

# Summary of Findings

## The Second Annual California Innovations Summit on Integrated Care

Taking Stock of Health Care Reform and Medi-Cal Expansion:  
The Good, the Challenging, and Shaping What's Next

July 2014



## Summit Overview

Over 150 leaders, representing county mental health plans, substance use disorder systems, community health centers and clinics, Medi-Cal managed care plans, community based providers, peer leaders, and statewide advocates, convened June 4-5, 2014 for the Second Annual California Innovations Summit on Integrated Care. At the Summit, participants examined California's initial experience implementing the expanded behavioral health benefit under Medicaid and identified local, regional, and statewide strategies to build coordinated and accountable care for individuals with complex and co-occurring behavioral health and medical conditions. The Innovations Summit was sponsored by the CalMHSA Integrated Behavioral Health Project, in collaboration with the California Institute for Behavioral Health Solutions.

## Strategies to Improve Accountability and Coordination of Care

Summit participants engaged in cross-sector dialogues, using case studies and a scenario planning process, to identify and prioritize challenges and strategies for promoting and improving care integration and coordination for persons with complex medical and behavioral health conditions. Participants were sorted into seven cross-sector breakout groups and organized by geographic proximity, to encourage local networking and planning during and after the Summit. The case studies presented were designed to foster discussion about the challenges faced by patients, their families, and providers in California's complex, under-resourced and fragmented health delivery system.

## Challenges to Providing Integrated Care

The challenges summarized below were identified as key barriers to integrated and coordinated care, particularly in light of California's carve-out of specialty behavioral health Medi-Cal systems.

- 1. Lack of consistent screening, access and referral standards, or processes across systems and providers, leading to redundancy, inefficiency, and delayed access**
  - Service capacity gaps, especially substance use/abuse treatment and psychiatry
  - Lack of common referral and follow-up and coordination protocols
  - Confusing care pathways and transitions, that create "ping ponging" between systems, especially for individuals with a criminal justice background
- 2. Services and levels of care are fragmented, unclear, and lack flexibility based on patient need and choice due to carve-out (mild/moderate or severe/intensive)**
  - Lack of consistency in level of care determination; no single authorizing process or body
  - Barriers to accessing more than one level of behavioral health care at the same time
  - Lack of flexibility to provide needed supports to do whatever it takes
- 3. Care coordination/management is not routinely provided to individuals with complex health and behavioral health conditions**
  - No payment or financing structure for high-touch (intensive) care coordination
  - Barriers to sharing patient data, incompatible data systems, and confidentiality myths and requirements
  - Limited availability of health navigator services or systems through peer providers

**4. Patients' and clients' choices regarding services and level of care are often limited; service determination is system or clinician-driven, not consumer-driven**

- System fragmentation limits access, knowledge, and choice of services and providers
- Peer and family supports are not recognized or mobilized
- Patient assets and strengths are not mobilized

**5. Patients' care outcomes are not monitored or tracked across providers or levels of care**

- Poor data system interface and incompatibility, as well as real or perceived confidentiality barriers, limit outcome measurement and tracking
- Within and across systems there is limited to no agreement regarding outcome measures, particularly with a focus on the whole person

## Improving Care Integration and Care Coordination

Summit participants identified local/regional strategies for improving care integration and care coordination, as well as considerations for state-level action in the following **four key areas**:

1. Screening, assessment, and referral processes
2. Service access, adequacy, and continuity of care for individuals with complex needs
3. Consumer choice regarding services and level of care for services
4. Financing and payment strategies to incentivize care coordination

### 1. Improve screening, assessment, and referral processes

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#### Local Strategies:

- > Managed care plans and their contracted behavioral health vendors mental health plans (MHPs), and provider systems (statewide or regional) should select or develop standardized and validated screening and assessment tools, and implement standard criteria and protocols for use.
- > Centralize and coordinate point(s) of access for screening and referrals, including integrated access for county mental health and substance use disorder specialty care systems.
- > Establish a patient ombudsman program accessible in principal languages of each community.
- > Use peer navigators/health resilience specialists to engage and help patients use services.
- > Consent and releases of information should be completed proactively to include all known providers and facilitate care coordination/care management.

### Recommendations for the State:

- > Develop statewide standards for screening, assessment, and timeliness of access.
- > Formalize level of care criteria for mild/moderate and specialty behavioral health services and create a process to reduce disputes between counties and MCOs.
- > Develop statewide guidance regarding privacy laws and regulations to support care coordination and clinical information sharing.

## 2. Increase and ensure service adequacy and continuity of care for individuals with complex medical and behavioral health conditions

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### Local Strategies:

- > Managed care plans and specialty care systems should ensure continuity of care and care transitions through access and treatment protocols, as well as integrated services for clients who fall into the gray zone level of care between mild/moderate and specialty care. Protocols and services should be designed to allow for flexibility as needs change.
- > Develop a mix of person-centered health home options to address consumer choice by integrating behavioral health into primary care settings and primary care into behavioral health settings.
- > Provide peer and community health navigator supports across care systems. Promote peers in providing recovery support through the substance use disorder systems (SUDS) Medi-Cal waiver and offer scholarships for The California Association of Alcoholism and Drug Abuse Counselors (CADAAC) certification.
- > Address gaps in local or regional systems of care, particularly substance use disorder services, by a) developing incentives to increase the number of PCPs licensed in Medication Assisted Treatment (MAT) and b) clarifying Suboxone prescription rules regarding pain management and addiction. Increase availability of behavioral health respite care and mobile outreach.
- > Improve care transitions, including continuation of existing services until transition to new services is completed. Focus on transitions from hospitals and institutions to community care.
- > Managed care plans, mental health plans and provider systems should adopt local or regional agreements, standards, and protocols for information sharing and communication about administrative and clinical policies.
- > Determine criteria and clinical guidelines to provide intensive care coordination, focusing on high-frequency users and individuals with complex conditions/care needs.

- > Expand telemedicine projects to promote specialty access, including psychiatry and consulting psychiatry.
- > Collaborate with public health and community-based partners to increase focus on wellness, prevention, and early intervention.
- > Provide team-based care, including shared care plans that involve and engage patients.
- > Strengthen provider networks by providing cross-training among mental health, substance use disorder, and primary care partners on integrated service processes and workforce education resources.

### Recommendations for the State:

- > Apply for 2703 Health Home Pilot that includes both primary care and behavioral health home options. Pursue a 1915-i waiver to fill gaps in Medi-Cal funded systems of care including non-medical treatment supports, such as outreach, housing, and employment.
- > Streamline and improve efficiency of certification, re-certification, and processing of Drug Medi-Cal provider applications.
- > Expand SUD residential services access by advocating for the Centers for Medicare and Medicaid Services (CMS) to remove the federal Institutions for Mental Disease (IMD) restriction of 16 beds or less for residential treatment. Provide incentives and technical assistance to increase Medi-Cal reimbursable SUD residential treatment.
- > Increase Medi-Cal reimbursement rates to attract quality providers.
- > Allow same-day visits in FQHCs for persons with behavioral health needs.
- > Upgrade state data systems to improve interoperability and data reporting.
- > Improve support for workforce capacity and growth through:
  - Mandated continuing education for primary care physicians regarding mental health/SUD; for mental health providers, education regarding health risks/conditions.
  - Certification of peer run and peer provider services.
  - Workforce stipends – focus on recruitment and retention.
  - Submit Federal waiver to allow Marriage and Family Therapists (MFTs) and Licensed Professional Clinical Counselors (LPCCs) as eligible providers in FQHCs.
  - Allow specially trained psychologists to provide psychiatric medication prescribing services, especially in under-served, high-need areas.

### 3. Improve consumer choice with options to select or continue to use a service provider that does not fit level of care requirements

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#### Local Strategies:

- > Align services to support consumer literacy, activation, and choice.
- > Promote the use of consumers and peer providers to educate primary care providers in recovery and wellness principles.
- > Promote and provide culturally competent/culturally relevant services, including non-traditional health and behavioral health services.
- > Pilot and implement models of self-directed care.
- > Build health neighborhoods that address needs and supports beyond health and behavioral health services.
- > Provide peer run educational programs to support self-advocacy.

#### Recommendations for the State:

- > Include consumers in all integrated care planning and discussions.
- > Continue and expand stigma reduction campaigns.

### 4. Develop financing and payment strategies to provide incentives for care coordination that better serve individuals across the mild/moderate to specialty care spectrum

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#### Local Strategies:

- > Develop local financing strategies that allow dollars to follow patients as they shift across levels of care or require services with mixed intensity.
- > Explore alternative payment models: capitation, increased delivery flexibility (define services and population).
- > Demonstrate the business case for integration and care coordination.

## Recommendations for the State:

- > Permit MCO and MHP flexibility to pay for services to clients on the border of moderate to severe care spectrum.
- > Support voluntary pilots /local option to carve-in behavioral health with physical health managed care and create regional Accountable Care Organizations (ACOs).
- > Support funding for care coordination (pilots, case rate, capitation).
- > Provide guidance on payment for substance use services within FQHCs.
- > Provide payer incentives for navigator programs.

## Summit Sponsors and Presenters

**The CalMHSA Integrated Behavioral Health Project and the California Institute for Behavioral Health Solutions are grateful for the support and contributions of the following co-sponsors and presenters:**

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California Association of Health Insuring Organizations (CAHIO)  
Local Health Plans of California (LHPC) California  
Primary Care Association (CPCA)  
California Mental Health Directors Association (CMHDA)  
California Council of Community Mental Health Agencies (CCCMHA)  
Alcohol and Drug Policy Institute (ADPI)  
Association of Alcohol and Drug Program Executives (CADPE)  
California Mental Health Services Authority (CalMHSA)

### Presenters

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