<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Presenter or Facilitator</th>
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</thead>
<tbody>
<tr>
<td>8:30 a.m.</td>
<td>Planning Council Member Issue Requests</td>
<td></td>
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<tr>
<td>8:35 a.m.</td>
<td>Welcome and Introductions</td>
<td>Robert Blackford, Chairperson</td>
<td></td>
</tr>
<tr>
<td>8:40 a.m.</td>
<td>Review and Approve Meeting Highlights from October/December</td>
<td>Robert Blackford, Chairperson</td>
<td>A</td>
</tr>
<tr>
<td>9:00 a.m.</td>
<td>Presentation by Dr. Laura Vleugels regarding psychotropic medication use for youth.</td>
<td>Dr. Laura Vleugels</td>
<td></td>
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<tr>
<td>10:00 a.m.</td>
<td>Discussion by phone with California Association of Health Plans regarding regulations and legislation pertaining to health care integration.</td>
<td>Jennifer Alley, Legislative Advocate Athena Chapman, VP of State Programs</td>
<td>B</td>
</tr>
<tr>
<td>10:30 a.m.</td>
<td>Break</td>
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<tr>
<td>10:40 a.m.</td>
<td>Work plan revision for 2017: Consideration to reduce the number of goals. Committee discussion on projects to pursue for 2017.</td>
<td>All</td>
<td>C</td>
</tr>
<tr>
<td>11:00 a.m.</td>
<td>Literature review of psychotropic medication and next steps regarding this topic. Recommendations to DHCS?</td>
<td>Robert Blackford, Chairperson</td>
<td>D</td>
</tr>
<tr>
<td>11:30 a.m.</td>
<td>Barriers to Integration: A discussion with Health Plus Advocates about the same day billing barrier and other areas where integration of MH and physical health are critical.</td>
<td>Liz Oseguera, Health Plus Advocates</td>
<td>E</td>
</tr>
<tr>
<td>11:55 a.m.</td>
<td>Wrap up: Report Out/ Evaluate Meeting</td>
<td>Robert Blackford, Chairperson</td>
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<tr>
<td>12:00 p.m.</td>
<td>Adjourn Committee</td>
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The scheduled times on the agenda are estimates and subject to change.

Committee Members:

**Chair:**
Robert Blackford

**Chair-Elect:**
Deborah Pitts

**Members:**
Patricia Bennett
Josephine Black
Vera Calloway
Peter Harsch

Dale Mueller
Gail Nickerson
Melen Vue

Terry Lewis
Cheryl Treadwell
Daphyne Watson
Veronica Kelley

If reasonable accommodations are required, please contact Chamenique Williams at (916) 323-4501 not less than 5 working days prior to the meeting date.
Committee members will Review and Approve October and December Meeting Highlights.
Meeting Commenced at 8:30 a.m.

<table>
<thead>
<tr>
<th>Item #</th>
<th>Issue</th>
<th>Discussion/Options</th>
<th>Action/Resolution</th>
<th>By Whom?</th>
<th>By When?</th>
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<tbody>
<tr>
<td>1.</td>
<td>Review and Approve Minutes</td>
<td>Laura Grossman, Program Director, Beacon Health Options spoke about psychotropic medications and the impact on youth and families. She addressed the following questions:</td>
<td>Motion made by Patricia Bennett and seconded by Dale Mueller: June Minutes were approved as written.</td>
<td>No Abstentions</td>
<td></td>
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<tr>
<td>2.</td>
<td>Presentation: Beacon Health Options</td>
<td>Our request was related to persons who are the Health Plan’s enrollees/members with payors connected with the CA Department of Healthcare (MediCal and CHIP).</td>
<td>Staff will send the PowerPoint presentation and the 18 diagnoses that qualify for County Specialty Mental Health services to members.</td>
<td>All</td>
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</table>

1. What if any monitoring processes/analysis do they have for the use of psychiatric medications
<table>
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<tr>
<th>Item #</th>
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<th>Action/Resolution</th>
<th>By Whom?</th>
<th>By When?</th>
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<tbody>
<tr>
<td></td>
<td>by Pediatrician for Children and Adolescents?</td>
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<tr>
<td>2.</td>
<td>What monitoring processes/analysis do they have for use of psychiatric medications prescribed by Psychiatrists?</td>
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<tr>
<td>3.</td>
<td>Do their Psychiatrists need to be board certified in Child Psychiatry to see children and adolescents? If not do they have a credentialing process for General Psychiatrist to treat Children and Adolescents?</td>
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<tr>
<td>4.</td>
<td>If a child or adolescent falls into the category of Serious Emotional Disturbance (SED) how is care coordinated between the Pediatrician and the Psychiatrist?</td>
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<td>5.</td>
<td>Are there other treatment providers that are used prior to medication being prescribed for children with behavioral health issues? If so, what disciplines are they?</td>
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<td>6.</td>
<td>Do they use standardized screening tools for determining Behavioral</td>
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<tr>
<td>Item #</td>
<td>Issue</td>
<td>Discussion/Options</td>
<td>Action/Resolution</td>
<td>By Whom?</td>
<td>By When?</td>
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<td></td>
<td></td>
<td>Health diagnosis for children and adolescents?</td>
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<tr>
<td>3.</td>
<td>Review CMHPC HCI Alternatives to Medication Chart: Explore health effects of psychotropic medications on children and alternatives to medication.</td>
<td>Staff reviewed the chart drafted by Deborah Pitts that outlines different alternatives to psychotropic medications for children. The committee looked over what approaches are being taken, resources identified, and considered potential invitees to the committee over the next several meetings. (LMHPs with expertise in some of the psychosocial interventions, occupational therapist with expertise in sensory processing interventions, an organization leadership representative that has implemented a workforce development effort in trauma informed care for this population.) Alternatives to medication could be clustered/categorized in to four (4) broad areas: ✓ <strong>Policy level</strong> initiatives to address systematic challenges to delivering care, addressing</td>
<td>Members discussed inviting the following for a panel presentation in January: 1. Nurse Practitioner 2. Mental Health Plan in San Diego County (Robert Blackford offered to reach out) 3. School district</td>
<td>Members will discuss panel further at the November meeting</td>
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<tr>
<td>Item #</td>
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<td>Discussion/Options</td>
<td>Action/Resolution</td>
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<td>By When?</td>
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</table>
| 4.    | **Review HCI Report: Medi-Cal coverage of Mild to Moderate Mental Health Conditions** | child to staff ratios for example, or define what type of providers should be on a team or practices that should occur prior to medications being introduced.  
- **Workforce development** approaches that improve/strengthen skill sets of providers to address behavioral and psychosocial needs typically targeted by medications.  
- **Psychosocial interventions** offering targeting particular psychiatric conditions, and often delivered by licensed mental health providers  
- **Neuro-science informed therapeutic approaches**, including sensory processing approaches in occupational therapy.  
- **Alternative and complementary medicine** | Jane Adcock advised that she is reviewing the draft report by staff and that the data requested by the committee regarding mild to moderate hospitalization rate data within the health plans (and mentioned in the report) | Jane Adcock will follow up with her source to determine if the specific data the committee is seeking is available. |
### Item # | Issue | Discussion/Options | Action/Resolution | By Whom? | By When?
--- | --- | --- | --- | --- | ---
4. | | report recommendations) may be available through DHCS. Steven Grolnic-McClurg responded that the California Health Care Foundation and the HCI Committee were both unable to extract the data. The mild to moderate data in the health plans is not accessible. The committee will double check to make sure the data is not available now. Grolnic-McClurg advised that the document by the committee was meant to be a companion document (an introduction) to the report written by the California Health Care Foundation. | | | |
5. | New Business | Deborah Pitts requested that the HCI committee take a look at the CCBHC application. If OTs are not explicitly included it would be an opportunity to take action on our work plan in this regard by advocating to get OTs included as members of the core CCBHC team in California’s application. | | | | Members discussed this request and preferred to make this decision at a later date after reviewing the information. |
<table>
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<tr>
<th>Item #</th>
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<th>Discussion/Options</th>
<th>Action/Resolution</th>
<th>By Whom?</th>
<th>By When?</th>
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<tbody>
<tr>
<td>4.</td>
<td><strong>Discussion: Next Steps/ Develop Agenda for Next Meeting</strong></td>
<td>Members discussed inviting the following for a panel presentation in January: 1. Nurse Practitioner 2. Mental Health Plan in San Diego County (Robert Blackford offered to reach out) 3. School district</td>
<td>Members will discuss further at the November meeting.</td>
<td>All</td>
<td>N/A</td>
</tr>
<tr>
<td>5.</td>
<td><strong>Public Comment</strong></td>
<td>None</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>6.</td>
<td><strong>Wrap up: Report Out/ Evaluate Meeting</strong></td>
<td>Members provided thoughts on the meeting.</td>
<td>Terry Lewis would like time carved out on the agenda for members to speak.</td>
<td>All</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Attendees:
Robert Blackford
Gail Nickerson
Vera Callaway
Cheryl Treadwell

- Revise the Work plan and move the Mild to Moderate to 16-17
- Need to follow up with Jane to determine where we are with the report and if the data for Mild to Moderate can be obtained from DHCS.
- Gail N. suggested that we explore how tele-psychiatry could assist in integration efforts.
- Reviewed the work plan. Will discuss the need to thin out the number of goals and focus more intently on one or two areas related to health care integration.
- Need an update on the CCBHC process. Which counties are participating?
- Robert was referred to Dr. Laura Vleugels who may be able to present at the January meeting
- Discussed the January meeting agenda. Will have the following items: Literature review, Dr. Laura Vleugels (Psychotropic medication use in youth), CAHP (regulatory and legislation for health care integration), CA Health Advocates (Barriers to Integration), work plan review.
AGENDA ITEM: Discussion with California Association of Health Plan representatives, Athena Chapman and Jennifer Alley regarding regulations and legislation pertaining to health care integration.

ENCLOSURES: CAHP: About Us

OTHER MATERIAL RELATED TO ITEM:

“The California Association of Health Plans' mission is to serve our members by creating and sustaining an environment that permits them to maintain viability and grow as organizations dedicated to coordinating or providing high quality, affordable, accessible health care to their members.” (taken from website)

CAHP advocates for the interests of health plans and their members. The CAHP has a strong presence in state policy and they work to inform policy makers and regulators about the impact of their decisions on the ability of the health plans to meet their goals.

Athena Chapman and Jennifer Alley can speak to the most important legislation and regulatory issues facing health care integration.

For more information, please follow the link at http://www.calhealthplans.org/about-us.html
At the December call-in meeting there was significant discussion about trimming the number of goals on the HCI work plan moving forward into 2017. Reducing the number of goals would allow the committee to focus more intently on one or two areas in order to make recommendation to the larger Council as well as the Department of Health Care Services. This agenda item will allow committee members to discuss the goals on the work plan and determine how they would like to proceed moving forward.
# Work Plan 2015-2016

**Goal 1:** Explore Best Practices for the Delivery of Mild to Moderate level of Services.

**Rationale:** MCPs are responsible for the delivery of certain mental health services through the MCP provider network to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder as defined by the current DSM, that are outside of the PCP’s scope of practice (ACL 13-021)

**Measure of Success:** Written Report?

**Target Audience:** Counties, Public, Legislature

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Action Steps</th>
<th>Timeline</th>
<th>Leads</th>
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</thead>
</table>
| • To find and highlight different ways mental health services are being delivered for mild to moderate levels. | • Ongoing Presentations at Meetings.  
• Literature Review | | Staff |
<table>
<thead>
<tr>
<th><strong>Goal 2:</strong> Advocate to position Occupational Therapists under Licensed Mental Health Professionals</th>
<th><strong>Rationale:</strong> Increase workforce and access to care</th>
<th><strong>Measure of Success:</strong> Occupational Therapists are moved to the Mental Health Professional Category</th>
<th><strong>Target Audience:</strong> TBD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objectives</strong></td>
<td><strong>Action Steps</strong></td>
<td><strong>Timeline</strong></td>
<td><strong>Leads</strong></td>
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<tr>
<td>TBD</td>
<td></td>
<td>April 2015- December 2015</td>
<td>TBD</td>
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</tbody>
</table>
CMHPC
Healthcare Integration Committee

<table>
<thead>
<tr>
<th>Goal 3: Find what the existing data is around the psychiatric hospitalization rates for members of the managed Medi-Cal health plans. Working with Catherine Teare, CHCF.</th>
<th>Rationale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>This project will fall under the full council's theme: <em>alternatives to locked facilities.</em></td>
<td>Measure of Success:</td>
</tr>
<tr>
<td>Target Audience: TBD</td>
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<table>
<thead>
<tr>
<th>Objectives</th>
<th>Action Steps</th>
<th>Timeline</th>
<th>Leads</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committee has agreed to look at acute hospitalization rates and long-term hospitalization rates.</td>
<td>Contractor document review late April</td>
<td>Steven Grolnic-McClurg, Catherine Teare, CHCF</td>
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# CMHPC

## Healthcare Integration Committee

### Goal 4: Create a comprehensive list of health plans that are “carving in” and those “carving out”?

<table>
<thead>
<tr>
<th>Rationale:</th>
<th>Measure of Success:</th>
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<tbody>
<tr>
<td>MCPs are responsible for the delivery of certain mental health services through the MCP provider network to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder as defined by the current DSM, that are outside of the PCP’s scope of practice (ACL 13-021)</td>
<td>Written Report via CHCF</td>
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<tr>
<th>Objectives</th>
<th>Action Steps</th>
<th>Timeline</th>
<th>Leads</th>
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<tbody>
<tr>
<td>• Highlight some successes</td>
<td>• Work with CHCF (Catherine Teare)</td>
<td>Contractor document review late April</td>
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</tr>
<tr>
<td>• Link to all of the MOU’s between the counties and the Managed Medi-Cal Health Plans</td>
<td>• CHCF Consultant mapping out which health plan is carving in and which health plan is carving out and who they are carving out too, and how they are paying for those services</td>
<td></td>
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<tr>
<td>• Training/Presentation to the CALMHB/C regarding MOU’s (Health plans and mental health plans)</td>
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<td>• Question #1: Is it better in places where they are carving in versus carving out</td>
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<td>• Question #2: Is there any difference in the way the county and health plan have arranged their interactions or meeting schedule which leads integration to work better in certain places</td>
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<table>
<thead>
<tr>
<th>Target Audience:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Boards Counties Public</td>
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</table>
**Goal 5:**
HCI Committee to monitor the DHCS (Certified Community Behavioral Health Clinics) preparation for the California’s plan.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Action Steps</th>
<th>Timeline</th>
<th>Leads</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>TBD</td>
<td>Deborah Pitts</td>
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</tbody>
</table>

**Rationale:**

**Measure of Success:**

**Target Audience:**
TBD
## Goal 6:
The health effects of psychotropic medications on children. Look into what innovative practices are counties and mental health plans doing to decrease the use of psychotropic medications, and what are the alternatives to medications for children.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Action Steps</th>
<th>Timeline</th>
<th>Leads</th>
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<tbody>
<tr>
<td>Explore the health effects of psychotropic medications on Children. Research innovative practices and alternatives to medications. Gather information from Health Plans, County Mental Health, and the youth and family, and a Nurse Practitioner.</td>
<td>• Invite a panel to present at the April 2016 meeting</td>
<td>TBD</td>
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</table>
**ISSUE:**

The committee has been in review of the policies regarding psychotropic medication use among youth and foster youth. The literature included in this section relates directly to the subject and could inform the committee as it prepares to make recommendations.

<table>
<thead>
<tr>
<th>AGENDA ITEM:</th>
<th>Literature review of psychotropic medication and next steps regarding this topic.</th>
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<tbody>
<tr>
<td>ENCLOSURES:</td>
<td>• Literature summary</td>
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<tr>
<td>OTHER MATERIAL RELATED TO ITEM:</td>
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</table>
California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care


This was a project of the CDSS and DHCS to provide guidelines around the treatment of foster youth. The guidelines include information about treatment planning, the basic principles of care, psychiatric evaluation, diagnosis, and prescribing of medicine. The end of the document provides some nice checklists that prescribers should consider before prescribing, when prescribing, and after prescriptions have been made. There is discussion in the document about the importance of the Child and Family Team (CFT) and their involvement in the process of considering medications. The CFT is a major part of the Core Practice Model. Medications are approved for foster use through the use of a JV220, which is the authorization given by the court. I have always wondered why a judge is asked to approve psychotropic medications. Judges are lawyers, not psychiatrists. Should this approval be provided by a physician assigned by the court? What are the procedures with this?


The nuts and bolts of this report is the four policy recommendations made in 2004. They are:

1. The National Institute of Mental Health (NIMH) should make a significant investment in research on early onset mental disorders and the use of psychotropic medications in children and adolescents.
2. Children should only be diagnosed and treated by the best qualified mental health professionals and properly trained medical professionals. Children should be protected from inaccurate diagnoses.
3. Families and all professionals that work with children should receive appropriate information and education about early-onset mental illnesses - including how to recognize the early warning signs as well as information about the latest research related to the use of psychotropic medications.
4. Legislative or regulatory consideration related to the use of psychotropic medications for children and adolescents must be guided by science. Action should be taken only after obtaining testimony and input from qualified and well-recognized medical and mental health professionals and families and on the basis of sound scientific research.
AACAP (2015). Recommendations about the Use of Psychotropic Medications for Children and Adolescents Involved in Child-Serving Systems


This is a great report which gives an exhaustive description of best practices for the clinical practice of prescribing medications to youth, the monitoring and oversight of medication management, and the research needed to help us make the best decisions for treatment. There are a total of 18 recommendations made at the end of the report. The recommendations are broken down into the three categories mentioned above. Psychotropic medication has a legitimate role in the treatment of children. Prescribers should have an understanding of trauma informed care. It is also very important for prescribers to work within the framework of the family and to consider the child and families input before and while prescribing medications.


This is a short fact sheet from the AACAP which outlines guidelines for psychiatrists and families around prescribing of medications for youth. The article stated that psychiatrists should be experienced in child psychiatry, explain the benefits and risks, and alternatives available. The article goes on to list the types of disorders which are treated by psychotropic medications i.e. bedwetting, ADHD, OCD, eating disorders, depression.

AACAP (2012). Psychiatric Medications for Children and Adolescents: Part II-Types of Medications


This article outlines the importance of research so that psychiatrists are prescribing the medications that have achieved the best outcomes. The article lists the types of disorders experienced by children and the best options for medications to prescribe.

https://www.childwelfare.gov/pubPDFs/mhc_caregivers.pdf

This was written as a guide for foster parents, caregivers, and others who interact with foster youth. It is a follow up guide to “Making Healthy Choices” which was a guide written for youth in foster care. The guide would help them to know about trauma informed care and the prescribing of medications. This guide assists caregivers to advocate for youth who are being considered for medications. The topics discussed in the guide are:

- Consider options besides medication
- Learn about safe medication use
- Empower youth and give them a voice
- Learn about trauma and its effects
- Honoring youth’s specific ethnic, racial, cultural, and sexual identities
- Asking questions of the doctors and specialists who provide services to youth
- Realistic expectations of yourself, the young person, and your relationship

(copied from the document)

Guidance and Resources Regarding Agency-Based Trauma-Informed Care (TIC) Training—SAMHA’s Trauma Informed Care & Alternatives to Seclusion and Restraint

http://www.samhsa.gov/nctic/trauma-interventions

This article provides a definition of a trauma-informed approach. It is described as a program that does the following:

1. **Realizes** the widespread impact of trauma and understands potential paths for recovery;
2. **Recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. **Responds** by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively resist *re-traumatization.* (copied from the document)

SAMHSA’s six key principles are described which are safety, trustworthiness, peer support, collaboration, empowerment, and cultural competence.
**Trauma Informed Care Toolkit**

This is a collection of 50 articles on the subject of trauma informed care for youth. The last few articles listed are provided in Spanish.

**Klain & White from ABA Center for Children and the Law (2013).**
Implementing Trauma-Informed Practices in Child Welfare

This article discusses “complex trauma” and how it differs from other types of trauma. Also discussed is the ACES’s study and the area of a child’s life which are disrupted due to trauma. The article urges child welfare systems to adopt a trauma informed perspective for use throughout the system. This would include screenings of all children in foster care, and implementation of a trauma focused therapeutic approach to be used with children. This article discusses what a trauma informed child welfare system looks like and provides several models to review. The article discusses the importance of addressing secondary trauma. There is a list of practice recommendations and resources for caregivers.

http://archpedi.jamanetwork.com/article.aspx?articleID=2470861

A focus on providing a trauma-informed approach within hospital or primary care settings when children and youth are ill or injured and require hospitalization or treatment after a medical event. The article talks about the prevalence of trauma and its effects on ALL People within the healthcare system. Several definitions of “trauma-informed” approach are provided. There is a nice graphic which explains the overlap of “Family Centered” and “Trauma Informed” approaches. Pediatric healthcare providers require training which takes these two approaches into consideration. The HealthCareToolbox.org and the Trauma Toolbox for Primary Care are discussed as training tools.
Risking Connection
http://www.riskingconnection.com

This is a one-page web page. The mission of the project is included. “Our mission is to help people recover from traumatic experiences through RICH® relationships—those hallmarked by Respect, Information Sharing, Connection, and Hope, and in so doing to reduce the time, trauma, and costs of healing for all involved.”

https://www.apa.org/pi/families/resources/child-medications.pdf

The following is taken from the Preface to the report. This is a 246-page report and an exhaustive review of best practice in prescribing and monitoring youth who have been prescribed psychotropic medications.

“The Report of the APA Working Group on Psychotropic Medications for Children and Adolescents was completed over a two-year period—a time of rapid changes in the field of child and adolescent mental health. It has been a particularly challenging time for mental health care providers and caregivers as they struggle in their quest to determine the appropriate treatments for children and adolescents. The volatile nature of developments surrounding various pharmaceuticals, resulting in advisories and black box warnings, has complicated their decision making process. Against this backdrop, the American Psychological Association commissioned this working group and charged it with reviewing the literature and preparing a comprehensive report on the current state of knowledge concerning the effective use, sequencing, and integration of psychotropic medications and psychosocial interventions for children and adolescents. This review includes a comparative examination of the risk–benefit ratio of psychosocial and pharmacological treatments and the range of child and adolescent psychopharmacology, including the appropriateness of medication practice.”
http://www.mentalhealthamerica.net/sites/default/files/MHA_CAM.pdf

The report states that “this outline has been developed by Mental Health America (MHA) from the principal available evidence-based sources of information concerning "complementary," "alternative," "integrative," "natural," and often self-administered treatments for mental health conditions.” This 272-page resource provides several alternative methods to treat mental health conditions.
Liz Osequera will provide information about Health Plus Advocates and their work in the area of Mental Health integration. There are existing policies which make integration of BH and physical health care difficult. Federally Qualified Health Centers and Certified Community Behavioral Health Clinics are making strides to integrate health care services. This discussion will provide some clarity on future HCI Committee actions in regards to recommendation to the DHCS regarding the removal of barriers.
Promising Practices to Integrate Physical and Mental Health Care for Medi-Cal Members

By Allison Hamblin, Michelle Herman Soper, and Teagan Kuruna, Center for Health Care Strategies

IN BRIEF

Effective coordination of physical and behavioral health services is critical to ensuring quality of care, particularly for low-income populations with high prevalence of chronic conditions and mental illness. Recent changes in how Medi-Cal, California’s Medicaid program, promotes access to and coordination of mental health care provide new incentives for collaboration between two historically siloed systems: Medi-Cal managed care and county mental health. Based on lessons from implementing these changes, this brief describes promising practices to improve collaboration across systems, and to provide a more seamless experience of care for beneficiaries. These insights, while gleaned from California, can inform physical and mental health care integration in other states as well.

All over the country, policymakers, payers, and providers are increasingly aware of the need to better integrate physical and behavioral health care. At the state level, approaches to integration are taking different forms — some efforts consolidate the management of physical and behavioral health — including both mental health and substance use services — benefits through “carve-in” arrangements, while others are working to improve coordination and share accountability across separately managed systems.

California provides an example of both strategies in action. In 2014, the state rolled out a set of enhanced mental health benefits to be covered by Medi-Cal managed care plans (MCPs), creating a newly integrated benefit for individuals with mild-to-moderate mental health needs. Around the same time, the Cal MediConnect demonstration implemented new requirements and incentives for collaboration between Medi-Cal Medicare-Medicaid Plans (MMPs) and select county mental health plans (MHPs) for individuals with serious mental illness (SMI) who are dually eligible for Medi-Cal and Medicare. Under both initiatives, health plans and counties needed to build new infrastructure and strengthen relationships to coordinate care more effectively for individuals with mental health needs, particularly since individuals’ needs can fluctuate from mild to moderate to severe.

MEDI-CAL DEFINITIONS

- **Medi-Cal Managed Care Plans (MCPs):** Contract with the California Department of Health Care Services (DHCS) to manage physical and some behavioral health services for Medi-Cal members.

- **Medi-Cal Medicare-Medicaid Plans (MMPs):** Contract with DHCS and the Centers for Medicare & Medicaid Services under the Cal MediConnect financial alignment demonstration program to manage Medicare and most Medi-Cal benefits – including physical, most long-term services and supports, and some behavioral health services – for dually eligible Medi-Cal members who choose to enroll.

- **County Mental Health Plans (MHPs):** Contract with DHCS to manage specialty behavioral health services for Medi-Cal members who are eligible to receive care through the specialty system.

- **Managed Behavioral Health Organization (MBHO):** Contract with Medi-Cal MCPs to manage “mild-to-moderate” health benefit package; most MCPs that subcontract for these benefits work with Beacon Health Strategies (Beacon).

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Based on experiences from implementing these Medi-Cal initiatives, this brief draws from interviews conducted with health plans, counties, and other system stakeholders to highlight promising practices for: (1) successfully integrating mental health benefits into health plan benefit packages; and (2) building partnerships between health plans and counties to coordinate care for individuals who receive treatment in the county mental health system.

Given the array of new Medi-Cal initiatives that will promote further physical-behavioral health integration — such as the Drug Medi-Cal Organized Delivery System and the Whole Person Care pilots under the Medi-Cal 2020 waiver — the lessons from these 2014 behavioral health reforms should continue to inform efforts to improve care coordination across health plan and mental health county-led systems. In addition, these insights may be relevant to initiatives in other states that are working to improve coordination of physical and behavioral health care.

### Background

For the two decades before 2014, Medi-Cal-funded mental health services were almost exclusively provided through county MHPs, and were only available to members with serious mental health conditions and functional impairments. This meant that Medi-Cal members who did not meet medical necessity criteria to access county-based, specialty mental health services were limited to mental health treatment available from their primary care providers (PCPs). In recognition of this treatment gap, and further spurred by enhanced behavioral health benefit requirements for the Medicaid expansion population, the California Department of Health Care Services (DHCS) expanded Medi-Cal mental health benefits in January 2014. The 2014 reforms added a new set of mental health benefits to be managed directly by the MCPs for members with mild-to-moderate mental health needs, while maintaining the separately managed county MHPs for severe, or specialty, mental health care. In July 2015, the 1915(b) waiver that authorizes this county-based carve-out of specialty mental health services was renewed for another five years.

### EXHIBIT 1: Division of Mental Health Care Services between MCPs and County MHPs in California Since 2014

<table>
<thead>
<tr>
<th>System</th>
<th>Medi Cal MCPs</th>
<th>County/MHP Outpatient</th>
<th>County/MHP Inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services Covered</td>
<td>When provided by a licensed mental health care professional acting within the scope of their license: Individual and group psychotherapy; Psychological testing used to evaluate a mental health condition; Outpatient services — medication monitoring; Outpatient laboratory, medication, supplies, and supplements; and Psychiatric consultation.</td>
<td>Mental health services, including: assessment, plan development, therapy, rehabilitation, and collateral; Medication support services; Day treatment intensive and day rehabilitation; Crisis residential and adult crisis residential; Crisis intervention and stabilization; and Targeted case management.</td>
<td>Acute psychiatric inpatient hospital services; Psychiatric health facility services; and Psychiatric inpatient hospital professional services if the beneficiary is in a fee-for-service hospital.</td>
</tr>
</tbody>
</table>

* Medications in the Medi-Cal MCP benefit exclude anti-psychotics. These are provided FFS and managed by DHCS.

Even before the January 2014 addition of mild-to-moderate mental health benefits, MCPs and county MHPs were required to establish Memorandums of Understanding (MOUs) to coordinate services for members receiving county specialty mental health services. However, the January 2014 reforms amended MOU requirements to address how plans and counties will coordinate mild-to-moderate and as well as specialty mental health services. Such agreements are intended to support MCPs and counties working together to ensure that members receive timely and medically appropriate mental health services. For example, under the 2014 benefit expansion, each MCP is
required to ensure that all members receive mental health screening by their PCP. Members with positive screening results may be treated by the PCP within the PCP’s scope of practice (e.g., prescribing anti-depressants) or referred to a network mental health provider. If individuals appear to have a mental health condition that is beyond the PCP’s scope of practice, the beneficiary is evaluated by a mental health provider using a tool identified in the MOU between the MCP and county. In some cases, primary care practices have hired or partnered with mental health providers to provide this screening onsite, as well as to deliver an array of mild-to-moderate services (e.g., brief intervention, counseling by LCSW). Once screened, if the level of impairment is deemed mild to moderate or the recommended treatment does not otherwise meet medical necessity criteria for the Medi-Cal specialty mental health services listed in Exhibit 1, then the MCP must provide access to outpatient mental health services through a contracted network provider. Meanwhile, members who screen positive for significant impairment, including those with uncertain diagnoses are uncertain, are referred to the county MHP.

Cal Medi-Connect

In April 2014, California began implementing Cal MediConnect as part of the federally authorized Financial Alignment Initiative for Medicare-Medicaid members. Under the program, contracted Medicare-Medicaid plans (MMPs) in participating counties receive a capitated payment to provide Medicare and most Medi-Cal services to eligible members. To avoid destabilizing the existing county-based behavioral health systems, Cal MediConnect maintains the mental health and SUD treatment carve-outs for enrolled members who meet medical necessity criteria to access specialty mental health and SUD services, and requires the MMPs to coordinate care with the county MHPs. Cal MediConnect MMPs provide mild-to-moderate mental health services for members who do not meet the criteria for specialty mental health services.

Until Cal MediConnect began in 2014, county MHPs did not have an official channel to access Medicare information or engage with Medicare providers. Cal MediConnect MMPs, county MHPs, and departments for alcohol and drug services must sign Cal MediConnect MOUs that seek to improve the alignment of behavioral health services for Medicare-Medi-Cal members and begin to bridge the gaps between Medicare and the county behavioral health system. These MOUs, which have similar requirements as those required between MCPs and MHPs, facilitate information sharing across acute care services covered by Medicare and the specialty mental health services to improve care for Medicare-Medicaid beneficiaries.

Opportunities to Inform Ongoing Integration Efforts

With the advent of several reforms to advance whole person care across service sectors in the Medi-Cal program, coupled with the carve-outs for specialty mental health and substance use treatment services, it is essential for MCPs, MMPs, and county entities to establish effective mechanisms for care coordination. The Medi-Cal reforms hold promise for expanding access to a broad continuum of behavioral health services for members who need them. However, to deliver on that promise, all stakeholders have to work together to mitigate systemic barriers to integration and ensure there is no wrong way to access care. The following sections summarize the relevant successes and challenges of implementing the mild-to-moderate mental health benefit in managed care plans and a continuum of mental health benefits across health plans and county providers. Findings from key informant interviews outline promising practices and current issues stakeholders continue to work through in managing these new benefits and improving collaboration across the Medi-Cal program for individuals with mental health needs.
Promising Practices for Incorporating the Mild-to-Moderate Mental Health Benefit

With only a few months between announcement and launch of the January 2014 changes, MCPs had to quickly decide how to incorporate the mild-to-moderate benefit into their existing benefit structure. Specifically, MCPs had to assess their capacity and organizational preference to either manage the new benefits internally or subcontract with a specialized managed behavioral health organization (MBHO). They also needed to develop strategies for working with physical and mental health providers, and for mitigating challenges with coordinating care on the ground. MCPs have employed a range of approaches to integrate the new benefits and communicate the changes to members and providers. Key insights from these experiences, as outlined below, can inform efforts to promote seamless, coordinated access to a broad array of behavioral health and social services that influence Medi-Cal members’ overall health.

1. Maximize collaboration with subcontractors

Due in part to the tight timeframe in which MCPs had to build their capacity to manage these new services, all but two of the plans interviewed (and the majority of plans statewide) chose to subcontract with an MBHO that had the clinical expertise, provider network, and administrative resources to manage the new benefit.† For plans without existing behavioral health infrastructure or that prefer to work with partners specializing in managing behavioral health benefits, subcontracting can be a valuable interim or long-term implementation strategy. Given the significant upfront financial and other resource investment involved, subcontracting can buy MCPs valuable time to develop this capacity internally.

MCPs and Beacon Health Options (Beacon), the principal MBHO partner among subcontracting MCP interviewees, spoke to the importance of aligning subcontracted activities with other internally managed operations to ensure smooth operations. For example, embedding subcontracted personnel on-site with other internal staff performing similar functions (e.g., utilization management) can enable close working relationships and facilitate ongoing communication. Accordingly, Beacon embeds staff on-site with MCPs as part of its standard practice.

In addition, establishing routine meetings and mechanisms for face-to-face communication between MCPs and Beacon can ensure that issues are addressed as they arise — such as in monitoring call wait times, network adequacy, timely payment of provider claims, and resolution of grievances and appeals. MCPs and Beacon alike report that their close contact was essential for the quick ramp-up of new members and new benefits and continues to be important for strong program management. One plan credits the joint provider outreach by MCPs and Beacon as key to building provider networks — particularly with safety net providers and tribal clinics that were already in the plans’ primary care networks, but also had capacity to deliver behavioral health services.

In an environment that is increasingly focused on cross-system partnerships and coordination of services managed by separate agencies (e.g., medical, mental health, SUD, and social services), the practices outlined above can facilitate a seamless experience of care at the member level.

† Of the interviewees, all plans that chose to work with an MBHO subcontracted with Beacon Health Options.
2. Leverage data to maximize accountability and coordination

Medi-Cal MHPs that subcontract for mild-to-moderate mental health services must comply with an array of reporting and audit requirements to ensure effective oversight of delegated entities. Accordingly, subcontractors must submit encounter data at least monthly, as well as report key utilization metrics and network participation, among other requirements. Annual state audits review oversight practices such as meeting agendas and minutes, corrective action plans and associated follow-up. While there is a large degree of consistency in these requirements across programs, some variation exists based on which agency holds state-level oversight responsibility (e.g., Department of Managed Health Care for most MHPs, DHCS for some County-Organized Health Systems.)

Interviewees cited a number of best practices to maximize accountability and coordination through these reporting and data-sharing activities. For example:

- **At the state level**, aligning delegation and associated reporting requirements across state agencies and programs can reduce administrative burden and facilitate implementation of standardized reporting processes across entities.

- **Among MCPs**, integrating oversight of subcontractors within each functional area (e.g., medical management, care management) — as opposed to creating separate oversight units specific to delegated mental health services — can promote collaboration and more integrated management of physical and mental health benefits.

- **At the subcontractor level**, sharing encounter data with MCPs as frequently as weekly can ensure that plans have access to timely information on the continuum of member needs.

Despite the data-sharing requirements for delegated entities, there are no current mandates for routine data sharing and integration between MCP and county MHPs. Also absent are mechanisms for integrating data on anti-psychotic medications, which are covered under fee-for-service by DHCS. Interviewees agreed that integrating these data would significantly enhance opportunities for coordinated management.

In highlighting the critical role of data sharing between subcontractors and plans to promote integration, interviewees acknowledged that the process of merging data from different organizations can be time and resource-intensive, often competing for limited analytics resources with other organizational priorities. As the Drug Medi-Cal Organized Delivery System waiver rolls out, and as Whole Person Care pilots potentially look to integrate an even broader array of service data at the individual level, MHPs and county entities can leverage and perhaps further bolster existing analytic capacity to support data integration. Particularly given the potential to develop more accurate insights into member needs, such investments are likely to have a significant payoff.

3. Take time to build capacity before managing benefits internally

Despite many of the plans’ initial decisions to subcontract, managing mental health benefits internally is a common long-term goal. Before the new benefits were announced, Inland Empire Health Plan (IEHP) had been developing its internal capacity to manage mental health services over several years. In 2010, recognizing the significant opportunity to reduce administrative costs associated with subcontracting for certain business lines, IEHP began moving the management of mental health benefits internally, including for its Medicare and Healthy Families members. By 2014,
IEHP was well positioned to leverage its existing infrastructure from these efforts to bring in the mild-to-moderate mental health benefit for Medi-Cal members.

With 2016 marking the third year of mild-to-moderate mental health benefit implementation, IEHP’s experience provides valuable insights for other plans that might be considering moving subcontracted benefits in-house in the future. Reflecting on its own efforts, IEHP leadership suggests that plans take two to three years to build internal capacity before taking on direct management of behavioral health benefits. IEHP leadership further credits the success of this gradual and ongoing effort to:

- **Garnering executive leadership support for the myriad of systems changes that needed to be developed and implemented**: During this key time of transition when IEHP first integrated behavioral health benefits into its service array, a behavioral health integration “SWAT team” met weekly, including the health plan CEO and chief medical officer.

- **Investing in staff training and development**: In addition to hiring clinical staff to provide behavioral health expertise, IEHP also invested in extensive bi-directional training, in which existing staff learned about providing mental health benefits while newly hired behavioral health staff were educated about IEHP administration and physical health services to foster internal integration and shared understanding.

- **Building key elements for a mental health infrastructure, including:**
  - Hiring staff with appropriate clinical expertise;
  - Developing utilization and medical management protocols;
  - Assembling adequate provider networks;
  - Upgrading IT systems; and
  - Fostering an internal culture of integration.

4. **Streamline credentialing processes to ease provider burden and ensure access to services**

The 2014 reforms required plans to quickly create new provider networks for mild-to-moderate mental health care. As a result, MCPs and Beacon needed to implement streamlined processes for provider credentialing that would increase provider participation and allow members to begin receiving services as soon as the new entitlement went into effect. This need was all the more acute considering the mental health provider shortages throughout much of the state. The credentialing strategies undertaken by MCPs were designed to ensure access to services during the rollout of the new benefit as well as to help reduce administrative burdens and broaden member access to services.

For example, Partnership Health Plan (PHP) allowed Beacon flexibility in provider credentialing during the initial rollout of the mild-to-moderate mental health benefit. Because new providers were being quickly integrated into the PHP provider network, Beacon could not credential the providers before they began seeing patients. Providers signed interim agreements with Beacon to provide services while the official credentialing process was taking place. This allowed PHP members to receive mental health care unimpeded by administrative processes. Meanwhile, San Diego County assured timely credentialing by working with its MCPs to establish a single credentialing authority. For counties with several plans, streamlining credentialing processes can ensure that providers are ready when needed to treat consumers and improve access to services. This approach is also consistent with new federal Medicaid managed care regulations that would establish minimum provider credentialing standards, with the goal of reducing duplicative efforts by individual MCPs.
Promising Practices for Establishing Medi-Cal Managed Care Plan-County Partnerships

The policy changes enacted in 2014 have placed a new premium on effective collaboration between health plans and counties. The increasing focus on high-cost populations reinforces the need for improved care coordination for individuals with SMI, particularly given recent Medi-Cal data highlighting the prevalence of SMI among the highest utilizers of hospital and emergency department services. Furthermore, the Cal Medi-Connect demonstration introduced a new concept to test health plan-county collaboration: shared accountability. The MOUs required between MMPs and MHPs included provisions under which both entities are eligible to earn incentive payments if they meet quality metrics that advance care coordination across the systems, such as decreased rates or emergency department utilization for individuals with SMI.

Health plans and county partners needed to invest significant resources to build relationships and develop new processes, particularly for determining which system bears responsibility for treating an individual member, managing transitions in care across systems based on members’ changing needs, and ensuring coordination of physical and behavioral health care services. These investments will need to continue as new reforms under Medi-Cal 2020 are implemented. In particular, the Drug Medi-Cal Organized Delivery System, Medicaid Health Homes, and the Whole Person Care pilots all demand increased collaboration between MCPPs, counties, and providers to better coordinate substance use disorder treatment and social service delivery (such as housing and related supports) with other physical and mental health services. As the 2014 reforms have demonstrated, coordinating care across multiple systems requires the development of new tools, infrastructure, and communication strategies to address systemic barriers to integration. Following are several approaches that can be useful in addressing both ongoing and emerging system needs.

1. Establish clear definitions for mild-to-moderate and severe mental health needs

Although medical necessity criteria for accessing specialty mental health services through the county MHPs have existed for many years (see Exhibit 2), the criteria leave substantial room for interpretation. Most counties have independently defined the threshold for determining “significant impairment.” The availability of covered services for individuals with mild-to-moderate mental health conditions created the need to distinguish between individuals with moderate versus severe needs. Without exception, MCP/MMP interviewees commented on the wide variation among counties in determining eligibility for specialty services. There are particular challenges for health plans operating across multiple counties, each with their own definitions.

Because members may move in and out of needing a particular level of care, determining who qualifies for which level of care at a given point presents a care coordination challenge for many plans and providers. It also exacerbates a key limitation of the current Medi-Cal system design — whereas separate delivery system and management approaches for mild-to-moderate and severe might work well for a statically defined population, the acuity of an individual’s behavioral health needs is inherently dynamic. Interviewees noted that it is difficult to define a “bright line” between mild-to-moderate and severe at any point in time on an individual basis. It is even more challenging when the distinctions differ based on which county one lives in. To mitigate the challenges
associated with establishing this "bright line," interviewees cited the need to establish a clear understanding between health plan and MHP partners in each county about where the line between moderate and severe would be drawn.

San Diego County and its health plan partners have worked collaboratively to clearly define a common language for what constitutes mild-to-moderate versus severe mental health needs. From this framework, they created a severity analysis grid, which is used to determine a patient’s needed level of care, especially when deciding whether to transition a patient from one level of care to another. Similarly, LA Care collaborated with the Los Angeles County MHP to jointly develop a screening tool to help determine if a patient should receive mild-to-moderate, severe, and/or drug Medi-Cal services. So long as a psychiatrist, PCP, or Beacon intake specialist uses this tool to screen a patient, the plan or county cannot dispute the patient’s status. Ideally, over time, consortia of plans and counties could develop common definitions and protocols that transcend county lines and streamline efforts to coordinate care at the regional or state level.

2. Establish clear policies and procedures to facilitate smooth transitions across systems

Transitioning patients across MCP/MMP and county-managed behavioral health systems poses challenges to all involved — most significantly to the members themselves. Interviewees identified an array of emerging practices to ensure that members do not encounter service disruptions as their needs fluctuate between mild-to-moderate and severe:

- Use a transition of care form that the health plan or county can initiate to begin discussions about shifting an individual’s care back to the health plan if needs have been stabilized, or to the county system if more intensive treatment is required;
- Allow patients to continue receiving care from the MCP/MMP if the county temporarily does not have space or if there is a categorization or billing dispute;
- Integrate providers in community-based clinics into the health plan’s network to ensure patients are not required to change providers in order to receive mental health services;
- Permit patients to receive care with their PCP if they express resistance to receiving care from the county;
- Ensure that support services not covered by Medi-Cal are not dropped when a patient transitions out of county services; and
- Encourage patients to see transitioning into plan-provided services as a step to work toward in the recovery process.
San Diego County uses its Access & Crises Line to assist MCPs and their providers with the referral process. This streamlines an often time-consuming or inefficient referral process, and increases the likelihood that providers will play an active role in helping patients access the care they need. Where available, information about specialty mental health program walk-in hours is included with the provided contact information. The MCPs have been valuable partners for the county in educating their network providers about how to access and use the referral line.

More generally, as MCPs and counties expand their collaboration to a broader array of behavioral health and social service provisions, clear definitions and mutual understanding of which system is responsible for what and for whom will be essential to ensuring accountability and coordinating care effectively.

3. Develop tools and infrastructure to facilitate data exchange

A fundamental component of integrated care is the ability for payers to facilitate information exchange about physical and behavioral health diagnoses and services among all providers involved in an individual’s care. The systematic exchange of physical and behavioral health information can be critical to support population health management efforts. However, a number of barriers exist that prevent seamless data exchange across separately managed systems, including:

- Philosophical differences among physical and mental health providers about data privacy;
- Constraints imposed by federal and state privacy laws such as HIPAA and 42 CFR Part 2; and
- Lack of interoperability and varying levels of information technology capability among MCPs and counties.

All interviewees acknowledged these challenges and described several joint MCP-county activities underway to mitigate. As a first step, plans and counties have been collaborating to address information sharing at the individual patient level. Accordingly, most plans and counties have already or are in the process of developing standard release of information forms, though there are differing viewpoints about the circumstances under which the releases need to be signed. The releases facilitate care coordination during in-person or phone meetings, but simply having releases signed does not ensure systematic and timely information exchange across systems and treating providers. This larger vision requires considerably more interoperability across information systems than exists today — particularly given that some providers or counties continue to use paper files rather than digital records.

However, plans and counties are beginning to develop solutions to enable more seamless information exchange, even where electronic health records are not widely available. IEHP, for example, has granted mental health providers in one of its counties access to its web-based provider portal system and is in the process of linking the county to the system as well. In turn, the county is building “crosswalks” from its system to IEHP’s to eliminate redundant work. This system also alerts PCPs when there is a mental health report available and tracks whether or not the PCP downloads the report, allowing IEHP to target its provider education and outreach efforts accordingly. Another plan has created a platform that allows Beacon employees to pull up general information about a beneficiary’s primary care without having to contact PCPs.

MCPs and counties have also effectively exchanged information by employing designated staff to serve as contacts for providers’ and members’ questions. LA Care employs staff specifically to coordinate between counties, Beacon, and physical health care providers. Likewise, San Diego County has a staff member dedicated to coordinating data.
4. Collaborate on outreach strategies for members and providers

As plans added new mental health benefits, reaching out to their members to clearly explain the changes was critical to support access to and use of the new services for eligible beneficiaries. Likewise, plans noted that clear communication with providers about new policies and procedures that affect their day-to-day responsibilities (e.g., billing, working with care coordinators) was essential to making the system work.

Counties can be valuable partners in this outreach effort, helping to educate consumers and providers about system changes and how to contact MCPs to access services. For example, San Diego County created cards with contact information for each plan, including phone numbers for physical health, mental health, transportation, and member services. Health Plan of San Joaquin sent out provider alerts explaining the new benefits and suggestions for how providers could build relationships with Beacon. In its provider education, Health Plan of San Joaquin emphasized the opportunities for increased access to mental health services, including telephone consults with psychiatrists.

5. Mitigate philosophical and organizational differences between physical and mental health systems and providers

Health plans and counties operate with different practices and procedures and are often driven by different incentives. Developing working relationships that include all perspectives equally is an important, ongoing collaborative effort. Interviewees noted that at times, adopting a whole person care mindset in which treatment plans are driven by both medical care and mental health can require “letting go of the reins” — which can be challenging for both systems. Counties need time and training to build knowledge about managed care contracting and operations, while many health plans have a learning curve with recovery-based models of care for individuals with mental health needs.

There are also differing standards and viewpoints for data sharing and privacy, with mental health system stakeholders generally more sensitive to issues of privacy and stigma than their physical health care system counterparts. Interviewees discussed approaches they employed to address these differences, including:

- Engage leadership as champions to demonstrating their commitment to effective coordination;
- Invest in outreach and education efforts for internal staff, providers, and members;
- Explain to members the benefits of information sharing as an important component of supporting recovery-focused care using clear communication strategies; and
- Develop personal and trusting relationships with partners across and members enrolled in the systems.

Several interviewees noted that bringing all parties to the table early and often — e.g., to discuss mutually acceptable standards for sharing information — is key to an integrated system’s success, and an ongoing focus. Many health plan and county partnerships have instituted regularly scheduled in-person meetings for staff at all levels to support this continuing dialogue. In some instances, plans’ chief executive officer or chief medical officer participate in the conversation and ensure that leadership understands the change processes. These forums can be used to develop and refine processes and procedures, build relationships, and address particularly challenging cases. In particular, these meetings are sometimes used to help determine if patients should be re-considered for specialty mental health services or if they no longer need that level of care.
Similarly, interviewees acknowledged several philosophical and organizational differences that exist at the provider level. For example, mental health providers who are newly contracting with MCPs/MMPs needed time to get acclimated to operating in a managed care environment—including how to get credentialed, how to bill and get paid on time, and how to manage reporting requirements.

Several interviewees noted that physical and mental health providers have their own terminologies and approach to treatment and recovery differently. Much like issues at the plan level, physical health providers are more likely to rely on medical models with set treatment parameters. In contrast, mental health providers’ recovery-oriented model views outcomes on a continuum and relies more heavily on consumer-driven treatment decisions. A few plans regularly facilitated discussions across providers—via structured trainings or informal meetings or phone calls as issues arose—to help assuage conflicts and develop relationships among providers who cared for the same members. Plans can also oversee provider efforts to improve communication. One plan monitored PCPs’ documentation of coordination with mental health providers when members presented with mental health concerns to ensure communication and coordination were occurring.

**Conclusion**

Health plans, counties, and other stakeholders have worked hard to adapt to the changing mental health care landscape in California by implementing new requirements that increase beneficiary access to mental health services and more effectively coordinate physical and mental health care. System partners are developing approaches to bolster cross-collaborative relationships, improve coordinated care planning and management, and promote information exchange across systems. There are some limitations with how far the system might progress under the current design for mental health services that distinguishes between mild-to-moderate and severe conditions, but stakeholders are hopeful that the series of reforms underway will facilitate a transition to a more integrated system across program partners and the full spectrum of behavioral health conditions. Current efforts provide a strong foundation and promising practices for Medi-Cal stakeholders to replicate and expand upon to continue to improve physical, behavioral health, and social service coordination efforts in the future.

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**ABOUT THE CENTER FOR HEALTH CARE STRATEGIES**

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.
ENDNOTES

1 The seven counties are: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.
3 Senate Bill X1 1 (Hernandez, Chapter 4, Statutes of 2013), effective January 1, 2014, mental health services included in the essential health benefits package adopted by the State, pursuant to Health and Safety Code Section 1367.005 and the Insurance Code Section 30112.27, and approved by the United States Secretary of Health and Human Services under Title 42, Section 18022 of the United States Code.
5 Ibid.
6 Title 9, Chapter 11—Medi-Cal Specialty Mental Health Services Regulations. 1810.370. MOUs with Medi-Cal Managed Care Plans.
7 Ibid.
8 M. Herman Soper and B. Ensslin. “State Approaches to Integrating Physical and Behavioral Health Service.” Center for Health Care Strategies, 2014.
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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.

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). 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. 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).

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. 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. 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.” 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. 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.

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%).

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

**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. 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.

- **Meaningful Information Sharing**
  Sharing costs, quality, and clinical data is critical for behavioral health integration. In fact, Collins et al. 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. 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.” Additionally, there are many well-documented reasons for integrating behavioral and physical health services. 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. 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.

- **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.
• **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; provision of mental health services for adults and children diagnosed with mild to moderate mental health disorders; 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.

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” 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:

<table>
<thead>
<tr>
<th>Task</th>
<th>Timeframe</th>
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<tbody>
<tr>
<td>Submit integration planning process to CMS</td>
<td>May 2016</td>
</tr>
<tr>
<td>Post integration planning document to website</td>
<td>May 2016</td>
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<tr>
<td>Coordinate stakeholder workgroup meeting</td>
<td>June 2016</td>
</tr>
<tr>
<td>Convene first stakeholder workgroup meeting</td>
<td>June 2016</td>
</tr>
<tr>
<td>Write draft integration concept design</td>
<td>July 2016</td>
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<tr>
<td>Reconvene stakeholders for input</td>
<td>August 2016</td>
</tr>
<tr>
<td>Finalize integration concept design</td>
<td>September 2016</td>
</tr>
<tr>
<td>Submit final concept design to CMS</td>
<td>October 2016</td>
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**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. 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

4 Behavioral Health Fact Sheet, CDPH, CTCP
7 The Commonwealth Fund, "In Focus: Using Housing to Improve Health and Reduce the Costs for Caring for the Homeless, " October/November 2014. And a presentation in "The Third Annual Innovations Summit on Integrated Care", June 2015 (the material is yet to be posted).
8 California Health Interview Survey (CHIS), 2012-2013.
9 DHCS, Website Medi-Cal Certified Eligibles - Recent Trends
13 BH Integration Plan FinalApril-DOF_CHHS.docx
14 http://www.ahrq.gov/engage/initiatives/TripleAim/Pages/default.aspx
19 Commissioning Stepped Care for People with Common Mental Health Disorders. UK National Institute for Health and Care Excellence (NICE) commissioning guides (CMG41), 2011
26 http://www.dhcs.ca.gov/Pages/DualsDemonstration.aspx