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IBHP
Integrated Behavioral Health Project

Health Reform and Transformation of the Delivery of Care

INTEGRATED CARE WORKFORCE ISSUE BRIEF **#2**

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KEY CONSIDERATIONS FROM THIS ISSUE BRIEF

The Integrated Behavioral Health Project (IBHP) team fielded a workforce survey to physical and behavioral health students and workers to better understand barriers to integration. This brief, the second in the series, focuses on key aspects and expectations of **health reform**, such as increased communication, collaboration, and use of data, and reports on respondent experience and comfort with these care components. The workforce survey was **completed by 590 students and professionals**, including nurses, physicians, social workers, marriage and family therapists (MFTs), and alcohol and other drug (AOD) professionals. Among the key findings described on this brief:

- **Communication:** Communication levels with other providers at their workplace about shared clients/patients generally show that nurses, social workers, and AOD professionals have high levels of communication with many providers. Communication between non-medical (mental health and substance use) and medical providers (physicians, nurses) needs to increase to improve care coordination and hospital transitions for complex patients.

- **Knowledge of skills across provider groups**: In general, medical providers report being more knowledgeable about the work of other medical providers; non-medical providers are better informed about the practice of their non-medical colleagues.

- **Provider comfort using technology and outcome measurement:** Providers vary in terms of preparedness for data collection, and there is limited experience using data for clinical decision-making. At least one-fifth of all provider groups, with the exception of AOD professionals, reported that they felt "minimally or not prepared" to collect and track patient outcomes. Almost one-half of the MFTs, psychologists, and social workers reported that there were no electronic health records where they work.

- **Provider knowledge about health reform**: About one-half or more of all providers indicated that they had "limited" or "no knowledge" of important aspects of health reform such as patient eligibility, population health management and performance-based incentives.

Expectations under health reform include greater communication and coordination across providers working in a team environment. Patient-centered medical home models and team-based care require an increase in the level of communication and knowledge across health care professionals to effectively provide care to patients. Care coordination across disciplines is a complex, yet critical component of overall efforts at integration. Research shows that case management and interdisciplinary team approaches have the potential to improve the quality of care and decrease costs. With shifts toward integrated care, survey findings support the need for enhancing communication with and knowledge of providers across the system of care.

BACKGROUND

In an effort to advance integrated behavioral health care in California, the Integrated Behavioral Health Project (IBHP) conducted an environmental scan of the training and capacity-building needs across the primary care, mental health, and substance use sectors. The IBHP project was administered by the California Mental Health Services Authority (CalMHSA) with funding from the Mental Health Services Act's Prevention and Early Intervention component. As part of this effort, IBHP researchers developed integrated care workforce surveys for behavioral health and physical health professionals to better understand:

IBHP Workforce Issue Briefs

1. Stigma and Attitudes Toward Working in Integrated Care
2. **Health Reform and the Transformation of the Delivery of Care**
3. Training Needs in Integrated Care

1. Attitudes about and preparedness for working in integrated care settings;
2. Experience coordinating care with providers and staff from other fields of practice;
3. Use of information technology and outcome measurement;
4. Knowledge of health reform and the changing care delivery system; and
5. Priorities and interest in relevant integrated behavioral health training topics.

The broad purpose of this analysis was to identify tangible issues that need attention in order to break down stigma within and across professional groups; to reduce stigma as a barrier to care among patients/clients with behavioral health needs; and to increase knowledge and competency in integrated behavioral health care in California.

Workforce capacity-building is critical to advancing integration and reducing stigma. Since workforce issues are widely identified as barriers to integration, the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) has targeted workforce and development issues related to the provision of integrated behavioral health and general healthcare as one of its major initiatives.[1] Some of the workforce issues identified as barriers to integration include:

- Attitudes and issues related to ***stigma within and across provider groups about working in integrated settings,*** as well as negative attitudes about persons with mental health and substance use problems;
- ***Reluctance to change practice patterns*** in the context of health reform and the transformation of the delivery of care; and
- ***Training needs*** or inadequate skills for integrated practice.[2]

The IBHP team fielded a workforce survey to physical and behavioral health students and workers to better understand these barriers to integration, and they created a series of briefs highlighting the survey findings. This brief, the second in the series, focuses on key aspects of health reform, such as increased communication, collaboration, and use of data, and it reports on respondent experience and comfort with these care components. It also describes provider knowledge of health reform and expectations related to transformation of the delivery of care, with specific attention on integrated care. The paper highlights responses from various groups of physical and behavioral health professionals about their attitudes toward integrated care, and their knowledge and preparedness for related practice changes expected under health care reform. The other two briefs describe 1) Stigma and Attitudes toward Working in Integrated Care; and 2) Training Needs in Integrated Care.

HEALTH REFORM OVERVIEW

National health reform, enacted in March 2010, has brought renewed attention and focus to workforce issues in the health care delivery system.[3] When fully implemented in January 2014,[*] the Patient Protection and Affordable Care Act (ACA) will establish a range of reforms aimed at improving health outcomes, enhancing the patient experience, and controlling the costs of care. One of the key components of comprehensive health care reform is the integration of care, specifically the integration of mental health, substance use, and primary care services.[4] ACA provisions expand support for integrated care services delivered by interdisciplinary health care teams for millions of additional Californians eligible for health care in 2014.

The ACA has accelerated efforts toward the development of new integrated care delivery models in health care.[5] For example, the **patient-centered medical home** (PCMH), also known as a "person-centered health home," is a model in which primary care providers work in teams with other health professionals to provide core services to patients and to coordinate that care. Services are facilitated by registries, information technology, health information exchanges and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. In **Accountable Care Organizations** (ACOs), multiple health care providers work together to provide coordinated care and accept collective responsibility for the cost and quality of care delivered to a defined patient population (see **Attachment 1, Glossary of Terms**.) These practice models must establish the following set of components to succeed:

[*] Most of the major provisions of the federal health care law will be phased in by January 2014; the remaining provisions will be phased in by 2020.

- Integrated care teams of health professionals;
- Practice culture changes, including care coordination efforts and information sharing; and
- Better implementation of health information technology, such as quality improvement reports tracking treatment outcomes.[6]

The ACA has created incentives for hospitals to work more closely with outpatient providers to better coordinate care for discharged patients. The **Hospital Readmissions Reduction Program** penalizes hospitals with excess readmissions, effective October 2012.[7] This regulation further supports communication and care coordination between hospitals and primary care providers, since effective patient follow-up can reduce the number of hospital readmissions.

In addition to changes under the ACA, California has concurrently implemented major reforms in its health care delivery system. California's Section 1115 "Bridge to Reform" Medicaid Demonstration Waiver, effective November 2010 through October 2015, includes approximately $10 billion in federal funds to invest in the delivery system in preparation for national health reform. Provisions of California's 1115 Waiver support improved access to mental health services and increased incentives for the integration of behavioral and primary care services.[8] Key initiatives of the 1115 Waiver include:

- The **Low Income Health Program** (LIHP), in which individuals whose family incomes are between 133% and 200% of the federal poverty level (FPL) will be covered through Medicaid expansion, and those between 133-200% FPL will be covered under the Health Care Coverage Initiative portion of the LIHP.
- **Mandatory Enrollment of Seniors and Persons with Disabilities** (SPDs), which allows the state to enroll Medicaid-eligible SPDs, excluding dual eligibles (Medicare and Medi-Cal), in Medicaid managed care programs.
- The **Delivery System Reform Incentive Pool** (DSRIP), in which public hospitals (University of California and county hospitals) can receive federal matching funds for activities that increase readiness for reform, such as becoming integrated, coordinated systems of care; becoming patient centered medical homes; creating positive patient experiences; and expanding chronic disease case management.[9]

Many **community clinics and health centers** (CCHCs) are working toward becoming formally recognized PCMHs, and they are making other changes to better compete in the marketplace under health reform. In addition to serving as PCMHs under LIHP and SPD programs, many CCHCs, with funding from the Health Resources and Services Administration (HRSA), are working toward becoming health homes that meet National Center for Quality Assurance (NCQA) recognition requirements. Some CCHCs are developing and implementing programs to improve the patient experience in order to better position themselves to compete for patients

who have more provider choices under health reform. More and more CCHCs are formally integrating their primary care and behavioral health programs.

With ACA implementation, many experts believe that California could face a **primary care provider shortage**, as approximately 6.5 million individuals become insured out of 8.2 million who are currently uninsured.[10] Practices that have adopted PCMH could be at an advantage since they are already making greater use of care teams, including behavioral health providers, health educators and care coordinators, in caring for the patient. Practices are working toward assuring that all team members are operating at the top of their license, thereby delegating certain activities from the primary care provider to other team members when appropriate. For example, some providers have given their medical assistants standing orders to refer patients for flu shots or for preventive screenings such as mammography or colonoscopy when their age or other history obviously indicates it. This frees the physician to focus on the most important clinical complaints during the patient visit. These types of strategies will be needed to minimize the impact of provider shortages as much as possible.

Workforce Survey Goals and Areas of Focus

The IBHP Team fielded the workforce survey broadly to the pipeline of students and recent graduates, as well as to the current workforce, using a "viral" or snowball approach to reach nurses, physicians, social workers (SWs), marriage and family therapists (MFTs), psychologists, and alcohol and other drug professionals (AODs). A range of academic programs, professional organizations and associations, and licensing bodies were identified as sources for obtaining potential survey respondents. The process of contacting the various universities and organizations also served to create visibility for survey efforts. The IBHP team pilot-tested the surveys, and in some cases modified the survey based on stakeholder input. The contact organizations helped to disseminate the survey to their students, alumni, or members, by sending emails and by advertising the survey on their websites with an electronic link to the questionnaire. They also publicized the survey in their newsletters and encouraged their members to complete the tool online. The surveys were customized to each professional group, and members answered the questions online using *SurveyMonkey*. A total of 590 surveys were completed (see **Table 1** for the number of respondents by profession).

> The workforce survey was completed by 590 students and professionals, including nurses, physicians, social workers, MFTs, and alcohol and other drug professionals.

Table 1: Number of Individuals Completing the Survey, by Professional Group

Professional Groups	Number	Percentage
Nurses	75	12.7%
Physicians	40	6.8%
Social Workers	188	31.9%
MFTs	83	14.1%
Psychologists	56	9.5%
AOD Professionals	148	25.1%

(n = 590)

With the exception of alcohol and other drug professionals, fewer than half of all respondents worked or interned in integrated care settings (see Figure 1). Three-quarters (75%) of the **AOD professionals** indicated that they were currently working/interning in an integrated care setting such as a residential or outpatient substance abuse treatment program

that included mental health and/or primary care services. Close to one-half of the **nursing professionals** (45%) was working or interning in an integrated care setting such as acute care hospitals, federally qualified health centers (FQHCs), and inpatient psychiatric units. More than one-third (38%) of **social workers** were employed or interned in integrated care settings, including medical clinics with behavioral health services, social service organizations offering mental health services, and school-based clinics. Approximately one-third (33%) of **MFTs**, and one-quarter (25%) of **psychologists** had experience working in integrated settings such as acute psychiatric inpatient facilities, FQHCs, and school-based health centers. Respondents from integrated care settings reported devoting most, if not all, of their time to direct service tasks. This was the case for 73% of social workers, 71% of nurses, 67% of MFTs, 64% of psychologists, and 51% of AOD professionals.

Figure 1: Percentage of Respondents Indicating They Worked or Interned in an Integrated Care Setting, by Professional Group

Profession	Percent	Examples of integrated care settings
AOD Professionals	75%	Residential or outpatient substance abuse treatment programs that included mental health and/or primary care services
Nursing Professionals	45%	Acute care hospitals, FQHCs, and inpatient psychiatric units
Social Workers	38%	Medical clinics with behavioral health services, social service organizations offering mental health services, and school-based clinics
MFTs	33%	Acute psychiatric inpatient facilities, FQHCs, and school-based health centers
Psychologists	25%	Acute psychiatric inpatient facilities, FQHCs, and school-based health centers

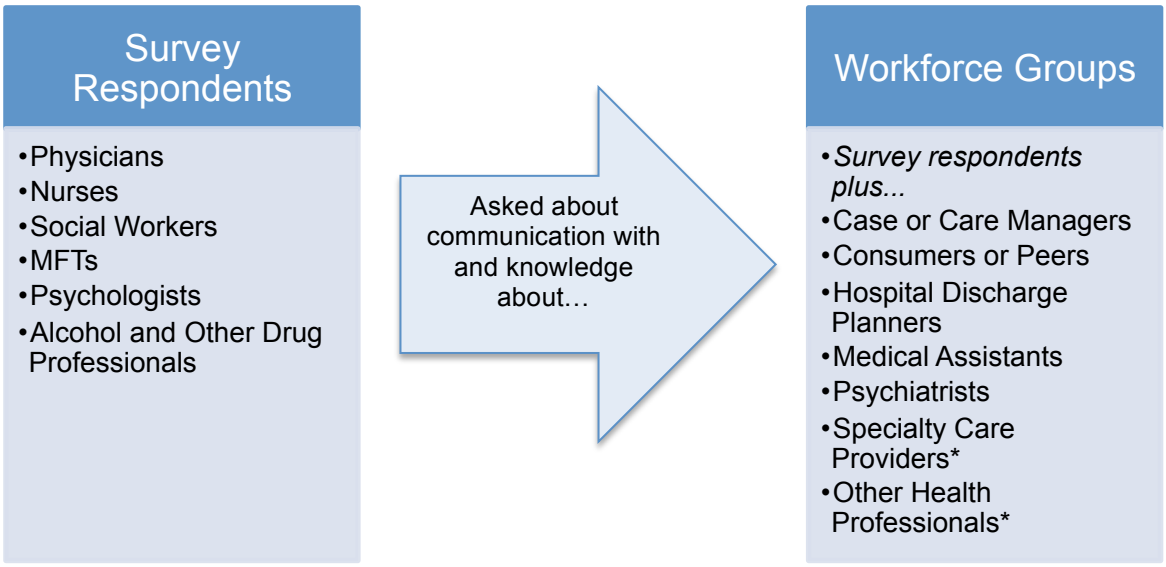
KEY FINDINGS

There are certain expectations under health reform around the preparedness and capacity of the workforce for communication and collaboration among and between professions. In this new health care environment, team-based care and shared electronic health records between providers are increasingly becoming the norm. Key findings are reported below about the level of communication that survey respondents had among and between their own groups, the level of communication with other providers, and knowledge of other providers' scopes of practice. Additional tables show detailed responses to questions asking about respondents' comfort using information technology and outcome measures, and putting data to use in changing practice patterns. The section ends with information about provider knowledge about health reform.

CROSS-PROVIDER COMMUNICATION

Respondents were asked to rate their level of communication with other workforce groups -- whether high, moderate, low -- or to indicate if they do not work with a particular provider group (see **Figure 2**). For each survey respondent group, **Table 2** provides a summary of some of the other workforce groups with whom they had the highest and lowest levels of communication, as well as those they were least likely to work with. **Attachment 2A** shows detailed findings for all workforce groups.

Figure 2: Survey Respondents and Workforce Groups Targeted in Survey Questions



* Not asked of all respondents

Most Communication. Communication levels with other providers at their workplace about shared clients/patients* generally show that nurses, social workers, and AOD professionals have high levels of communication with many providers. For example, more than half of the nurses reported having high levels of communication with social workers (70.8%), psychiatrists (64.6%), consumers/peers (61.9%), and primary care providers (PCPs) (56.9%). About half of the nurses, social workers, and AOD professionals had good communication with case/care managers, consumers/peers, social workers, and psychiatrists. Nurses were most likely to have high levels of communication with PCPs. For all provider groups, consumers/peers were among the professional groups with whom they had the highest communication.

Least Communication. Communication between non-medical and medical providers needs to increase to improve care coordination and hospital transitions for complex patients. Findings reveal that at least one-quarter of all respondents (with the exception of nurses) had the lowest levels of communication with PCPs. In addition, at least one-quarter of MFTs, psychologists, and social workers reported that they do not work with many of the other listed providers. For example, a significant portion of MFT respondents stated they do not work with nurses (39.1%), and AOD counselors (47.1%). All of the professional groups surveyed reported very low levels or a complete lack of communication with hospital discharge planners and medical assistants.^

Provider reports of high and moderate levels of communication with other professionals are more often concentrated within their specific sector of care (for example, nurses with PCPs, social workers with case managers) rather than across disciplines. This would suggest there is room to elevate communication across disciplines to improve multidisciplinary perspectives on care for shared patients/clients.

* Some of the questions and response options included on each survey were unique, as surveys were customized for each professional group. Physicians were not asked this question.

^ The same gap in communication was evidenced in relation to specialty care providers and other health professionals (physical therapists, pharmacists). Findings are not shown in Table 2.

Table 2: Level of Communication with Other Providers, by Professional Group, Summary

	HIGHEST COMMUNICATION	LOWEST COMMUNICATION	DON'T WORK WITH PROVIDER
Nurses	Social Workers (70.8%) Psychiatrists (64.6%) Consumers/Peers (61.9%) PCPs (56.9%)	Psychologists/MFTs/MHs (27.7%) MAs (24.2%) AOD Counselors (21.1%)	MAs (45.2%) AOD Counselors (38.6%) Discharge Planners (29.2%)
Social Workers	Consumers/Peers (65.8%) Psychiatrists (55.7%) Case/Care Mgrs (55.0%)	PCPs (29.9%) MAs (23.3%) AOD Counselors (22.4%)	MAs (39.7%) AOD Counselors (36.4%) Discharge Planners (32.7%)
Marriage and Family Therapists	Social Workers (47.1%) Case/Care Mgrs (36.8%) Consumers/Peers (31.9%)	PCPs (35.2%) Discharge Planners (34.3%) MAs (31.9%) Nurses (31.9%)	MAs (52.2%) AOD Counselors (47.1%) Discharge Planners (44.3%) Nurses (39.1%)
Psychologists	Social Workers (34.7%) PCPs (30.0%) Consumers/Peers (26.2%)	Social Workers (28.6%) PCPs (28.0%) Nurses (24.5%)	AOD Counselors (66.0%) MAs (61.2%) Discharge Planners (50.0%)
Alcohol and Other Drug (AOD) Professionals	Case/Care Mgrs (71.5%) Consumers/Peers (66.1%) Social Workers (56.8%)	PCPs (27.0%) MAs (25.8%) Nurses (23.1%)	Discharge Planners (35.0%) MAs (33.3%) Nurses (19.8%)

Notes:
Physicians were not asked this question.
PCPs = Primary care providers
Discharge Planners = Hospital Discharge Planners

KNOWLEDGE OF SKILLS ACROSS PROVIDER GROUPS

In order to function as a cohesive team within the new health care environment, it is critical to understand the skills and value that different providers bring to a common practice. For this reason, respondents were asked to rate their level of knowledge* of other providers' scope of practice as it pertains to services benefitting clients at their place of employment/internship^ (see **Table 3**, with detail in **Attachment 2B**).

Primary care providers reported being very knowledgeable about the work of other health professionals (90.3%) and specialty care providers (83.9%), in addition to mental health providers such as psychologists, MFTs, and mental health clinicians (74.2%). **MFTs** and **psychologists** reported having high knowledge, not only about the practice of other mental health professionals, but also about social workers (65.7% and 72.9%, respectively). Over one-half of psychologists indicated that they have a good deal of knowledge about the work of PCPs (67.3%), and specialty care providers (52%). **MFTs were most likely to indicate that they did not work with many of the other listed providers. In addition, over one-third of the physicians, nurses, MFTs, and psychologists reported that they did not work with AOD counselors.**

The remaining professional groups (nurses, social workers, and AOD professionals) were asked to report on their level of knowledge of other providers' scope of practice using the scale good/excellent and very limited/fair (see detail in **Attachment 2C**). **Nurses** were the most likely to indicate having high knowledge about the work of many of the providers listed including psychiatrists (87.5%), consumers/peers (85%), and social workers (83.1%). **Social workers** and **AOD professionals** were well informed about the practice of many of their colleagues, with the exception of medical professionals (MAs, nurses, PCPs) and hospital discharge planners.

Again, these ***findings reveal gaps in cross-disciplinary knowledge.*** In general, medical providers report being more knowledgeable about the work of other medical providers; non-medical (mental health and substance use) providers are better informed about the practice of their non-medical colleagues. ***In moving toward team-based care, which fosters inter-professional communication and collaboration, shared knowledge across disciplines will play an increasingly important role in work within the health care delivery system.***

* Physicians, MFTs, and psychologists used the scale: 1=Very Low; 2=Low; 3=Moderate; 4=High; and 5=Very High. Nurses, social workers, and AOD professionals used the scale: 1=Very Limited; 2=Fair; 3=Good; and 4=Excellent.

^ Some questions and response options included on each survey were unique, as surveys were customized for each professional group.

Table 3: Level of Knowledge of Other Providers' Scope of Practice as it pertains to Services Benefitting Clients, by Professional Group, Summary

	HIGHEST KNOWLEDGE	LOWEST KNOWLEDGE	DON'T WORK WITH PROVIDER
Physicians	Other Health Professionals (90.3%) Specialty Care Providers (83.9%) Psychologists/MFTs/MHs (74.2%)	AOD Counselors (37.5%) *(Other professions were less than 10%)*	AOD Counselors (37.5%) Social Workers (16.4%) *(Other professions were less than 10%)*
Nurses	Psychiatrists (87.5%) Consumers/Peers (85.0%) Social Workers (83.1%)	MAs (24.6%) AOD Counselors (23.5%) Psychologist, MFTs, MHs (23.4%)	AOD Counselors (35.3%) MAs (29.5%) Discharge Planners (18.5%)
Social Workers	Case/Care Managers (78.9%) Consumers/Peers (76.4%) Psychiatrists (74.7%)	MAs (41.7%) Discharge Planners (31.0%) PCPs (29.3%)	MAs (29.2%) AOD Counselors (27.1%) Psychologist/MFT/MHs (19.4%)
Marriage and Family Therapists	Social Workers (65.7%) Case/Care Mgrs (56.7%) Consumers/Peers (46.8%)	MAs (22.6%) Discharge Planners (17.7%) Other Health Professionals (15.9%)	MAs (45.2%) AOD Counselors (41.0%) Discharge Planners (40.3%)
Psychologists	Social Workers (72.9%) PCPs (67.3%) Specialty Care Providers (52.0%)	Discharge Planners (22.4%) MAs (21.3%) AOD Counselors (20.5%)	AOD Counselors(43.2%) Consumers/Peers (33.3%) Discharge Planners (30.6%)
Alcohol and Other Drug (AOD) Professionals	Case/Care Managers (83.3%) Consumers/Peers (75.7%) Social Workers (69.2%)	Nurses (51.7%) Discharge Planners (31.6%) PCPs (31.6%)	MAs (30.1%) Discharge Planners (29.9%) PCPs (14.5%)

Notes:
Physicians were not asked about all provider types.
PCPs = Primary care providers
MHs = Mental health clinicians
Discharge Planners = Hospital Discharge Planners

PROVIDER COMFORT USING TECHNOLOGY AND OUTCOME MEASUREMENT

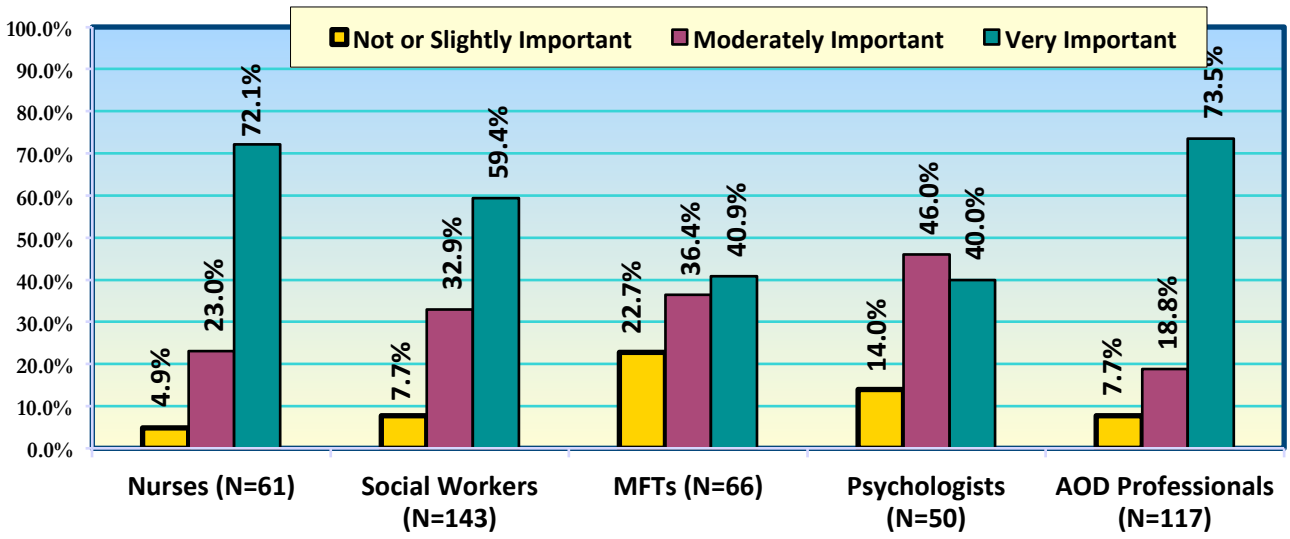
Collecting, reporting, and using data to support quality improvement will be essential for complying with certain ACA-related program requirements, for demonstrating the value of services provided during health reform implementation, and for payment to organizations that are part of ACOs. Equally important is for the workforce to have the comfort and experience of working with electronic health records (EHRs) and in some cases registries to track clinical outcomes, and to share data and records with other providers. Expectations under health reform include tracking health outcomes and generating reports to drive client care decisions.

The following section presents information on provider comfort and readiness in using technology and measurement. Respondents rated their preparedness and competency in areas relating to:

- Collecting and tracking treatment outcomes with their patients/clients
- Using their collected data to modify or enhance service delivery for their clients/patients
- Using data collected by their agency/program/clinic to modify or enhance service delivery for their clients/patients

AOD professionals (73.5%), nurses (72.1%), and social workers (59.4%) were most likely to report that outcome measurement in service delivery is "very important" (see **Figure 3**). Close to one-quarter of MFTs (22.7%) and 14% of psychologists indicated that outcome measurement is "not or slightly important."

Figure 3: Importance of Outcome Measurement on Service Delivery, by Professional Group



Note about Figure 3: Physicians were not asked this question. Don't Know/Not Sure responses were excluded from this analysis. "Not Important" and "Slightly Important" were combined.

PREPAREDNESS TO COLLECT AND TRACK TREATMENT OUTCOMES

Providers vary in terms of preparedness for data collection, and there is limited experience using data for clinical decision-making. At least two-thirds of respondents (85.9% AOD professionals, 77.3% social workers, 74.7% MFTs, 69.4% nurses, and 64.7% psychologists) indicated that they feel "moderately" or "sufficiently" prepared to collect and track treatment outcomes for their patients/clients (see **Table 4**). However, at least one-fifth of all provider groups, with the exception of AOD professionals, reported that they felt "minimally or not prepared" to collect and track patient outcomes.

The majority of respondents (82.2% AOD professionals, 78.6% social workers, 77.4% nurses, 66.7% psychologists, and 64.7% MFTs) reported feeling "moderately" or "sufficiently" prepared and competent to use data they collect to modify or enhance service delivery for their clients/patients (see **Table 5**). However, at least one-fifth of the mental health professionals (MFTs, social workers, and psychologists) believed that they were "minimally" or "not at all" prepared and competent to use their collected data to affect service provision to clients.

A similar response pattern was reported by all professional groups when rating their degree of preparedness and competency using data collected by their organization to modify or enhance service delivery for their clients/patients (see **Table 6**). As more organizations, both medical and behavioral health, move toward a population health management approach, with increasing use of disease registries and quality improvement metrics, providers will need to increase their level of competency in applying these metrics to inform and improve clinical decision-making.

Table 4: Percentage of Responses to Statement: "To what extent do you feel prepared to *collect and track treatment outcomes* with your patients/clients?"

Level of Preparedness	Nurses (N=62)	Social Workers (N=145)	MFTs (N=67)	Psychologists (N=51)	AOD Professionals (N=120)
Moderately or Sufficiently Prepared	69.4%	77.3%	74.7%	64.7%	85.9%
Not or Minimally Prepared	24.2%	20.0%	22.4%	31.4%	12.5%
Don't Know/Not Sure	6.5%	2.8%	3.0%	3.9%	1.7%

Table 5: Percentage of Responses to Statement: "To what extent do you feel prepared and competent to *use data you collect to modify or enhance service delivery* for your clients/patients?"

Level of Preparedness	Nurses (N=62)	Social Workers (N=145)	MFTs (N=68)	Psychologists (N=51)	AOD Professionals (N=118)
Moderately or Sufficiently Prepared	77.4%	78.6%	64.7%	66.7%	82.2%
Not or Minimally Prepared	16.1%	20.0%	26.5%	23.5%	15.3%
Don't Know/Not Sure	6.5%	1.4%	8.8%	9.8%	2.5%

Table 6: Percentage of Responses to Statement: "To what extent do you feel prepared and competent to *use data collected by your agency/program to modify or enhance service delivery* for your clients/patients?"

Level of Preparedness	Nurses (N=61)	Social Workers (N=143)	MFTs (N=68)	Psychologists (N=49)	AOD Professionals (N=119)
Moderately or Sufficiently Prepared	75.4%	75.6%	64.7%	63.3%	84.9%
Not or Minimally Prepared	19.7%	21.0%	22.1%	18.4%	12.6%
Don't Know/Not Sure	4.9%	3.5%	13.2%	18.4%	2.5%

Notes regarding Tables 4-6:
Physicians were not asked these questions.
"Not Prepared" and "Minimally Prepared" were combined.

Electronic Health Records (EHRs) are an important part of the infrastructure supporting integrated care, but provider experience with these systems varies greatly. Clinics implementing PCMHs believe EHR is a prerequisite for carrying out the practice model since it is the best way to link a patient with a provider or care team, and to manage provider panels. EHRs can provide many benefits for communication between providers and quality improvement in patient care, but these depend on how they are used (i.e., "meaningful use").

Respondents were asked about the frequency with which they use data from EHRs to modify or enhance service delivery for their clients/patients (see **Table 7**). Nurses (48.4%) were most likely to report using data from EHRs to guide service delivery as standard or routine practice at their place of work. One-third (33.6%) of AOD professionals reported using EHRs as standard practice in their work setting, yet close to one-quarter (21.8%) of these providers "did not know or were not sure" about the use of EHRs in the context of service delivery. **Over 40 percent of the MFTs, psychologists, and social workers reported that there were no EHRs where they work.**[*] Many of the expectations under national health reform assume a level of information technology and data infrastructure within the health care system, as well as experience and competence using electronic records. The infrastructure and capacity are not in place for much of the field within their own sector, let alone across professional sectors.

Respondents using EHRs to guide service delivery for their clients/patients were asked to rate their usefulness (see **Figure 4**). Findings show that when practitioners *have* access to electronic health records they generally find them useful. At least one-half of the nurses (63.4%), social workers (54%), and psychologists (50%) noted that EHRs are "very useful," and about one-third of respondents across the groups reported that they are "moderately useful" for service delivery.

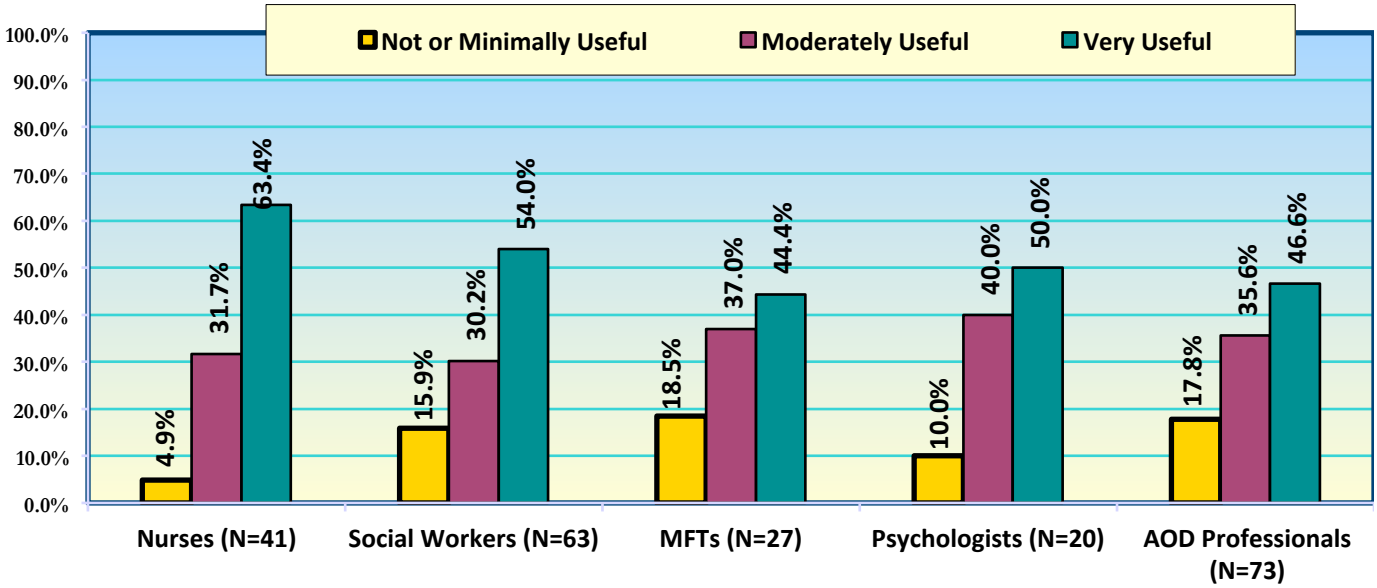
[*] This was as of Summer 2012 when the survey was administered.

Table 7: Frequency that Data from Electronic Health Records (EHRs) is used to Modify or Enhance Service Delivery

Frequency Using EHRs to Modify Service	Nurses (N=62)	Social Workers (N=146)	MFTs (N=67)	Psychologists (N=49)	AOD Professionals (N=119)
Standard/Routine Practice	48.4%	6.2%	17.9%	30.6%	33.6%
No EHRs where I work	17.7%	40.4%	49.3%	46.9%	16.0%
Never, though I know that there are EHRs where I work	6.5%	28.1%	3.0%	6.1%	6.7%
Rarely (crisis events, etc).	6.5%	11.0%	14.9%	0.0%	10.1%
Periodically (e.g., prior to meeting with new clients/ patients)	16.1%	6.8%	7.5%	10.2%	11.8%
Don't Know/Not Sure	4.8%	7.5%	7.5%	6.1%	21.8%

Note: Physicians were not asked this question.

Figure 4: Usefulness of Electronic Health Records (EHRs) to Enhance Service Delivery



Notes regarding Figure 4: Physicians were not asked this question; "Not Useful" and "Minimally Useful" were combined; Don't Know/Not Sure responses were excluded from analysis.

Sharing client data is a necessary condition for team-based care in integrated health care models. Respondents were asked to rate the extent to which they feel comfortable sharing case notes with 1) members of the treatment team; 2) other providers at their place of employment; and 3) providers in other organizations (see **Table 8**). **More than three-quarters of providers reported a high degree of comfort sharing case notes with team members. The majority of provider groups felt slightly less comfortable sharing notes with other providers at their workplace.** One-quarter of MFTs indicated having "little" or "no comfort" sharing notes with other providers at their place of work. When looking at their level of comfort sharing notes with providers in other organizations, percentages dropped again. **About one-quarter of the MFTs, psychologists, and AOD professionals expressed "little" or "no comfort" sharing case notes with providers outside of their agencies.** Differences in organizational cultures and strict regulations protecting patient privacy (e.g., HIPAA, 42-CFR Part 2; see **Attachment 1,** Glossary of Terms) have often been cited by providers working in integrated behavioral health as barriers to data sharing, despite efforts to improve care coordination for shared patients/clients with complex conditions.

Table 8: Level of Comfort Sharing Notes with Others, by Professional Group

Sharing Notes with...	Level of Comfort	Nurses (N=58)	Physicians (N=29)	Social Workers (N=124)	MFTs (N=50)	Psychologists (N=31)	AOD Professionals (N=103)
Members of the treatment team at my place of employment	High	89.7%	86.2%	83.9%	88.0%	77.4%	83.5%
	Moderate	8.6%	13.8%	11.3%	10.0%	16.1%	12.6%
	No or Little	1.7%	0.0%	4.8%	2.0%	6.5%	3.9%
		Nurses (N=55)	**Physicians (N=28)**	**Social Workers (N=121)**	**MFTs (N=48)**	**Psychologists (N=31)**	**AOD Professionals (N=99)**
Other providers at my place of employment	High	80.0%	85.7%	58.7%	60.4%	67.7%	61.6%
	Moderate	18.2%	14.3%	28.1%	14.6%	25.8%	30.3%
	No or Little	1.8%	0.0%	13.2%	25.0%	6.5%	8.1%
		Nurses (N=54)	**Physicians (N=29)**	**Social Workers (N=132)**	**MFTs (N=52)**	**Psychologists (N=40)**	**AOD Professionals (N=93)**
Providers in other clinics/ organizations/ programs	High	51.9%	55.2%	38.6%	34.6%	40.0%	34.4%
	Moderate	33.3%	37.9%	43.9%	30.8%	32.5%	44.1%
	No or Little	14.8%	6.9%	17.4%	34.6%	27.5%	21.5%

Notes:
N/A and Don't Know/Not Sure responses were excluded from this analysis.
"No Comfort" and "Little Comfort" were combined.

PROVIDER KNOWLEDGE ABOUT ASPECTS OF NATIONAL HEALTH REFORM

Questions targeting specific aspects of national health reform and related regulations, programs, and policies, were included in the survey to gain a better understanding of respondents' knowledge, or lack thereof, of the dynamic health care environment in which they are practicing. Considering the broad impact of health reform on practices in terms of accountability, reimbursement, patient care models, and the need for additional providers, the medical community will need to be informed to varying degrees about these new drivers of the health care industry, depending upon how much they will be impacted by the changes.

Respondents were asked about their knowledge relating to the following aspects of the ACA and how these changes impact client/patient eligibility for services and other issues at their workplace:

- Client/Patient eligibility for services
- Types of services offered
- Provider roles/scope of services
- Reimbursement
- Information technology strategies for population health management
- Performance-based incentives

More than half of the AOD professionals and nurses reported being "moderately" or "very knowledgeable" about some of these components (for example, types of services offered and client/patient eligibility) (see **Attachment 2D**). Strikingly apparent is the lack of knowledge reported by all providers about many of these components transforming the delivery of health care. ***About one-half or more of all providers indicated that they had "limited" or "no knowledge" of important aspects of health reform such as patient eligibility, population health management and performance-based incentives.*** With full implementation of health reform less than one year away, these findings suggest that there is a steep learning curve ahead for many providers to gain a better understanding of the components affecting the transformation of the delivery of care.

PROVIDER KNOWLEDGE OF HEALTH REFORM REGULATIONS, POLICY AND PROGRAMS

There is a profound knowledge gap between the policy decision-makers, organizational advocates (e.g., California Primary Care Association, California Mental Health Directors Association, California Institute for Mental Health, and California Public Health Association), implementers of health reform (e.g., the California Department of Health Care Services, health plans, and Covered California), and the field of providers across the various disciplines, when it comes to understanding how policies and regulations will shape clinical practice in 2014.

Survey findings show that the majority of respondents in all provider groups have "limited" or "no knowledge" about the following aspects of health reform regulations, programs, and public policies, and their implications for service delivery (see **Attachment 2E**).

- Accountable care organizations
- Patient-centered medical home
- Essential health benefits
- Low Income Health Program
- Transition of Medi-Cal-eligible seniors and persons with disabilities from fee-for-service to managed care
- Transition of dually eligible Medicare/Medi-Cal beneficiaries from fee-for-service to managed care
- Implications of HIPAA
- Implications of 42-CFR part 2 (substance abuse confidentiality law)
- Mental Health Parity and Addiction Equity Act
- CMS E.H.R. meaningful use criteria

The one exception to this is knowledge of HIPAA regulations. More than one-half of respondents across most provider groups report either "moderate knowledge" or being "very knowledgeable" about the implications of HIPAA. Surprisingly, over 40 percent of AOD professionals indicated they had "limited" or "no knowledge" of the implications of 42-CFR Part 2, the federal regulation that governs confidentiality in the substance abuse field. Again, there is much opportunity to educate the workforce about the many and complex changes driving health care on the national and state level.

DISCUSSION

COMMUNICATION WITH OTHER PROFESSIONALS

Some of the findings related to communication with other professionals point to the need for additional analysis. Communication with other members of the workforce depends in part upon whether or not an individual works in an integrated care setting. Since only 25% of responding psychologists work in integrated care settings (refer back to **Figure 1**), it is not surprising that there is a relatively low level of communication with other groups. Since 75% of AOD professionals work in integrated care settings, it makes sense that they have a high degree of communication with other groups.

Respondents had the highest levels of communication with **social workers** and **case/care managers**, who seem to play a central role in respondents' organizations. It would be interesting to look in more depth at the roles played by these two groups to better understand how they operate in their organizations. Is communication formal or informal? How is it that they have become so effective at communicating? Organizations early in their integration efforts could learn from them in setting up their own internal communications.

One finding that stands out is the lack of communication with **hospital discharge planners**, who are responsible for care transitions when a patient leaves the hospital. Many vulnerable and complex patients require aftercare in the community in order to maximize their health and to avoid being readmitted. It is difficult to know from study findings whether or not other individuals in the organization have effectively established the link between inpatient and outpatient care. Medical record staff, care coordinators, or MAs (for example at FQHCs) may have a role in obtaining needed hospital information from hospital discharge planners and emergency departments. It would be interesting to know if organizations have established relationships with their local hospitals, and if so, what staffing they are using and what communication systems they have put into place. Health plans are also in a position to communicate with outpatient

Key Findings: Communication with Other Professionals

1. Professionals currently working in *integrated care settings* are more likely to communicate with professionals outside his or her own group.
2. Respondents had the highest levels of communication with social workers and case/care managers, who seem to play a central role in respondents' organizations.
3. There is a lack of communication with hospital discharge planners and medical assistants, though this may be more due to organizational structure than missed opportunities to interact.
4. PCPs need to increase their communication with other types of providers, especially when working in a team-based environment.

providers about members who have had a hospital stay and need follow-up care. Linkages between hospital discharge planners and outpatient providers warrant further study.

Most professionals surveyed do not communicate with **medical assistants**. It is difficult to know how to interpret this since the use of MAs will vary by organization. For example, FQHCs rely on medical assistants, but that is not necessarily the case with acute care hospitals, inpatient psychiatric units, residential care facilities, social service organizations, or school-based health centers – all settings where respondents worked. It would be interesting to know within FQHCs, how much nurses, social workers and others are communicating with MAs, who play a critical role in PCMHs.

Finally, regarding **primary care providers**, it may be a dramatic organizational culture change to increase communication between PCPs and other providers. Since PCMH and integrated care require high levels of communication between all team members, physicians in these settings will need to better understand the roles of others.

Other Workforce Considerations Under Health Reform

Both federal and state programs are moving the health care industry into a new direction, a development that will require workforce changes. Current staff may find their responsibilities changing, and may be required to develop new skills. For example, organizations will need to increase their capacity to collect and report data, and will either need to train existing staff or hire new staff to do so. Finance staff may need to set up new systems to track patient services, expenses and revenues. More care coordinators may be needed to coordinate specialty care and to interface with hospital discharge planners and health plans. Organizations without EHR may need to purchase and implement a new system, especially since it is essential to implementing PCMHs and integrated care. Some organizations will invest in programs to improve the patient experience in order to

Key Findings:
Other Workforce Considerations under Health Reform

1. Organizations will need to increase their capacity to collect and report data by training existing staff or hiring new staff.
2. More care coordinators may be needed to coordinate specialty care and to interface with hospital discharge planners and health plans.
3. Organizations without E.H.R. will need to develop plans to purchase and implement it.
4. Organizations may need to work to improve the patient experience in order to be more competitive in the marketplace.
5. Organizations may need to address PCP shortages by assuring all team members are operating at the top of their license.

attract the newly insured patients and avoid losing patients who now have more choices in who their provider might be. New employee orientation will need to be modified in order to prepare new employees to work in a more integrated environment. Some existing staff may not be able to adapt to the changes, so organizations will need to address turnover and new hiring requirements.

Lastly, health reform could result in primary care physician shortages. Clinics and other primary care providers will need to enhance their PCMH to assure all team members are operating at the top of their license, and may need to look at boosting other types of primary care staff such as nurse practitioners and physician assistants. On a broader level, more primary care residency program slots will be needed, as will greater encouragement to medical students to pursue primary care professions. **Payment reform** will have to follow changes in staffing models to assure organizations can sustain new approaches to care, and that unreimbursed costs such as collecting and reporting data, workforce training and development, and patient/client education, will be covered.

CONCLUSION

With full implementation of health reform on the horizon and major reforms taking place in California, health and behavioral health care providers are operating in a dynamic and complex environment. Expectations under health reform include greater communication and coordination across providers working in a team environment. Patient-centered medical home models and team-based care require an increase in the level of communication and knowledge across health care professionals to effectively provide care to patients. Care coordination across disciplines is a complex, yet critical component of overall efforts at integration. Research shows that case management and interdisciplinary team approaches have the potential to improve the quality of care and decrease costs.[11] **With shifts toward integrated care, survey findings support the need for enhancing communication with and knowledge of providers across the system of care.**

Key Findings:
Under health reform the workforce needs to…

1. Increase communication with and learn about the roles of other professionals in their workplace.
2. Build their capacity to use technology in collecting and reporting data in order to demonstrate positive health outcomes.
3. Learn more about the changes associated with health care reform.

Furthermore, under health reform, all sectors within the system will be required to build capacity and use technology to collect and report data to demonstrate health outcomes. **Data needs to be more accessible and relevant in order to generate meaningful reports that will yield information about how to improve care for the individual patient as well as the patient population overall.** Information sharing, through electronic health records, or through data exchange protocols, is part of the essential infrastructure supporting integrated care. Although EHR use was limited at the time of the survey, findings show that it is very useful and viewed favorably in organizations that have implemented it. Electronic health records increased organizational capacity to use technology in meaningful ways to improve patient care.

Findings show an overall lack of knowledge about many of the regulations, programs, and policies under national and state health reforms. **There is an opportunity to partner with state associations such as the California Primary Care Association, California Institute for Mental Health, and California Mental Health Directors Association to educate the workforce about the complex changes transforming the health care system.**

The integration of physical and mental health systems of care is beneficial to patients, families, and care providers.[12] Yet notable knowledge and skill gaps are evident in integrated care

settings, as are considerable structural, information/data sharing, and other barriers to effective integration in California counties.[13] **Effective integrated care requires additional training for the workforce, a developed HIT infrastructure that allows for the collection and sharing of data, collaboration across providers, and attitude shifts toward working in integrated care.**[14]

It is the IBHP team's hope that these survey findings will assist counties, professional organizations, and state associations in understanding some of the information needs of the provider community to develop a plan that will create a knowledgeable and prepared integrated care workforce, capable of meeting the needs of complex patients in a transformed health care system.

ATTACHMENT 1: GLOSSARY OF TERMS

42-CFR Part 2 – a federal regulation protecting confidentiality in the substance abuse field. It outlines the circumstances under which client treatment information may be disclosed with and without the client's consent.

Accountable Care Organization (ACO) - set of health care providers that work together to provide coordinated care and accept collective accountability for the cost and quality of care delivered to a defined population of patients. ACOs manage the full continuum of patient care. They are characterized by a payment and care delivery model that seeks to tie provider reimbursement to quality metrics and reductions in the total cost of care for an assigned patient population.

Dual-eligible transition – a process approved by the Centers for Medicare & Medicaid Services, in which nearly half a million low-income California seniors and disabled patients who receive both Medi-Cal and Medicare will move into a managed care program called *Cal MediConnect* beginning in early 2014. Enrollment will be capped at 465,000 rather than 800,000 as originally planned. The purpose of the transition is to increase care coordination, reduce costs, and enhance dual eligible beneficiaries' health care experiences. Beneficiaries will receive medical and mental health services as well as dental, vision care, and nonemergency transportation. The project will last for three years, but the state hopes to continue beyond that time and add more participants. The project will take place in eight counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, Alameda and Santa Clara.

Essential Health Benefits – a statute in the ACA establishing minimum coverage standards for health insurance plans. ACA law defines the comprehensive package of health care items and services, including mental health and substance use disorder services, that must be covered by certain plans. Health plans will be required to offer the same benefits to individual and small group markets, both inside and outside of the exchanges, starting in 2014.

HIPAA (Health Insurance Portability and Accountability Act of 1996) – the first major attempt to use federal law to prevent insurers from discriminating against people with health conditions and disabilities. HIPAA bars discrimination based on health status at the point of enrollment and renewal. HIPAA also requires the protection and confidential handling of protected health information. It protects health insurance coverage for workers and their families when they change or lose their jobs. Standards encourage widespread use of electronic data interchange in the health care system.

Low Income Health Program (LIHP) - a coverage program for low-income uninsured adults in California that was included as part of California's Section 1115 Medicaid Waiver. The program builds off and expands the previous Coverage Initiative that was part of California's previous waiver. LIHP provides counties and public hospitals with partial federal reimbursement for expanding coverage to

low-income, uninsured residents. The LIHP is available to all California counties, subject to their ability to provide the matching funds for partial federal reimbursement. Adults must meet eligibility requirements of being uninsured, between 19 and 64 years of age, and earning up to 200% of the Federal Poverty Level. Each participating county can establish their own income eligibility limit from 0-200% of FPL. All LIHP enrollees are assigned to a "medical home," primary care clinics where patients receive care tailored to their needs. The benefits available to enrollees are comprehensive and include preventive, outpatient, hospitalization, prescription and emergency services.

Meaningful Use – a set of standards defined by Centers for Medicare & Medicaid Services (CMS) Incentive Programs that governs the use of electronic health records and allows eligible providers and hospitals to earn incentive payments by meeting specific criteria. The goal of MU is to promote the spread of EHRs to improve health care in the U.S. The benefits of MU include complete and accurate information, better access to information, and patient empowerment.

Medicaid Health Homes – an optional Medicaid State Plan program created by Section 2703 of the ACA as a benefit for interested states. Medicaid Health Homes coordinate care for Medicaid beneficiaries who have chronic conditions. Health home services include comprehensive care management, care coordination, health promotion, transitional care, patient and family support, and referral to community and social support services. (See also, *patient-centered medical home*)

Mental Health Parity Act of 1996 – an Act that broadly addresses the problem of discrimination against mental illness and addiction disorders in both benefit design and plan administration. Amendments in 2008 required group health insurance plans that offer coverage for mental illness and substance use disorders to provide those benefits in no more restrictive way than all other medical and surgical procedures covered by the plan.

Patient-Centered Medical Home (PCMH) - according to the National Committee for Quality Assurance accrediting agency, a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. (See also, *Medicaid Health Homes*)

Seniors and Persons with Disabilities (SPD) transition into Medi-Cal Managed Care – a demonstration project that provides for enrollment of seniors and persons with disabilities in managed care to achieve better care coordination and management of chronic conditions. Beginning in June 2011, the state of California transitioned SPDs from fee-for-service into managed care in 16 counties with two-plan and geographic managed care models. (SPDs who receive care through county organized health systems have always been enrolled in managed care.)

ATTACHMENT 2: DETAILED TABLES

ATTACHMENT 2A: LEVEL OF COMMUNICATION WITH OTHER PROVIDERS, BY PROFESSIONAL GROUP, DETAIL

Providers	Level of Communication	Nurses (N=57)	Social Workers (N=143)	MFTs (N=68)	Psychologists (N=47)	AOD Professionals (N=123)
AOD Counselors	High	17.5%	21.7%	16.2%	8.5%	75.6%
	Moderate	22.8%	19.6%	10.3%	10.6%	13.8%
	Low	21.1%	22.4%	26.5%	14.9%	4.9%
	Don't Work w/ Provider	38.6%	36.4%	47.1%	66.0%	5.7%
		Nurses (N=65)	**Social Workers (N=149)**	**MFTs (N=68)**	**Psychologists (N=49)**	**AOD Professionals (N=123)**
Case or Care Managers	High	50.8%	55.0%	36.8%	24.5%	71.5%
	Moderate	18.5%	18.8%	25.0%	24.5%	17.9%
	Low	20.0%	12.1%	14.7%	18.4%	5.7%
	Don't Work w/ Provider	10.8%	14.1%	23.5%	32.7%	4.9%
		Nurses (N=63)	**Social Workers (N=146)**	**MFTs (N=69)**	**Psychologists (N=42)**	**AOD Professionals (N=121)**
Consumers or Peers	High	61.9%	65.8%	31.9%	26.2%	66.1%
	Moderate	17.5%	11.6%	21.7%	11.9%	17.4%
	Low	4.8%	9.6%	20.3%	14.3%	7.4%
	Don't Work w/ Provider	15.9%	13.0%	26.1%	47.6%	9.1%
		Nurses (N=57)	**Social Workers (N=143)**	**MFTs (N=68)**	**Psychologists (N=47)**	**AOD Professionals (N=123)**
Hospital Discharge Planners	High	29.2%	28.6%	11.4%	6.3%	17.5%
	Moderate	24.6%	17.0%	10.0%	20.8%	25.0%
	Low	16.9%	21.8%	34.3%	22.9%	22.5%
	Don't Work w/ Provider	29.2%	32.7%	44.3%	50.0%	35.0%
		Nurses (N=62)	**Social Workers (N=146)**	**MFTs (N=69)**	**Psychologists (N=49)**	**AOD Professionals (N=120)**
Medical Assistants	High	19.4%	16.4%	8.7%	14.3%	20.0%
	Moderate	11.3%	20.5%	7.2%	10.2%	20.8%
	Low	24.2%	23.3%	31.9%	14.3%	25.8%
	Don't Work w/ Provider	45.2%	39.7%	52.2%	61.2%	33.3%
		Nurses (N=65)	**Social Workers (N=147)**	**MFTs (N=69)**	**Psychologists (N=49)**	**AOD Professionals (N=121)**
Nurses	High	69.2%	36.1%	17.4%	16.3%	36.4%
	Moderate	24.6%	21.1%	11.6%	14.3%	20.7%
	Low	6.2%	17.0%	31.9%	24.5%	23.1%
	Don't Work w/ Provider	0.0%	25.9%	39.1%	44.9%	19.8%
		Nurses (N=65)	**Social Workers (N=147)**	**MFTs (N=70)**	**Psychologists (N=48)**	**AOD Professionals (N=120)**
Primary Care Physicians	High	56.9%	33.3%	18.3%	30.0%	31.1%
	Moderate	15.4%	23.8%	25.4%	36.0%	28.7%
	Low	16.9%	29.9%	35.2%	28.0%	27.0%
	Don't Work w/ Provider	10.8%	12.9%	21.1%	6.0%	13.1%

		Nurses (N=65)	Social Workers (N=149)	MFTs (N=68)	Psychologists (N=49)	AOD Professionals (N=118)
Social Workers	High	70.8%	61.1%	47.1%	34.7%	56.8%
	Moderate	13.8%	22.8%	14.7%	22.4%	23.7%
	Low	7.7%	8.1%	14.7%	28.6%	13.6%
	Don't Work w/ Provider	7.7%	8.1%	23.5%	14.3%	5.9%
		Nurses (N=65)	**Social Workers (N=140)**	**MFTs (N=69)**	**Psychologists (N=50)**	**AOD Professionals (N=122)**
Psychologists, MFTs, MH Clinicians	High	35.4%	30.0%	58.0%	52.0%	45.9%
	Moderate	18.5%	30.0%	17.4%	20.0%	22.1%
	Low	27.7%	18.6%	14.5%	18.0%	19.7%
	Don't Work w/ Provider	18.5%	21.4%	10.1%	10.0%	12.3%
		Nurses (N=65)	**Social Workers (N=149)**	**MFTs**	**Psychologists**	**AOD Professionals (N=122)**
Psychiatrists	High	64.6%	55.7%	--	--	47.5%
	Moderate	18.5%	18.8%	--	--	27.9%
	Low	12.3%	15.4%	--	--	17.2%
	Don't Work w/ Provider	4.6%	10.1%	--	--	7.4%

Notes:
High + Moderate + Low + Don't work with provider = 100% for each type of provider
Don't Know/Not Sure responses were excluded from this analysis.
Physicians were not asked this question.
"Very High" and "High" were combined; "Very Low" and "Low" were combined.

ATTACHMENT 2B: LEVEL OF KNOWLEDGE OF OTHER PROVIDERS' SCOPE OF PRACTICE AS IT PERTAINS TO SERVICES BENEFITTING CLIENTS, FOR PHYSICIANS, MFTS, AND PSYCHOLOGISTS, DETAIL

Providers	Level of Knowledge	Physicians (N=24)	MFTs (N=61)	Psychologists (N=44)
AOD Counselors	High	12.5%	37.7%	22.7%
	Moderate	12.5%	9.8%	13.6%
	Low	37.5%	11.5%	20.5%
	Don't Work w/ Provider	37.5%	41.0%	43.2%
		Physicians (N=29)	**MFTs (N=67)**	**Psychologists (N=47)**
Case or Care Managers	High	55.2%	56.7%	44.7%
	Moderate	31.0%	14.9%	23.4%
	Low	6.9%	6.0%	12.8%
	Don't Work w/ Provider	6.9%	22.4%	19.1%
		Physicians (N=25)	**MFTs (N=62)**	**Psychologists (N=39)**
Consumers or Peers	High	56.0%	46.8%	38.5%
	Moderate	32.0%	12.9%	10.3%
	Low	8.0%	12.9%	17.9%
	Don't Work w/ Provider	4.0%	27.4%	33.3%
		Physicians	**MFTs (N=62)**	**Psychologists (N=49)**
Hospital Discharge Planners	High	--	29.0%	24.5%
	Moderate	--	12.9%	22.4%
	Low	--	17.7%	22.4%
	Don't Work w/ Provider	--	40.3%	30.6%
			MFTs (N=62)	**Psychologists (N=47)**
Medical Assistants	High	--	19.4%	27.7%
	Moderate	--	12.9%	21.3%
	Low	--	22.6%	21.3%
	Don't Work w/ Provider	--	45.2%	29.8%
			MFTs (N=60)	**Psychologists (N=48)**
Nurses	High	--	33.3%	43.8%
	Moderate	--	21.7%	22.9%
	Low	--	13.3%	8.3%
	Don't Work w/ Provider	--	31.7%	25.0%
		Physicians	**MFTs (N=66)**	**Psychologists (N=49)**
Primary Care Physicians	High	--	40.9%	67.3%
	Moderate	--	24.2%	18.4%
	Low	--	6.1%	8.2%
	Don't Work w/ Provider	--	28.8%	6.1%
		Physicians (N=31)	**MFTs (N=63)**	**Psychologists (N=50)**
Specialty Care Providers	High	83.9%	34.9%	52.0%
	Moderate	12.9%	20.6%	22.0%
	Low	3.2%	11.1%	12.0%
	Don't Work w/ Provider	0.0%	33.3%	14.0%
		Physicians (N=31)	**MFTs (N=63)**	**Psychologists (N=50)**
Other Health Professionals	High	90.3%	31.7%	56.0%
	Moderate	6.5%	20.6%	22.0%

	Low	3.2%	15.9%	8.0%
	Don't Work w/ Provider	0.0%	31.7%	14.0%
		Physicians (N=30)	**MFTs (N=67)**	**Psychologists (N=48)**
Social Workers	High	70.0%	65.7%	72.9%
	Moderate	20.0%	11.9%	12.5%
	Low	3.3%	6.0%	6.3%
	Don't Work w/ Provider	6.7%	16.4%	8.3%
		Physicians (N=31)	**MFTs (N=67)**	**Psychologists (N=50)**
Psychologists, MFTs, MH Clinicians	High	74.2%	74.6%	76.0%
	Moderate	16.1%	13.4%	12.0%
	Low	6.5%	4.5%	2.0%
	Don't Work w/ Provider	3.2%	7.5%	10.0%

Notes:
High + Moderate + Low + Don't work with provider = 100% for each type of provider
Don't Know/Not Sure responses were excluded from this analysis.
"Very Low" and "Low" were combined; "Very High" and "High" were combined.
"--" signifies that the professional group was not asked about the provider type.

ATTACHMENT 2C: LEVEL OF KNOWLEDGE OF OTHER PROVIDERS' SCOPE OF PRACTICE AS IT PERTAINS TO SERVICES BENEFITTING CLIENTS, FOR NURSES, SOCIAL WORKERS, AND AOD PROFESSIONALS, DETAIL

Providers	Level of Knowledge	Nurses (N=51)	Social Workers (N=140)	AOD Professionals (N=122)
AOD Counselors	Good and Excellent	41.2%	48.6%	84.4%
	Very Limited and Fair	23.5%	24.3%	10.7%
	Don't Work w/ Provider	35.3%	27.1%	4.9%
		Nurses (N=65)	**Social Workers (N=147)**	**AOD Professionals (N=120)**
Case or Care Managers	Good and Excellent	75.4%	78.9%	83.3%
	Very Limited and Fair	18.5%	10.9%	14.2%
	Don't Work w/ Provider	6.2%	10.2%	2.5%
		Nurses (N=60)	**Social Workers (N=144)**	**AOD Professionals (N=115)**
Consumers or Peers	Good and Excellent	85.0%	76.4%	75.7%
	Very Limited and Fair	5.0%	11.8%	19.1%
	Don't Work w/ Provider	10.0%	11.8%	5.2%
		Nurses (N=65)	**Social Workers (N=145)**	**AOD Professionals (N=117)**
Hospital Discharge Planners	Good and Excellent	63.1%	44.8%	38.5%
	Very Limited and Fair	18.5%	31.0%	31.6%
	Don't Work w/ Provider	18.5%	24.1%	29.9%
		Nurses (N=61)	**Social Workers (N=144)**	**AOD Professionals (N=113)**
Medical Assistants	Good and Excellent	45.9%	29.2%	38.9%
	Very Limited and Fair	24.6%	41.7%	31.0%
	Don't Work w/ Provider	29.5%	29.2%	30.1%
		Nurses (N=64)	**Social Workers (N=145)**	**AOD Professionals (N=116)**
Nurses	Good and Excellent	93.8%	55.2%	31.0%
	Very Limited and Fair	6.3%	27.6%	51.7%
	Don't Work w/ Provider	0.0%	17.2%	17.2%
		Nurses (N=63)	**Social Workers (N=147)**	**AOD Professionals (N=117)**
Primary Care Physicians	Good and Excellent	82.5%	55.8%	53.8%
	Very Limited and Fair	12.7%	29.3%	31.6%
	Don't Work w/ Provider	4.8%	15.0%	14.5%
		Nurses (N=65)	**Social Workers (N=148)**	**AOD Professionals (N=120)**
Social Workers	Good and Excellent	83.1%	85.8%	69.2%
	Very Limited and Fair	12.3%	6.8%	23.3%
	Don't Work w/ Provider	4.6%	7.4%	7.5%
		Nurses (N=64)	**Social Workers (N=144)**	**AOD Professionals (N=119)**
Psychologist, MFTs, MH Clinicians	Good and Excellent	62.5%	61.1%	65.5%
	Very Limited and Fair	23.4%	19.4%	23.5%
	Don't Work w/ Provider	14.1%	19.4%	10.9%
		Nurses (N=64)	**Social Workers (N=146)**	**AOD Professionals (N=119)**
Psychiatrists	Good and Excellent	87.5%	74.7%	67.2%
	Very Limited and Fair	10.9%	15.8%	26.9%
	Don't Work w/ Provider	1.6%	9.6%	5.9%

Notes:
Don't Know/Not Sure responses were excluded from this analysis.
"Good" and "Excellent" were combined; "Fair" and "Very Limited" were combined.

ATTACHMENT 2D: LEVEL OF KNOWLEDGE ABOUT ASPECTS OF NATIONAL HEALTH REFORM, BY PROFESSIONAL GROUP

Aspects of Nat'l Health Reform	Level of Knowledge	Nurses (N=60)	Social Workers (N=143)	MFTs (N=65)	Psychologists (N=48)	AOD Professionals (N=115)
Client/Patient Eligibility for Services	Moderate or Very	50.0%	36.4%	40.0%	43.8%	60.0%
	Limited or No	50.0%	63.6%	60.0%	56.2%	40.0%
		Nurses (N=60)	**Social Workers (N=143)**	**MFTs (N=64)**	**Psychologists (N=48)**	**AOD Professionals (N=115)**
Types of Services Offered	Moderate or Very	53.3%	34.3%	37.5%	39.6%	59.1%
	Limited or No	46.7%	65.7%	62.5%	60.4%	40.9%
		Nurses (N=60)	**Social Workers (N=141)**	**MFTs (N=64)**	**Psychologists (N=48)**	**AOD Professionals (N=115)**
Provider Roles/ Scope of Services	Moderate or Very	46.7%	34.8%	35.4%	37.5%	54.8%
	Limited or No	53.3%	65.2%	64.6%	62.5%	45.2%
		Nurses (N=60)	**Social Workers (N=142)**	**MFTs (N=64)**	**Psychologists (N=48)**	**AOD Professionals (N=115)**
Reimbursement	Moderate or Very	28.3%	20.4%	29.7%	22.9%	40.9%
	Limited or No	71.7%	79.6%	70.3%	77.1%	59.1%
		Nurses (N=60)	**Social Workers (N=142)**	**MFTs (N=64)**	**Psychologists (N=48)**	**AOD Professionals (N=114)**
IT Strategies for Population Health Management	Moderate or Very	35.0%	16.9%	20.3%	20.8%	41.2%
	Limited or No	65.0%	83.1%	79.7%	79.2%	58.8%
		Nurses (N=59)	**Social Workers (N=138)**	**MFTs (N=63)**	**Psychologists (N=47)**	**AOD Professionals (N=111)**
Performance-Based Incentives	Moderate or Very	42.4%	22.5%	23.8%	23.4%	40.5%
	Limited or No	57.6%	77.5%	76.2%	76.6%	59.5%

Notes: Physicians were not asked these questions; "Moderate Knowledge" and "Very Knowledgeable" were combined; "Limited Knowledge" and "No Knowledge" were combined.

ATTACHMENT 2E: LEVEL OF KNOWLEDGE ABOUT ASPECTS OF HEALTH REFORM REGULATIONS, PROGRAMS AND PUBLIC POLICIES, BY PROFESSIONAL GROUP

Aspects of Health Regulations, Programs and Policies	Level of Knowledge	Nurses (N=59)	Social Workers (N=140)	MFTs (N=64)	Psychologists (N=48)	AOD Professionals (N=114)
Accountable Care Organization (ACO)	Moderate or Very	32.2%	15.7%	10.9%	12.5%	36.0%
	Limited or No	67.8%	84.3%	89.1%	87.5%	64.0%
		Nurses (N=60)	**Social Workers (N=141)**	**MFTs (N=64)**	**Psychologists (N=48)**	**AOD Professionals (N=115)**
Patient-Centered Medical Home (PCMH)	Moderate or Very	45.0%	22.0%	17.2%	22.9%	37.4%
	Limited or No	55.0%	78.0%	82.8%	77.1%	62.6%
		Nurses (N=60)	**Social Workers (N=142)**	**MFTs (N=64)**	**Psychologists (N=48)**	**AOD Professionals (N=113)**
Essential Health Benefits under the Affordable Care Act	Moderate or Very	31.7%	16.9%	14.1%	27.1%	36.3%
	Limited or No	68.3%	83.1%	85.9%	72.9%	63.7%
		Nurses (N=59)	**Social Workers (N=139)**	**MFTs (N=64)**	**Psychologists (N=48)**	**AOD Professionals (N=115)**
Low Income Health Program (LIHP)	Moderate or Very	23.7%	26.6%	15.6%	6.3%	43.5%
	Limited or No	76.3%	73.4%	84.4%	93.7%	56.5%
		Nurses (N=60)	**Social Workers (N=141)**	**MFTs (N=64)**	**Psychologists (N=48)**	**AOD Professionals (N=115)**
Transition of Medi-Cal Eligible Seniors and Persons with Disabilities from Fee-For-Service to Managed Care	Moderate or Very	28.3%	26.2%	14.1%	14.6%	35.7%
	Limited or No	71.7%	73.8%	85.9%	85.4%	64.3%
		Nurses (N=60)	**Social Workers (N=140)**	**MFTs (N=64)**	**Psychologists (N=48)**	**AOD Professionals (N=114)**
Transition of Dually Eligible Medicare/Medi-Cal Beneficiaries from Fee-For- Service to Managed Care	Moderate or Very	28.3%	26.4%	14.1%	16.7%	32.5%
	Limited or No	71.7%	73.6%	85.9%	83.3%	67.5%
		Nurses (N=60)	**Social Workers (N=142)**	**MFTs (N=64)**	**Psychologists (N=48)**	**AOD Professionals (N=114)**
Implications of HIPAA	Moderate or Very	65.0%	57.0%	60.9%	45.8%	55.3%
	Limited or No	35.0%	43.0%	39.1%	54.2%	44.7%

		Nurses (N=60)	Social Workers (N=142)	MFTs (N=64)	Psychologists (N=48)	AOD Professionals (N=115)
Implications of 42-CFR Part 2 (Substance Abuse Confidentiality Law)	Moderate or Very	41.7%	30.3%	25.0%	18.8%	**57.4%**
	Limited or No	58.3%	69.7%	75.0%	81.2%	42.6%
		Nurses (N=56)	**Social Workers (N=137)**	**MFTs (N=63)**	**Psychologists (N=48)**	**AOD Professionals (N=106)**
Mental Health Parity and Addiction Equity Act	Moderate or Very	46.4%	48.2%	27.0%	37.5%	50.0%
	Limited or No	53.6%	51.8%	73.0%	62.5%	50.0%
		Nurses (N=60)	**Social Workers (N=138)**	**MFTs (N=63)**	**Psychologists (N=48)**	**AOD Professionals (N=115)**
CMS EHR Meaningful Use Criteria	Moderate or Very	25.0%	17.4%	11.1%	8.3%	27.8%
	Limited or No	75.0%	82.6%	88.9%	91.7%	72.2%

Notes:
Physicians were not asked these questions.
"Moderate Knowledge" and "Very Knowledgeable" were combined.
"Limited Knowledge" and "No Knowledge" were combined.

ENDNOTES

[1] SAMHSA-HRSA Center for Integrated Health Solutions. Primary and behavioral health integration-guiding principles for workforce development. www.CenterforIntegratedHealthSolutions.org

[2] SAMHSA-HRSA Center for Integrated Health Solutions. Primary and behavioral health integration-guiding principles for workforce development. www.CenterforIntegratedHealthSolutions.org

[3] Patient Protection and Affordable Care Act. Retrieved from www.gpo.gov/fdsys/pkg/PLAW-111publ148/content-detail.html

[4] Technical Assistance Collaborative/Human Services Research Institute (TAC/HSRI). (2012, February 29). California mental health and substance use service system needs assessment - Final report, p. 211.

[5] Pourat, N., Salce, E., Davis, A.C. & Hilberman, D. (2012). Achieving system integration in California's health care safety net. UCLA Center for Health Policy Research. August, p. 7. www.healthpolicy.ucla.edu

[6] Bates, T., Blash, L., Chapman, S., Dower, C., & O'Neil, E. (2011, December). California's health care workforce - Are we ready for the ACA? UCSF Center for the Health Professions Research Brief , p 3.

[7] Centers for Medicare and Medicaid Services. Readmissions Reduction Program. Retrieved from http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html

[8] Technical Assistance Collaborative/Human Services Research Institute (TAC/HSRI). (2012, February 29). California mental health and substance use service system needs assessment - Final report.

[9] Kaiser Commission on Medicaid and the Uninsured. (2011, October). California's "Bridge to Reform" Medicaid Demonstration Waiver. Policy Brief. Henry J. Kaiser Family Foundation. Washington, DC. www.kff.org

[10] Coffman JM & Ojeda G. (2010, October). Impact of national health care reform on California's health workforce. California Program on Access to Care, UC Berkeley School of Public Health.

[11] McRee, T., Dower, C., Briggance, B. , Vance, J., Keane, D. & O'Neil E.H. (2003, February). California Workforce Initiative. The mental health workforce: Who's meeting California's needs? p. xi.

[12] McRee, T., Dower, C., Briggance, B. , Vance, J., Keane, D. & O'Neil E.H. (2003, February). California Workforce Initiative. The mental health workforce: Who's meeting California's needs? p. xi.

[13] Technical Assistance Collaborative/Human Services Research Institute (TAC/HSRI). (2012, February 29). California mental health and substance use service system needs assessment - Final report, p. 271.

[14] Technical Assistance Collaborative/Human Services Research Institute (TAC/HSRI). (2012, February 29). California mental health and substance use service system needs assessment - Final report, p. 256.