

DHCS Plan for Behavioral Health Integration



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Introduction

The Affordable Care Act provided an opportunity for the California Department of Health Care Services (DHCS) to better understand the complex issue of integrating physical, behavioral, and social health services, and to consider recommendations for better integration in California, especially for the Medi-Cal program. The Drug Medi-Cal – Organized Delivery System was approved by the Centers for Medicare and Medicaid Services (CMS) on August 13, 2015. As a condition of this demonstration waiver, CMS requires DHCS to specify an integration approach by April 2016, a concept design for integrated care by October 2016 and a goal of implementing the model by April 2017. This plan outlines the integration approach for continued integration of physical and behavioral health care for California’s beneficiaries with the overarching goal of improving health outcomes for beneficiaries with a substance use disorder while reducing costs in the Medi-Cal program.

Decision-makers across the health care spectrum recognize the need to better serve patients with behavioral health conditions by better coordinating and integrating care across a wide range of systems.

The most important aspects of integration and coordination that improve overall health status for people with co-occurring behavioral and physical health conditions and are proven effective and/or cost-effective must be highlighted and prioritized.¹

Methods

An extensive literature review was conducted to inform this report. The review included, but was not limited to: national and California-specific published reports on prevalence of mental health and substance use conditions among Californians and nationally; current gaps in treatment; a review of studies and reports on State and national initiatives to integrate behavioral and physical health services; and published reports of evidence based models and emerging promising strategies for behavioral health integration.

In addition, DHCS led an extensive feedback process that started in November 2014 with a Mental Health and Substance Use Disorder Services (MHSUDS) Integration Task

Force meeting of experts and other stakeholders focusing on identifying short-term and long-term strategies to integrate physical and behavioral health care services.

Issues

Prevalence of Behavioral Health Conditions

Nearly 20 percent of the adults in Californians (18.5%) and nationally (18.5%) have experienced some mental illness in the past year, and about 4 percent (3.9% and 4.1%, respectively) have experienced Serious Mental Illness (SMI).² The average life expectancy of individuals with SMI is 20 to 25 years shorter than that of the general population. People with SMI have higher rates of unhealthy behaviors, such as lack of exercise, smoking, alcohol use, and poor nutrition, which increase the risk of developing chronic conditions.³ For example, Californians that report poor mental health are almost twice as likely to be smokers as Californians without any mental health disorder (21.7 % and 11.7%, respectively).⁴

Additionally, 8.8 percent of Californians 12 years and older and 8.4 percent nationally have had an alcohol or drug abuse problem in the past year.³ A high percentage of individuals with SMI suffer from co-occurring physical and behavioral health (mental health and substance use) conditions and thus are in need of both physical and behavioral health care services. A recent report by the Institute for Clinical and Economic Review (ICER) noted that about 70 percent of adults with behavioral health conditions have one or more physical health issues as well.⁵ Research indicates that individuals with co-occurring behavioral and physical health conditions “experience high fragmented systems of care, contributing to poor health outcomes and elevated levels of unmet treatment needs.”⁶ A holistic approach to care including prevention, intervention, and treatment is needed in order to best meet the needs of the high proportion of Californians, and especially low-income Medi-Cal members, with co-occurring physical and behavioral health conditions. Furthermore, people suffering from behavioral health conditions have total health care costs far greater than twice that of people with no behavioral health problems.⁷ In a recent analysis of high Medi-Cal utilizers (the beneficiaries in the highest cost cohorts), DHCS found that 5 percent of Medi-Cal beneficiaries, most of whom had at least one behavioral health condition, accounted for 51 percent of total Medi-Cal expenditures. Several pilots in California, based on the “housing first” model, aim to address this issue of very costly yet ineffective treatment for high utilizers. Early results show 60 to 80 percent reductions in costs and improved health status and patient satisfaction.⁸

Though behavioral health issues affect people of all race/ethnicities, genders/sexual identities, cultural and geographic backgrounds, and ages, not all sub-populations

experience behavioral health conditions in the same way. For example, Latino adults have higher rates of self-reported binge drinking (33%) and fair or poor health (30.8%) than other race/ethnicities. Black adults are more likely to report being diagnosed with serious psychological distress in the past year (11.5%).⁹

Adults are more than twice as likely (8.7%) as teens (3.7%) to report serious psychological stress in the past month.¹⁰

Advancing the Behavioral Health System in California

The California Mental Health and Substance Use Needs Assessment, which is a product of extensive quantitative and qualitative analyses, documents major projects that have been implemented in California in recent years to advance integration, as well as the barriers to full-scale implementation of integration.¹¹ In collaboration with partners, stakeholders, and advocates, four areas for potential integration were identified: 1) information sharing; 2) structure and financing; 3) workforce shortage and development; and 4) treatment capacity.¹²

- *Meaningful Information Sharing*

Sharing costs, quality, and clinical data is critical for behavioral health integration. In fact, Collins et al.¹³ wrote extensively about technology and its critical role in promoting a holistic approach to health care. Collins et al. found that information exchange across physical, mental health and substance use services could improve among providers, health plans, counties, and the state.

- *Structural and Financial Barriers*

Since the merger of the former Departments of Mental Health and Alcohol and Drug Programs with DHCS in 2012, there has been a structural shift towards greater integration and coordination of care at the state level. Distinct cultures and practices that dominated three separate departments now must work together in a coordinated manner in a single department.

- *Financial Considerations*

As of May 2015, approximately 80 percent of Medi-Cal members are enrolled in Medi-Cal Managed Care Plans (MCPs), up from 54 percent in 2011, making it one of the highest proportions among Medicaid programs in the nation.¹⁰ Effective January 1, 2014, MCPs provide mental health services for individuals with mild to moderate mental health impairments as well as the Alcohol Screening, Brief Intervention and Referral to

Treatment (SBIRT) benefit among other preventive care benefits. These coverage changes may increase the quality and efficiency of services for members with mild to moderate mental health conditions and at-risk for alcohol abuse. Specialty Mental Health services are provided in a carve out through the county mental health plans and there needs to be care coordination between the mental health plan and the managed care plan.

- *Workforce*

- *Workforce Shortage*

As in other parts of the country, workforce shortages were identified in California in primary care, mental health, and substance use domains. More specifically, many counties (including in urban areas, but magnified in rural areas) experience severe shortages of family physicians, pediatricians, certified substance use providers, and child psychiatrists. Some national experts recommended using other health care professionals and non-professional workers to help reduce the gap. Additionally, stakeholders have also recommended utilizing peer support specialists as a viable opportunity to expand the workforce.

- *Treatment Capacity*

SAMHSA notes that only 2.6 percent of Californians 12 years and older who are in need of treatment for illicit drug use are receiving treatment, and only 6.79 percent of those in need of treatment for alcohol use are receiving treatment.³¹⁴

The California Substance Use Disorder Block Grant and Statewide Needs Assessment and Planning Report noted that the rates for SUD-related emergency department visits have steadily increased over the past several years.¹⁵

Integration

Argument for Integration

Due to the implementation of the Patient Protection and Affordable Care Act (ACA), the way health care is delivered is changing and will continue to change dramatically in the next decade. In this new environment, the providers and systems that will best cope are those that embrace the Institute for Health Improvement's Triple Aim: 1) to improve the experience of care, 2) to improve the health of populations, and 3) to reduce per capita health care costs.¹⁶ When done effectively, the integration of mental health,

substance use, and physical health services has the potential to effectively achieve the Triple Aim.

Behavioral health integration changes the way systems deliver care, coordinate care, and require partnerships between different types of providers with different professional cultures that historically have worked in silos. Many of the terms related to behavioral health integration have multiple definitions and variations. The Agency for Healthcare Research and Quality (AHRQ) produced extensive work defining these terms, which is now commonly used by clinicians, care systems, health plans, policymakers and others. One definition of integration from AHRQ described integrated care as “the care that results from a practice of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance use conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms and ineffective patterns of health care utilization.”¹⁷ Additionally, there are many well-documented reasons for integrating behavioral and physical health services.¹⁸ The four main arguments for integration are:

1. The economic and social burden of behavioral health conditions. Mental illness can create a personal burden that may result in significant economic and social hardships.
2. The high prevalence of co-occurring physical and behavioral health conditions.
3. Improvements to Care:
 - a. The prevalence of behavioral health conditions in conjunction with the low supply of mental health and substance use providers.
 - b. The difference between the prevalence of behavioral health conditions and the number of people receiving treatment.
 - c. Stigma and discrimination associated with receiving treatment in behavioral health care settings.
 - d. Individual reluctance to certain settings and provider types.
4. The emerging evidence that shows the effectiveness and cost-effectiveness of treating physical and behavioral conditions simultaneously for individuals with co-morbidities.

Core Concepts

DHCS looked at the core concepts of integration that are common to evidence-based integration models. In addition, DHCS took into account expert opinion, input from California stakeholders and other states’ officials, as well as other frameworks for

integration such as the AHRQ Lexicon for Behavioral Health and Primary Care Integration. DHCS is considering how these concepts are compatible with and enhance the four core concepts of effective and efficient integration practices.

The four core concepts of integration when presented together that researchers believe will lead to better population health, better care, and lower per capita costs are: 1) patient centered medical home, 2) health care team, 3) stepped care recovery, and 4) four-quadrant clinical integration.¹⁹ DHCS is also considering health equity as a fifth domain, which is unique to California given its diverse population.

- *Patient Centered Medical Home*

Patient centered medical home refers to the provision of comprehensive care that meets the large majority of each patient's physical and behavioral health care needs, including prevention and wellness, acute and chronic care. When broader health services are required, the medical home must coordinate care across systems, including specialty care, hospitals, and other community services. The medical home must respect patients' needs, culture, values, and preferences. It also sees the patients and their family as part of the health care team and actively supports and educates patients and families on how to organize and advocate for their own care. In addition, it emphasizes accessibility (e.g., short waiting times and around-the-clock access to quality care). Quality Improvement and patient safety are also central focuses of medical homes.²⁰

- *Team-Based Care*

The health care team concept refers to a team of health care providers (e.g., Primary Care Physician, psychiatrist, pharmacist, care coordinator, non-traditional health workers) sharing responsibility for patient care, rather than a provider-patient relationship; the patient and/or patient's family are part of the care team.

- *Stepped Care*

The stepped care recovery model emphasizes treating patients in the lowest appropriate service tier to cause minimal disruption to the patient's life. It is the least intensive and extensive level of care needed to achieve positive results, and is the most cost-effective. If a patient's functioning does not improve, a "step up" treatment will be offered, including specialty care when needed. Patients can also be "stepped down" to primary care after adequate treatment is provided and the patient is stabilized.²¹

- Four-Quadrant Clinical Integration*

The fourth element is four-quadrant clinical integration which is a conceptual framework for addressing the needs of the population. The types of services and the organizational models are chosen according to population needs. Quadrant I include patients with low behavioral and low physical health needs who should be served in the primary care setting. Quadrant II includes patients with high behavioral and low physical health needs who should be served in both behavioral health and primary care settings with the assistance of a care coordinator. Quadrant III includes patients with low behavioral and high physical health needs who should be served in the primary care setting with behavioral health consultation and access to behavioral health services, as needed. Finally, Quadrant IV includes patients with high behavioral and high physical health needs who should be served primarily in the primary care setting with the assistance of a care coordinator and disease manager. In severe behavioral health episodes, services could be provided in behavioral health settings. Once the patient is stabilized she/he should return to the primary care provider.²²
- Health Equity (race/ethnicity, gender/sexual identity, cultural and geographic background, and age)*

Communities of color represent about 60 percent of all Californians, and nearly three quarters of children (72.6%).²³

Efforts in Integration

Several institutions at the federal level, such as the CMS and SAMHSA, recognize the importance of behavioral health integration and are actively supporting it. Initiatives focus on high utilizers, population-based activities to coordinate care, certain sub-populations (e.g., based on gender, race/ethnicity), and/or certain health conditions or comorbidities. At the state level, the California Health and Human Services Agency (CHHS), as is described in the “Let’s Get Healthy California” report, is supporting coordination of care between primary and specialty care services, including mental health and substance use disorder services.²⁴

DHCS is in a unique position to advance integration. The former Departments of Mental Health and Drug and Alcohol Programs are now part of DHCS, which administers Medi-Cal, California’s Medicaid program, providing opportunities for collaboration like never before. DHCS recognizes the potential of improved communication and integration between physical, mental health and substance use delivery systems to advance the Triple Aim as well as DHCS’ three linked goals,²⁵ and thus is active in promoting integration of care. DHCS’ efforts in integration include: the Drug Medi-Cal Organized Delivery System Waiver; Medi-Cal’s Coordinated Care Initiative (CCI): The Duals

Demonstration;²⁶ provision of mental health services for adults and children diagnosed with mild to moderate mental health disorders;²⁷ development of a Health Home Program for high utilizers, including individuals with behavioral health conditions; and Whole Person Care Pilot in the Medi-Cal 2020 waiver.²⁸

California's Approach to Integration

Achieving Integration

The development of the vision is created with a health equity lens, guided by the four core concepts of integration and has flexibility and diversity for ease of implementation in this large and complex state. SAMHSA – HRSA Center for Integrated Health Solutions produced “A Standard Framework for Levels of Integrated Healthcare”²⁹ which fits with California’s diverse delivery system. The SAMHSA model describes integration in a continuum structure - with minimal integration on one end of the spectrum (Level One) and total integration on the other end (Level Six). This model helps organizations evaluate the degree of their integration and to determine if additional steps are needed in order to enhance their level of integration.

The three main categories in the SAMHSA six-level continuum model are 1) Coordinated Care, 2) Co-located Care and 3) Integrated Care. Each category identifies two levels which move from minimal integration to total integration. DHCS considers this model of integration as a viable option for California.

Coordinated Care

Level 1 – “Minimal Collaboration” which is defined by physical health care and behavioral health is located in separate facilities, the communication between the organizations is rare regarding client care and there is little appreciation for each other’s organizational culture.

Level 2 – “Basic Collaboration” at a Distance which means that the physical health care and behavioral health providers view each other as a resource but remain at separate facilities, communication about a shared client is periodic but mostly written and through telephone interactions, and there is little understanding of the other’s culture. Behavioral Health is viewed as specialty care.

Co-Located Care

Level 3 – “Basic Collaboration Onsite” which is defined as the physical health care and behavioral health providers share a physical location and have more regular face-to-face communication with occasional meetings to discuss shared clients and share some

appreciation of each other's role in the delivery system. However, the decisions about client care and service delivery are made independently.

Level 4 – “Close Collaboration with Some System Integration” which means that the behavioral health provider and the physical health provider share the same physical space, have regular face-to-face communications, coordinate treatment plans for high needs clients and a basic understanding of each other's role in the delivery system.

Integrated Care

Level 5 – “Close Collaboration Approaching an Integrated Practice” which means that the physical health care and behavioral health providers share the same physical location, they function as a team regarding the delivery of services in accordance with the treatment plan and understand each other's role. The providers have begun to change their practice in order to provide more integrated care to the client.

Level 6 – “Full Collaboration in a Transformed/Merged Practice” which is the highest level of integration. There is more collaboration between the providers on all of the clients and they work as one team. The organizational culture is of all providers treating the whole person as a single health care provider.

Stakeholder Process

Over the course of the next few months, DHCS will provide stakeholder engagement opportunities to collect input regarding the details of the integration concept design. In order to develop the integration pilots within the DMC-ODS structure, DHCS will host in-person Wavier Advisory Group meetings in an effort to reach out to stakeholders and other impacted parties. DHCS will use the same stakeholder process used to gather the initial input on the DMC-ODS waiver. Evaluating the SAMHSA integration model for potential use in California will require extensive coordination and collaboration between physical health, mental health and SUD partners.

Framework for Integration Concept Design

In developing the integration plan, DHCS will look at several key areas. These topic areas include, but are not limited to, framework, model, criteria for selection, requirements and evaluation.

Framework for the Integration Plan:

- Does the SAMHSA model work for California?
- If so, how will the SAMHSA model be tested through the DMC-ODS pilot?
- Will pilots occur within all three levels of the integration continuum or will counties move throughout the continuum?
- What is the goal for participating counties?

- How will the integration pilot intersect with other California efforts such as Health Homes and the Whole Person Care Pilot?
- Would DHCS need to request a waiver to any Medicaid or other federal authorities?

Model:

- What current restrictions due to 42CFR Part II can be tested in the model?
- Will the model be required throughout the county system or tested in portions of the county? Or would the model be provider specific and more localized?
- What federal technical assistance would be needed?

Criteria for Selection:

- How will participating counties and/or providers be selected for participation?
- How will counties and/or providers be recruited to participate?
- Will selection be limited to a capped number of counties or will all DMC-ODS counties be able to participate, if interested?
- What will be the timeline and process for application and selection?

Potential Requirements:

- Shared Program Improvement Projects through the EQRO process
- Plan on how to identify and treat high-utilizers
- What would be the specific requirements in the three main categories of Coordinated Care, Co-located Care and Integrated Care? For example, in the integrated care level, shared electronic health records with SUD, Mental Health and primary care could be a requirement

Evaluation:

- What key areas will be evaluated?
- How will effectiveness of the model be determined?
- What data will need to be collected?
- Will this model impact Emergency Room visits, the Child Welfare System and the criminal justice system?

Funding

- What would the reimbursement mechanisms look like?
- How would we promote innovative value-based strategies that align financial incentives, at the plan, county and provider level

Timeline

The following timeline will be utilized to facilitate the planning process:

| Task | Timeframe |
|---|----------------|
| Submit integration planning process to CMS | May 2016 |
| Post integration planning document to website | May 2016 |
| Coordinate stakeholder workgroup meeting | June 2016 |
| Convene first stakeholder workgroup meeting | June 2016 |
| Write draft integration concept design | July 2016 |
| Reconvene stakeholders for input | August 2016 |
| Finalize integration concept design | September 2016 |
| Submit final concept design to CMS | October 2016 |

Summary

Those struggling with mental health and/or substance use disorders die earlier and have more complex physical and social health needs than the general population.³⁰ Individuals with behavioral health conditions are costly both to the public and to employers, and are less able to live high quality, productive lives. Because of this, systems of care—including physical, mental health, substance use, and social services—must coordinate care in order to best meet the needs of patients.

Because California is a large, diverse and complex state, it requires a flexible and diverse model for integration which is why the use of the model defined by SAMHSA HRS Center for Integrated Solutions as described above is an approach worth investigating.

Endnotes

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