to “Carve-In” Funding
- Behavioral Health Homes
  - Piloting new Treatment Models and combinations of Providers
  - Promoting Innovation County by County

#### Lessons learned:

- Integration of Behavioral & Physical Health Care at the Health Plan enables Population Health Care
- Health Plans Need to develop direct relationships with BH Providers in private practice, County BH programs and Community Based Orgs
  - Direct Relationships are best: Minimize use of Sub-Capitated Middle Men with separate 800 #s that carve out BH care and often limit access
  - Health Plans must bring BH expertise “In House” to ensure Quality BH Care
  - Providers should contract at the highest possible level of the Funding Stream - Directly with Health Plans when possible
- In a well-integrated Model of Care, Open Access to BH Services pays for itself in Medical Cost Offsets
  - Not treating BH conditions drives up Medical & Social Costs
  - BH Providers need to demonstrate Value by Measuring Results and demonstrate “Return on Investment” (ROI) BH services yield for Health Plans

#### **Questions/Comments**

- Steven Grolnic-McClurg: We have been struggling in this group with what active steps we could take do help with the development of the health plan. Where can we be helpful in this process? *Answer:* I am seeing movement with the plans where they are bringing on the behavioral health expertise? There needs to be a best practice guide that can guide the plans. It has to happen at the county partnership level. Get to know the health plans. Communication is key. Help the plans look at what they are buying and is it of value? We need to put the people we are serving at the center.
- Grolnic-McClurg: How would the CMHPC go about asking the health plans: what is the amount you are spending on administration versus services? Is there any value in us

inviting the California Health Care foundation to come and talk about this issue? *Answer:* They can tell you that information because they are rated on their medical loss/cost ratio. This is public knowledge. How much is actually in claims payment and how much is being paid to Beacon? What does that ratio look like and how does that jive with the medical loss/cost ratio for the plans? They have this data. Is there a way we can shift that loss/cost ration to get more treatment?

- Grolnic-McClurg: Is there any value in us inviting the California Health Care foundation to come and talk about this issue? *Answer:* There is a strong initiative now growing around Behavioral health integration. I see CHCF as an excellent and highly respected entity in the state to say we would like to join forces with you and what can we do to inform this process.
- Dale Mueller: What are your thoughts on workforce needs? And what is the role of psychiatric nurse practitioners? *Answer:* We have had psychiatric nurse practitioners from day one. We just don't have enough though. We contract with every one that we can and we still do not have enough capacity. I would love to work with the counties to see if there a way to make the use of psychiatric nurse practitioners more efficient. What kind of barriers happens in the county when a patient has to get queued up to see a psychiatrist? What if that assessment was repurposed into therapy? We are in a crisis of capacity.
- Deborah Pitts: In California Occupational Therapists are not considered licensed mental health professionals and this serves as a barrier. Because of parity a person can be seen by an Occupation Therapist as well and often times they are paid through the health plan benefit for OT as opposed to the mental health side. I would suggest including Occupational Therapists. Occupation Therapy for children with autism is not the same as Occupation Therapy for adults with serious mental illness. It is not a practition that can cross ages.

### **Committee Discussion**

Members discussed the HCI presentations at the full council and the chair and vice-chair assignments.

### **Discuss Chair and Vice-Chair Assignments**

Terry Lewis advised that she will assume the role of vice-chair. Steven Grolnic-McClurg will remain as Chairperson.

### **Choose mentors for new members**

Robbie Powelson: Cheryl Treadwell

Daphyne Watson: Deborah Pitts

## **Work Plan Review and update**

- Grolnic-McClurg: Given our growing knowledge how do we want to support and influence? You may be pro or con the health plan carving in specialty mental health services, but they have responsibility for mental health services already and there is a lot of reason why they may get responsibility for all mental health services. And as we move towards a “carved in” world and where mental health is part of the health plan responsibility and not “carved out” to someone else it is going to be a lot better if they know what they are doing and they take that responsibility and use it well. We can support the health plans in developing their capacity to better serve the public mental health system. This area is woefully lacking. We have been tracking this as a group and are developing a knowledge base to do this. We are not advocating for services to be carved in, but rather we want the health plans to be as knowledgeable and capable of providing the mental health benefit that they are responsible for. Supporting through our actions.
- Josephine Black: I think it is a good idea to invite someone from the Health Care Foundation. There are some really promising practices and they would benefit from broader publication across the state in terms of demonstrating what is possible. I wonder if we could take a role in promoting that in having them come to present to us and we could assist in disseminating this information. It really struck me that there is 50% going to administration when it should be more like 5-10%.
- Grolnic-McClurg: If we were to push the issue on administration I would want everyone to be aware that the amount of public resources in the mental health plan going towards administration is far more than 5%. There is an automatic 25%.
- Cheryl Treadwell: What I heard here today is an example of how integration can work if you have a thoughtful approach. We could lift up where the shared interest is between the health plans and mental health plans and where it benefits families and clients if you have a thoughtful approach such Inland Empire. How can the health plans and mental health plans do a good job of collaborating in terms of care for the lives they share responsibility for? Maybe it is about info sharing or bringing forth the best practice model. How would we disseminate this issue? White papers etc.?
- Grolnic-McClurg: This is a really important conversation regarding the “carve in” and the “carve out” and there is some value in us having this conversation in a public forum.
- Dale Mueller: What are the resources now for health plans? Dr. Currie was a consultant and had a prior relationship with the Inland Empire Health Plan. Maybe we could have a series of panel presenters around this issue so we have a dialogue and then at the end there is a culmination of information.
- Daphyne Watson: I think assisting the health plans in understanding best practices and the value of carving in the mental health services is important.

- Joseph Robinson: One of the things the HCI committee can be doing is forging these relationships with the health plans. We should be thoughtful and organized about how we go about this.
- Jane Adcock: I think it would be a good idea for the committee to continue as we move around the state to find models and become educated on how the counties are doing this. **This could roll up into a report at the end of the year** about models and best practices that we can disseminate and educate other counties. It would also serve to educate the members on what are the possibilities, barriers, and issues are that they found and how they are working on overcoming them.
- Grolnic-McClurg: Another product for the HCI committee regarding the health plans and low to moderate health care could be **a list: counties in Ca that carved it in and those that carved it out and if they carved it out who did they carve out too?** What are some of the promising practices in terms of what worked and what didn't work?
- Adcock: Even just for the regions we go to this is how they are handling it. We may not be able to address every county but some of them.
- Grolnic-McClurg: There is some work that needs to be done on the work plan at the next meeting. We have at least one piece at this point regarding collaboration and best practices.

### **Public Comment**

No public comment at this time.

### **Next Steps/Develop Agenda for Next Meeting**

- **Invite health plan or mental health plan in LA – how are the individual counties rolling this out?**
- **Invite California Health Care Foundation to talk about their role in capacity development in the system and supporting them.**
- List of 22 health Plans was re-sent to committee members 2/5/2015
- **Staff and Joseph Robinson are drafting the letter to the CALMHB/C encouraging them to invite the head of their health plan and mental health plan to talk about their MOU.**
- **ADD REVIEW MINUTES ON THE NEXT AGENDA**

### **Wrap up: Report Out/ Evaluate Meeting**

- Robinson: I think Dr. Currie was a wonderful speaker and he spoke to what we wanted to hear.

*Adjourn Committee*



March 9, 2015

Larry Gasco, PhD, LCSW  
2557 Palos Verdes Dr  
W Palos Verdes Estates, CA 90274

**CHAIRPERSON**

Cindy Claffin

**EXECUTIVE OFFICER**

Jane Adcock

- **Advocacy**
- **Evaluation**
- **Inclusion**

Dear Dr. Gasco,

We are writing from the Health Care Integration Committee of the California Mental Health Planning Council (CMHPC). As you know, the CMHPC is mandated by federal and state statute to advocate for children with serious emotional disturbances and adults and older adults with serious mental illness, to review and report for the public mental health system, and to advise the Administration and the Legislature on priority issues and participate in statewide planning.

The Health Care Integration Committee's overall focus is healthcare integration. A specific area of focus for us, brought about by national healthcare reform, has been the services now available to some Medi-Cal beneficiaries and the new providers of those services. Pursuant to Information Notice 14-020, issued to County Mental Health Directors, effective January 1, 2014, Medi-Cal Managed Care Plans (MCPs) are now responsible for the delivery of certain mental health services through the MCP provider network to Medi-Cal beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning. This change has significant implications to our entire system of care including the relationship between the health plans and the mental health plans (MHPs). Existing Title 9, California Code of Regulations (CCR), Chapter 11 regulations and the DHCS/MHP contract require MHPs to enter into a Memorandum of Understanding (MOU) with any MCP that enrolls beneficiaries covered by the MHP. The HCI Committee has heard from multiple counties that have implemented this differently.

The HCI Committee would like to share with the CALMHB/C what we have learned with regards to health plans, including how we can collaborate with this new significant partner in the provision of mental health services. To that end, is it possible for a member of our HCI Committee to join a meeting with CALMHB/C on Friday afternoon, April 17, 2015, to present this information?

Please contact us if you have any questions or need additional information.  
tracy.thompson#cmhpc.ca.gov (916) 552-8665

MS 2706

PO Box 997413

Sincerely,

Cindy Claflin, CMHPC Chair  
Steven Grolnic-McClurg, HCI Chair

x   INFORMATION

TAB SECTION        A

       ACTION REQUIRED

DATE OF MEETING    04/16/15

MATERIAL  
PREPARED BY:    Tracy Thompson

DATE MATERIAL  
PREPARED        03/9/15

<b>AGENDA ITEM:</b>	Presentation: California HealthCare Foundation
<b>ENCLOSURES:</b>	
<b>OTHER MATERIAL RELATED TO ITEM:</b>	

**ISSUE:**

The HCI Committee has been focusing on issues around integration and the responsibility of the Medi-Cal Managed Care Plans (MCPs) for the delivery of certain mental health services through the MCP provider network to Medi-Cal beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning. This change has significant implications to our entire system of care including the relationship between the health plans and the mental health plans (MHPs). Thus far, the HCI Committee has heard presentations from Abbie Totten from the California Association of Health Plans and Dr. Peter Currie from Inland Empire integration. Catherine Teare, Associate Director, California HealthCare Foundation, will present to the committee on their role in capacity development within the system.

x   INFORMATION

TAB SECTION        **B**

       ACTION REQUIRED

DATE OF MEETING    **04/16/15**

**MATERIAL  
PREPARED BY:**    Tracy Thompson

**DATE MATERIAL  
PREPARED**        03/9/15

<b>AGENDA ITEM:</b>	Work Plan Review and Update
<b>ENCLOSURES:</b>	Health Care Integration Work Plan
<b>OTHER MATERIAL RELATED TO ITEM:</b>	

**ISSUE:**

The HCI Committee is currently working on an updated work plan. Please see enclosed attachment for review and discussion.