Office for Oregon Health Policy and Research

Behavioral Health Integration:

Medicaid Advisory Committee Recommendations for the Oregon Health Plan

August 2009

Medicaid Advisory Committee Report

Submitted to:
Bruce Goldberg, MD
Director, Department of Human Services
Director-Designee, Oregon Health Authority

August 17, 2009

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August 17, 2009

Bruce Goldberg, MD
Director, Department of Human Services
Director-Designee, Oregon Health Authority

Dear Dr. Goldberg:

In response to the health disparities that exist among populations that experience mental health or addictions problems, the Medicaid Advisory Committee (MAC) has reviewed key issues surrounding integration of physical, behavioral, and oral health services within the Oregon Health Plan. An introduction to the topic and a description of the MAC's deliberation process accompany the recommendations outlined in this report.

The MAC would like to take this opportunity to commend the State of Oregon for its commitment to improving health care for all Oregonians and taking decisive steps toward reforming its delivery system through HB 2009 and HB 2116. This legislation will position Oregon to provide more of its citizens with access to health care while also ensuring the sustainability of such coverage expansions. Deliberation around this package of health reform bills, however, acknowledged that true health reform cannot occur without integration of care delivery.

As this Committee has previously stated, health care services should not be segregated based on the part of the body they involve or the qualified health professionals who deliver them. The integration of medical services becomes even more critical when one examines the vast health disparities that exist among the population that experiences mental health or addictions issues. People with serious mental illness served by the community mental health system are dying an average of 25 years earlier than the general population. Moreover, recent estimates show that, on average, 30 years of life are lost per alcohol-attributable death. When disparities of this magnitude are present within Oregon's communities, policy shifts must be made in order to move towards a more equitable existence for all Oregonians.

The momentum around behavioral health integration in Oregon, both in the public and private sectors, is moving in parallel with national discussions on health reform and integration. Alignment of these discussions and initiatives could propel this concept from planning stages to actual implementation allowing the State and all Oregonians to reap the benefits of an integrated delivery system in an expedited manner. This report illustrates connections that can be made between current initiatives and recommendations around behavioral health integration within separate divisions in the State government.

Aligning these actions is the first step to creating an efficient, well-orchestrated movement toward a statewide integrated care delivery system. This effort would better poise Oregon to serve as a primary example in the national reform discussion.

During the development of these recommendations, the MAC had the opportunity to become acquainted with both behavioral health services consumers as well as the professionals that treat them. The passion with which these individuals spoke about the need to ensure that Oregon Health Plan beneficiaries have timely access to effective behavioral health services and supports inspired the Committee to ensure that this voice is heard. Consumers of behavioral health services are an integral piece of our community and, likewise, the community and its supports are vital to these individuals. As Oregon moves forward with the health reform movement, the MAC hopes the State will make a concerted effort to take a holistic, community-based approach to providing medical assistance and social supports to its unique populations.

If the MAC can be of further assistance in supporting the State in these efforts, please do not hesitate to ask. We look forward to working with the Department of Human Services on this and many other issues that are central to the delivery of high-quality health care within the Oregon Health Plan.

Sincerely,

Carole Romm, RN, MPA
Co-Chair
Medicaid Advisory Committee

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Co-Chair
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Medicaid Advisory Committee's Recommendations for Behavioral Health Integration

Executive Summary

The Medicaid Advisory Committee (MAC) began examining the topic of behavioral health integration to further explore the etiology of the health disparities that exist among populations that experience mental health or addictions issues. Care integration has gained widespread national attention as a means for improving health outcomes and achieving cost-savings and has, likewise, been promoted by the Oregon Health Fund Board (OHFB) as an effective and comprehensive approach to improving access to care and health outcomes. During the 2009 Oregon Legislative Session, this approach to care delivery was also the focus of several discussions which acknowledged that delivering more integrated, coordinated care is a critical step in achieving true health care reform. While the primary goal of this report is to influence policy that will improve health outcomes and reduce the cost of care for the Oregon Health Plan (OHP) population, a secondary objective is to inform and enhance the work that has been started by several public and private organizations in Oregon. This document includes examples of how the current work on integration, particularly at the state-level, can be tied together and used synergistically to advance this initiative.

The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[1] In this spirit, the MAC has placed particular importance on the social determinants of health and how they affect the Medicaid population as a whole. While a discussion of issues such as housing and employment may seem outside the scope of a health care discussion, the MAC believes that these issues are vital to achieving improved health outcomes. A truly integrated system which seeks to improve population health must address all factors influencing an individual's overall health. The MAC hopes these recommendations will influence policymakers to fully address the "whole life" changes needed to improve the health of the Medicaid population.

The following recommendations were crafted under a framework where true parity for mental health and addiction treatment services is realized, not simply parity in private insurance coverage. Equal treatment and access to these services, in a fully-coordinated fashion, must be achieved for all OHP beneficiaries. Furthermore, the funding structure must be designed such that reimbursement mechanisms promote these goals. Once in place, this system will ensure that patient health and program sustainability improve in parallel. The following is a summary of the MAC findings and recommendations on behavioral health integration in the OHP. The full recommendations follow this summary, with rationale and action steps for each.

Systems Integration

1. **Patient-centered primary care homes (PCPCH) which integrate behavioral, physical, and oral health care services should be established, and incentives**

should be provided for OHP clients who utilize PCPCHs. PCPCHs embody integrated, comprehensive care that addresses the whole person and their health care needs. Establishment of PCPCHs would allow Oregon to move towards a system of providing comprehensive care for OHP clients to ensure that all physical and mental health needs are met.

2. **Utilization of the Four Quadrant Clinical Integration Model by providers, health care organizations, and communities as a strategic planning tool for provision of care should be encouraged.** Providers and communities that use this tool as a guide for integration may be better equipped to identify and deliver care to consumers with different levels of health care needs.

3. **Development and implementation of electronic integrated information systems to facilitate integration of all aspects of health care including medication monitoring, chronic care management and treatment outcomes should be supported.** These systems would allow all disparate health care organizations to communicate vital information and track outcomes to improve patient care.

4. **Coordination between behavioral and physical health providers and health plans must be ensured to achieve effective and safe medication management for consumers.** This is particularly true for individuals who are on multiple medications and who are cared for by multiple providers.

5. **Coverage under the Oregon Health Plan should be expanded with the goal of increasing access to physical and behavioral health services for all Oregonians.** Ensuring that more individuals have access to care, especially those with behavioral health problems, will increase the overall health of Oregon's population.

Payment Reform

6. **As opposed to the traditional fee-for-service payment system, a reformed reimbursement framework should reward holistic care.** The current fee-for-service payment structure can be a hindrance for providers to use effective interventions. An outcome-based reimbursement system would encourage providers to give appropriate care, focusing on techniques that produce better health outcomes and create a sustainable path toward recovery.

7. **The services and supports outlined in these recommendations should be adequately supported and funded through the reimbursement structure.** Including services and supports which have been shown to improve health outcomes and overall wellness in a reformed payment system could lower the State's health care expenditures while also increasing the health of the OHP population.

Services and Supports

Medical Services and Supports

8. **Consistent mental health and substance abuse screening procedures using standardized assessment tools should be implemented throughout the program.** Consistent and reliable screening tools for mental health and substance abuse conditions allow providers to identify consumers who may need intervention. Such screening and intervention procedures have demonstrated cost-savings in Medicaid populations.

9. **Early intervention and screening mechanisms to facilitate identification and prevention of mental health issues in children should be employed.** Early intervention and screening can reduce the severity of symptoms and negative consequences experienced by children with behavioral health issues.

10. **Peer-delivered services such as mentoring programs should be adequately supported.** Peer-delivered services have been shown to produce positive outcomes and should be embraced as an effective means of treatment.

11. **Wellness programs, including health education and appropriate self-management programs, should be adequately supported.** These programs are vital to the recovery process, particularly for those individuals who have developed chronic physical conditions in addition to a behavioral disorder.

12. **A medical advocacy system aimed at improving access to primary and preventive care for individuals with behavioral health problems should be developed.** This system would help consumers navigate the complex health care system and eliminate barriers to care. Medical advocates should be trained to understand patient needs, identify services, and link consumers to appropriate care.

Self-Sufficiency Services and Supports

13. **Supported housing services should be provided to assist consumers with severe mental illness or substance abuse issues in obtaining or retaining housing within their community.** Safe, affordable housing is a key social determinant of health, and access to such living arrangements is critical to a successful recovery.

14. **Supported employment programs that emphasize a "place and then train model" which teaches needed skills and technical abilities on the job should be promoted.** Supported employment enhances tenure in the community and provides longevity in recovery. These programs address barriers to employment with both the employee and their employer, focusing on individualized job development and time-unlimited individual job coaching.

"Health care for general, mental and substance-use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind/brain and the rest of the body." -Institute of Medicine, Quality Chasm (2006)

Introduction

The Problem

People with serious mental illness served by the community mental health system are now dying an average of 25 years earlier than the general population. Sixty percent of these deaths are due to medical conditions including cardiovascular disease, diabetes, respiratory disease, and infectious diseases such as HIV.[2] Similar disparities are seen in individuals with alcohol and drug addictions. Nationally, it is estimated that in 2001 there were approximately 30 years of life lost on average per alcohol-attributable death due to excessive alcohol use.[3] Consumers of mental health and substance abuse treatment experience many personal and system-wide barriers to care which contribute to this serious health disparity. Much like diabetes, mental illness and addiction are chronic conditions that require continuous management over a person's lifetime. Access to treatment is an important issue; however, treatment should not be confused with recovery. Effective treatment provides the tools that a consumer implements throughout the lifetime recovery process, and recovery is only possible if consumers have the tools and natural community supports to attain their goals and improve their health.[4]

According to the World Health Organization the social determinants of health are largely responsible for existing health care disparities in health outcomes.[5] The social determinants of health faced disproportionately by behavioral health consumers include poverty, social isolation, group living situations, incarceration, and homelessness.[6] Each of these factors acts as a barrier to care and good health for those suffering from mental illness or substance abuse issues. In order to support lifetime recovery, behavioral health integration must address the rehabilitation of all aspects of a consumer's life, not just their health status.

Mental health and substance abuse consumers face a high incidence of poverty and homelessness as well as an increased likelihood of incarceration. These circumstances frequently result in a lack of access to health care and health insurance. At the same time, the social stigma attached to mental illness and substance abuse exists in the medical community and contributes to poor coordination between physical and behavioral health care. Mental health symptoms such as difficulty communicating and decreased motivation reduce the ability of consumers to advocate for themselves and manage their own care. Individuals taking psychotropic medications often face a difficult choice between stabilizing their mental health condition and avoiding debilitating side effects. These circumstances create barriers to achieving health and represent obstacles that must be overcome to improve the overall health of the Medicaid population.[7]

Mental health and substance abuse issues also have a major impact on the community as a whole. In 2002, behavioral health problems resulted in $193 billion in lost productivity

in the United States, an amount that is expected to rise to $300 billion by 2013. [8] Studies have shown that addiction disorders are often the cause of criminal activity; therefore, addiction treatment may act as source of prevention, both in terms of personal health and criminal status, and benefit the community as a whole.[9] Untreated substance abuse issues cost Oregon an estimated $5.93 billion each year, a number that includes $813 million spent on health care alone.[10] Moreover, twenty percent of all U.S. community hospital stays involve a primary or co-occurring behavioral health issue.[11] Financing an integrated health system that effectively serves consumers with behavioral health problems may be costly, but doing nothing is a financially unsustainable option.

Supportive Communities

It is critical to note that supportive communities are vital to the process of recovery, and in turn, communities that support recovery and health are an integral part of creating a life that works for consumers over the long-term. This concept of community integration is defined as "the right to live in the community as well as the opportunity to live, study, work, and recreate alongside and in the same manner as people without disabilities."[12] This community-based vision of behavioral and physical health integration includes: safe housing that supports recovery, peer delivered services that instill a sense of hope, medical advocates who help consumers navigate the complex medical world and overcome barriers to care, and viable employment that provides a future and enhances self-respect.[13] These key elements of community integration help consumers experience the process of recovery within a supportive and understanding environment.

Care Coordination & Models of Integration

Studies show that a significant portion of behavioral health treatment occurs in primary care settings. This may be due to the fact that people with serious mental illness frequently also have physical health care problems.[14] The Institute of Medicine has stated that in order to provide effective treatment for this segment of the population the health care system must achieve "coordination of care across patient conditions, services and settings over time."[15] This coordination can be achieved through an integrated health care system that promotes holistic treatment based on individual patient needs. Many organizations across the country have focused on system redesign in formulating a plan for integration. While the financial and structural aspects of integration are vital to a successful system, this redesign will not have a meaningful impact for consumer health without true clinical integration.[16]

Several models for behavioral health integration are currently being considered and tested at the community-level. Each of these models calls for the coordination and management of care among providers/services and co-location, in some instances, of behavioral health specialists in primary care settings.[17] The Four Quadrant Clinical Integration Model categorizes consumers into four continua of care based on the severity of their physical and behavioral health problems (see Appendix A). This population-based planning tool guides providers and communities to base a consumer's level and location of care on their individual needs. The Chronic Care Model is designed to facilitate effective care for chronic illnesses and combines methods of system reorganization with community resources and disease self-management to achieve improved health outcomes for

consumers (see Appendix B). The Pathway to Care Model (see Appendix C) provides a format for addressing the needs of consumers in the health care system and includes the on-going recovery process as part of the overall treatment plan. The Chronic Care Model and Pathway to Care Model have been provided as reference since they are frequently cited as systems which can produce improved health outcomes. However, this discussion, reflective of the MAC public meetings, focuses more heavily on the Four Quadrant Clinical Integration Model.

The Four Quadrant Clinical Integration (FQCI) Model is a framework for developing systems of care, using a population-based methodology, to treat individuals with different levels of health care needs. This model allows providers to identify levels of integration and care delivery that are appropriate for their specific client populations and organizational structures. Each quadrant outlines the infrastructure necessary to provide integrated care to a given population dependent upon the level of care complexity needed. After implementing a system of care using this framework, providers are then able to ensure that patients are being treated in the optimal location.

The FQCI Model is not intended to be entirely prescriptive about the level of care an individual should receive but rather as a conceptual framework and collaborative planning tool to address the needs of a given population. It is not suggested that every health care organization restructure itself so that it mirrors the system outlined in each quadrant. Rather, each community should develop its own system of operation based on local environmental factors including array and capacity of services in the community, consumer preferences, trained workforce, organizational support, and reimbursement factors.[18] For example, if only 5% of the population within a given community requires complex care, then services for those individuals could be aggregated into one location and serve the entire community. This model does not suggest that every health care organization in a community should restructure itself in order to meet the needs of the most at-risk populations. It is intended as a collaborative community, not individual, effort. See Appendix A for detail on the infrastructure recommended for each patient population as well as estimates on the percentage of Oregon's population requiring each level of care.

Environmental Scan

The Medicaid Advisory Committee (MAC) chose to examine the topic of behavioral health integration to explore solutions to eradicate health disparities experienced by this population and as a means to enhance the work that has been started by several public and private organizations. While the topic of integration has gained widespread national attention as a means for improving health outcomes and achieving cost-savings, local efforts have been committed to moving this model forward as well. Integration has been promoted by the Oregon Health Fund Board (OHFB) as an effective and comprehensive approach to improving access to care and health outcomes. In the greater context of health care reform, care integration is seen as one strategy for achieving direct cost-containment in health care expenditures. While the MAC's focus is typically directed toward the OHP population's health, the Committee fully recognizes the need to curtail health care costs in order to create a more sustainable delivery system.

In 2007, nearly thirty-three percent of adults in Oregon reported poor mental health, and there were almost 144,000 adults in Oregon diagnosed with severe mental illness in 2002.[19] Furthermore, as Table 1 illustrates, the need for services greatly outweighs the number of individuals currently provided with care through the public health care system. Left untreated, these conditions persist and manifest themselves as more severe behavioral health as well as physical health issues. This places further strain on the delivery system by increasing demand for specialty services and costly medical treatments.

Table 1. The Need for Addiction Treatment and Mental Health Services in Oregon.

Age/Category	Need for service	People served in the public system	% of need met
Addiction			
17 & under	26,765	6,635	25%
Over 17	235,516	56,138	24%
Mental Health			
17 & under	105,306	34,617	33%
Over 17	154,867	71,204	46%

Source: Oregon Addictions and Mental Health Division, February 2009.

As mentioned previously, individuals who experience mental health and/or addictions issues are disproportionately affected by chronic health conditions and consistently experience poorer health outcomes. In order to directly address this problem along with the unsustainable nature of the U.S. health care delivery system, a policy shift is needed in which resources become more efficiently allocated. Full care integration can act as a mechanism for improving population health while also bending the health care cost curve and moving Oregon's delivery system in the direction of true health care reform.

Political Environment. Oregon took a significant step towards comprehensive health reform during the 2009 legislative session with the passage of companion bills HB 2009 and HB 2116. While HB 2116 focuses on health insurance coverage expansion, HB 2009 seeks to ensure the sustainability of such expansions and reform the health care delivery system through streamlining state health care functions, improving population health, containing costs across the system, and enhancing the quality of care provided. Deliberation around this package of health reform bills included discussions which acknowledged that true health reform can not occur without care delivery integration.

Contained within HB 2009 are directives for the Oregon Health Authority to establish a Patient-Centered Primary Care Home (PCPCH) Program and a Health Information Technology Oversight Council (HITOC). The PCPCH Program Advisory Council, in conjunction with the Office for Oregon Health Policy and Research, is responsible for defining core attributes of the PCPCH, establishing a process to identify PCPCHs, developing uniform quality measures, and coordinating efforts around payment reform.

The HITOC is charged with, among other tasks, developing a strategic health information technology plan for the State, maximizing distribution of resources expended on health information technology within the State, creating a mechanism to help health providers and practices obtain affordable rates for electronic health record implementation, and educating the public and health care providers on health information technology infrastructures. The recommendations contained within this report create a discussion framework for both councils and should be regarded as a resource to guide the direction in which they can move. See Appendix D for an illustration of how the MAC envisions these recommendations being incorporated into the work established by HB 2009.

State-Sponsored Initiatives. The Oregon Department of Human Services (DHS) has convened a work group, the Behavioral Health – Primary Care Integration (BHPCI) Core Team, to compile recommendations for integration implementation within the OHP and across health care organizations throughout the State. The BHPCI Core Team has developed broad action steps for moving integration forward. The MAC supports these steps and believes that its work can enhance this effort by providing more detailed guidance on where to further focus that energy. For a side-by-side comparison of the MAC and BHPCI Core Team recommendations, see Appendix E.

In response to a request from Senator Bates and Representative Kotek in March 2009, the Addictions and Mental Health Division (AMH) also convened a workgroup to identify issues and possible approaches to redesign the addictions and mental health system for adults in Oregon. The intent of this effort was also to begin discussions on how to structure pilot programs that could begin implementing more integrated systems of care. In developing criteria for such programs, the State does not want to stifle innovation and has, therefore, not been overly prescriptive in defining the infrastructure of an integrated system. The recommendations contained within this report could serve as a guide for areas that AMH, as well as health plans and providers, could focus on in developing these pilot projects. The MAC recognizes that not all communities are alike, and as such, each population does not necessarily require the same kind of care. In developing pilot projects, health plans and providers should choose those aspects of care delivery and system integration which are most appropriate for the respective population. The overarching goal should be focused on improving health outcomes and reducing care costs, not necessarily on creating uniform infrastructures.

Private Sector Initiatives. In parallel to these public efforts, local, private entities have invested in integration initiatives. For example, CareOregon's Primary Care Renewal Project is working to model integrated care in several clinics around the state.[20] Crook County Mental Health Services, located in Central Oregon, has partnered with Lutheran Family Services to jointly staff mental health and substance abuse cases. Jackson County Mental Health has partnered with local physicians and community groups to provide integrated medical care for people living in Southern Oregon.[21] Central City Concern in Portland has also been working under an integrated model for some time and continues to refine its nationally-recognized system of care to further improve patient outcomes. These combined efforts have created local momentum for reform of the behavioral health care system.

The MAC Process

Between February and June 2009, the MAC discussed physical and behavioral health integration and heard testimony from mental health and substance abuse consumer advocates, providers, state program administrators, and other stakeholders. The following individuals presented oral testimony to the MAC:

- Karen Wheeler, Addictions and Mental Health Division, DHS
- Carla Ayers, Addiction Treatment Services Consumer Advocate
- Gary Cobb, Central City Concern/Addiction Treatment Services Consumer Advocate
- Rod Calkins, Marion County Health Department
- Richard Harris, Addictions and Mental Health Division, DHS
- Bob Nikkel, Health Services Integration, DHS
- Rachel Solotaroff, MD, Central City Concern
- Susan Marie, PMHNP, PhD, Multnomah County Health Department
- Al Levine, Lane County Behavioral Health Services
- Beckie Child, Mental Health Services Consumer Advocate
- Tammy Brister, Mental Health Services Consumer Advocate
- Meghan Caughey, Benton County Health Services/Mental Health Services Consumer Advocate
- Drake Ewbank, Community Liaison, Safe Inc.
- Ann Kasper, Mental Health Services Consumer Advocate
- David Pollack, MD, Oregon Health & Science University

These presentations, written testimony submitted to the MAC, and current research guided the Committee in developing recommendations for integrating behavioral and physical health care. The overarching objective of this process is to influence policy decisions aimed at improving the overall health of the OHP population. The MAC also seeks to enhance the efforts of other public and private groups, including the Oregon Health Authority, working on behavioral health integration and to contribute to a common vision for reform.

Recommendations in Full

Throughout the MAC's public meeting process, it was repeatedly indicated that patient populations vary from clinic to clinic and that each population has differing needs. Accordingly, providers may need to modify the way in which care is delivered in order to best meet those needs. The MAC proposes these recommendations for care integration not as an all-encompassing directive as to what every provider must do, but rather as suggestions for what may work for a given population. The common goal is to increase care coordination and improve health outcomes, but each community may differ in strategies used to achieve this goal. While each of these recommendations has been shown to produce improved outcomes and/or cost-savings for some populations, each one does not necessarily work for *all* populations. The MAC encourages all providers across the State to assess which strategies are most appropriate to increase care coordination and improve health outcomes for their specific clientele, and to then take aggressive action towards implementing those steps.

Systems Integration

1. **Establish patient-centered primary care homes (PCPCH) which integrate behavioral, physical, and oral health care services, and provide incentives for OHP clients to utilize PCPCHs. Move towards a system of providing comprehensive care to ensure that physical and mental health needs are met through PCPCHs.**

   Rationale: PCPCH demonstration projects have shown that this model can reduce hospitalizations, improve childhood immunization rates, and decrease visits to emergency rooms and specialists.[22] These integrated health settings create a culture that is patient-centered and foster important patient-provider relationships by encouraging providers to view the day's work from the perspective of patient needs. By requiring all Medicaid recipients to enroll in a PCPCH and shifting to a system of "care coordination" payments, other state Medicaid programs have realized significant cost savings while their respective populations have experienced improved health outcomes.[23]

   Action Steps:

   a) Create a PCPCH designation based on a nationally-accepted certification process, such as the National Committee for Quality Assurance (NCQA) recognition guidelines,[24] designed to facilitate communication and collaboration among providers.[i]

[i] PCPCHs can be established in many types of health care settings but they share common features. These include personal and continuous relationships with patients, team-based care, coordination and integration of care with other providers and organizations, and a focus on quality and safety. For more information see http://www.oregon.gov/OHPPR/docs/The_Medical_Home_Model_Final.pdf.

b) Promote integration of behavioral health consultants[ii] within primary care organizations and integration of primary care providers such as MDs, NPs, and PAs within behavioral health organizations.
c) Support utilization of "virtual" co-location techniques such as telemedicine to increase efficiency and provide patients with access to a wider array of health care professionals.
d) Require integration of oral health care services in PCPCHs to promote wellness and prevent costly oral health conditions from developing. Such integration does not necessarily require all of the equipment and hardware that would be found in a traditional dental office, but simply the presence of a dental professional to conduct screenings and basic preventive services.
e) Develop tools to measure the outcomes of integration for consumers of behavioral health services. Specifically focus on indicators that have historically led to elevated morbidity in the behavioral health consumer population (including BMI, blood pressure, blood glucose, and lipid profile).[25]

2. Encourage providers and health care organizations to utilize the Four Quadrant Clinical Integration Model (see Appendix A) as a strategic planning tool for provision of care.

Rationale: Individuals with serious mental illness are dying, on average, 25 years earlier than the general population. The majority of these deaths are attributed to chronic or infectious disease.[26] Similar disparities are seen in individuals with alcohol and drug addictions. This disparity exists, in part, due to individuals not having the ability to access necessary medical services in a setting most appropriate for their needs.

The Four Quadrant Clinical Integration Model is a framework for assessing and treating patients with different levels of health care needs. This model allows providers and health care organizations to choose a level of integration and care delivery that is appropriate for their specific client populations and organizational structures. Health care providers that use this tool as a guide for integration may be better equipped to identify and place consumers who are most at-risk in an appropriate care setting with all services delivered in a coordinated manner.

Action Steps:
a) Require health plans to identify members with serious mental illness and/or other behavioral health problems that are at-risk of having or developing physical

[ii] The behavioral health consultant provides guidance and information to the primary care provider. In addition this consultant can provide "behavioral health triage and assessment, brief treatment services to the individual, referral to community and educational resources, medication and symptom tracking, self-management supports and relapse planning." This person may also provide cognitive behavioral therapy, motivational interviewing and crisis management as needed. The consultant should be adequately connected to both mental health and substance abuse treatment resources and able to refer clients and provide support within the specialty behavioral health system. For more information see: Mauer, B. *Behavioral Health/Primary Care Integration and the Person-Centered Healthcare Home.* National Council for Community Behavioral Healthcare, April 2009.

health issues. Once identified, these individuals should receive all necessary services in a coordinated fashion in a location that best meets their health care needs.

b) Pursue quality improvement efforts related to health status of individuals identified with severe behavioral health issues.

3. Support development and implementation of electronic integrated information systems to facilitate integration of all aspects of health care including medication monitoring, chronic care management, and treatment outcomes.

Rationale: The current health care system requires consumers to procure care though complex and fragmented organizations that often communicate poorly. This can result in inefficiencies, redundancies, and errors that negatively impact consumer health and the health care system. Integrated information systems allow these disparate health care organizations to communicate vital information and track outcomes to improve future care. Health care organizations report that the major barriers to implementing electronic integrated information systems are high costs and an inability to identify appropriate systems.[27] Providing incentives and guidance may mitigate these concerns and encourage the adoption of this technology.

Action Steps:

a) Provide guidance and resources to help practices select appropriate and affordable electronic health record vendors and service companies that meet quality standards.
b) Provide subsidies for the purchase and maintenance of these products to primary care, rural, and other providers who may not have the resources to do so on their own.
c) Provide incentives and compensation to providers that utilize integrated information systems to track and improve consumer health outcomes.[28]

4. Foster coordination between behavioral and physical health providers and health plans to achieve effective and safe medication management for consumers.

Rationale: Medication management is essential to providing safe and effective health care. This issue is particularly critical to physical-behavioral health integration since consumers with multiple health care conditions need comprehensive medication management in order to prevent dangerous interactions and ensure appropriate treatment. Coordination between physical and behavioral health care providers is crucial to successfully monitoring adherence, potential interactions, and side effects.

Action Steps:

a) Require providers to conduct regular health screenings for all consumers who are prescribed psychotropic medication. These screenings should include a check of glucose and lipid levels as well as blood pressure and BMI measurements to ensure effective and safe medication management.[29]

b) Actively encourage collaborative relationships between primary care providers and psychiatrists to ensure that consumers' medications are stable, appropriate, and effective.
c) Promote non-narcotic approaches to pain management particularly for consumers in recovery who are vulnerable to opiate addiction.

5. Expand coverage under the Oregon Health Plan with the goal of increasing access to physical and behavioral health services for all Oregonians.

Rationale: Expanding health insurance coverage would ensure that more individuals have access to physical and behavioral health services. It has been shown that consumers with severe mental health needs who lack access to care have higher rates of untreated or poorly treated physical disorders such as diabetes and cardiovascular disease.[30] Left untreated, these individuals often end up in the emergency department needing costly treatments that could have otherwise been prevented. Those who do have access to care are better able to manage their conditions and maintain consistent relationships with medical providers.

In addition, it is critical to any coverage expansion that targeted outreach is conducted to the most vulnerable and hard-to-reach populations to ensure that they are aware of their eligibility for health care coverage. Application assistance and follow-up services are particularly important for ensuring that individuals with behavioral health problems, who may not be able to complete the application process on their own, are successfully enrolled in the program.

Action Steps:
a) Expand access to affordable health coverage for all children in Oregon.
b) Expand the OHP Standard to include all low-income adults in Oregon.
c) Conduct targeted outreach to ensure that all eligible individuals are enrolled in the OHP.
d) Develop educational and communications campaigns that emphasize the importance of health care coverage and utilization of preventive services.

Payment Reform

6. As opposed to the traditional fee-for-service payment system, the reimbursement framework should reward holistic care.

Rationale: The current fee-for-service payment structure can be a hindrance for providers to use effective interventions. In the literature, this system is often cited as placing the full risk of care on the payer by encouraging medical overutilization and resource inefficiency through financial incentives. Policies which further exacerbate this trend include the undervaluation of preventive services as well as the overvaluation of non-preventive services; non-payment to physicians for services required to provide patient-focused, care coordination; and the provision of incentives for volume of services without regard to quality of care or resource utilization.[31] A

reimbursement system based on outcomes and holistic, person-centered care would encourage providers to give appropriate levels of care and allow them to focus on techniques that produce better health outcomes and encourage a sustainable path toward recovery.

Action Steps:

a) In collaboration with the Oregon Health Care Quality Corporation, define a set of measurable health outcomes which providers should aim to achieve.
b) Support active and comprehensive case management by reimbursing providers for consultations with parents, teachers, health care workers, etc. that are supplemental to compensated patient interaction.
c) Financially support the integration of primary care providers into publicly-funded community mental health and other community-based behavioral health settings.

7. Promote the "Services and Supports" outlined in the following recommendation section through the reimbursement structure.

Rationale: Each of the recommendations in the following section have been shown to improve health outcomes and overall wellness which can, in turn, reduce the likelihood that an individual will need emergency and/or other costly medical procedures. Restructuring the payment system such that these services and supports are adequately funded would incent providers to offer services which could, most importantly, improve the health of the OHP population while also lowering the State's health care expenditures.

Action Steps:

a) Ensure that payment structures are in place to sufficiently reimburse providers for appropriately administered mental health and substance abuse screening procedures (see recommendations 8 & 9).
b) Reimburse for wellness, self-help, and peer-delivered services provided for both mental health and chemical dependency treatment (see recommendations 10 & 11).
c) Reimburse provider organizations for medical advocacy services through Medicaid (see recommendation 12).

Services and Supports

Medical Services and Supports

8. Implement consistent mental health and substance abuse screening procedures throughout the OHP using standardized assessment tools that reach people in the health care setting of their choice.

Rationale: Consistent and reliable screening tools for mental health and substance abuse conditions allow providers to identify consumers who may need intervention and make recommendations/referrals for appropriate resources. Outcome measures in

Washington State show that total medical costs declined for the Medicaid population that received a brief intervention known as the Screening, Brief Intervention and Referral to Treatment program (SBIRT) for substance abuse disorders as compared to consumers who received no intervention.[32] Using these assessment tools in a health care setting chosen by the consumer allows providers to reach a larger population and avoid issues of stigma that may arise in traditional mental health care settings.

Action Steps:

a) Develop an educational campaign to increase providers' awareness of available screening tools and appropriate utilization. Through this outreach, providers should be encouraged to incorporate use of standardized assessment tools such as the IMPACT (Improving Mood – Promoting Access to Collaborative Treatment for Late Life Depression) model, SBIRT and PHQ-9 (a nine-item Patient Health Questionnaire) into all health care practice settings.
b) Require screening in all preventive care settings including dental offices and women's health care clinics to increase the likelihood that consumers will be reached.

9. Require providers to regularly use early intervention and screening mechanisms to facilitate identification and prevention of mental health issues in children.

Rationale: Research has demonstrated that early identification and treatment of serious mental illness may prevent or reduce a destructive downward spiral caused by the condition. Early intervention methods have been shown to improve overall health and increase the likelihood that consumers will complete a high school education and enter the workforce.[33] These methods include: early and frequent visiting by a public health nurse; screening for early exposure to violence in Early Start and Head Start programs; and encouraging child care programs to identify and address behavioral health issues appropriately. [34] Emphasis should be placed on providing community-based services because children who are removed from their homes for treatment often relapse when they return to the community. Ideally, treatment should be provided in the child's home environment so that recovery occurs naturally as part of an on-going process.[35]

Action Steps:

a) Require increased EPSDT (Early and Periodic Screening, Diagnosis and Treatment) utilization in primary care settings. Children with behavioral health needs should be referred for further screening and treatment as appropriate in a timely manner.
b) Implement intensive treatment programs, such as the "Wraparound Model"[iii], which facilitate identification and integration of natural supports into the child's

[iii] The Wraparound Model is "a team-based planning process intended to provide individualized, coordinated, family driven care to meet the complex needs of a child involved in several systems of care, who are at risk for placement in an institutional setting and who experience emotional, behavioral or mental health difficulties." For more information see http://www.rtc.pdx.edu/nwi/.

care team.[iv] Wraparound plans can help keep children out of restrictive institutional settings and allow the family to create a life that works for them within their community.

10. Support peer-delivered services such as mentoring programs.

Rationale: Research demonstrates that individuals who lack social and family supports, have experienced trauma, or are exposed to intense stress are more likely to develop mental illness and/or substance abuse problems, often times leading to serious negative consequences.[36, 37] These consequences can manifest themselves as physical health conditions causing the health disparities that currently exist among the population of individuals with serious mental illness and substance abuse disorders.

In order to provide true comprehensive care, the entire context of an individual's circumstances must be addressed. The creation of social supports in a consumer's natural environment can more adequately address "whole person" health as opposed to merely a single aspect of care. Peer mentoring has also been shown to increase the effectiveness of substance abuse treatment programs for consumers facing addiction issues.[38] These mentors support consumers in establishing new behavior patterns and developing a life that allows them to remain sober and in recovery. Working with mentors gives consumers hope that recovery is possible because they see the living proof embodied in a peer who has had similar experiences. This system can help to mitigate the negative consequences that result from a lack of such support, facilitate the recovery process, and improve the overall health of the target population.

Action Steps:

a) Amend the Oregon Administrative Rules to include community integration[v] in the definition of medical necessity for people with behavioral health disorders.
b) Seek federal approval to amend the Oregon State Medicaid Plan to add certified peers as qualified providers for specific services.
c) Support peer-to-peer skill-training programs that assist consumers with serious mental illness and/or substance abuse disorders in developing practical skills such as job searching.
d) Encourage health care organizations to use licensed professionals when necessary, and also encourage the use of non-licensed peers to provide services such as wellness programs and psycho-education activities.
e) Develop training and certification processes for peers to ensure that quality assistance is provided and reimbursable through Medicaid.

[iv] A "care team" is composed of a child's family members, health care providers, and key members of their social support network. This team engages in a collaborative process to build a creative plan that addresses the particular needs of the child and family. The team meets at regular intervals until they determine that the process is no longer necessary.

[v] The UPenn Collaborative on Community Integration defines this concept as "the right to have the opportunity to live, study, work and recreate in the community alongside and in the same manner as people without disabilities." For more information see: http://www.upennrrtc.org/issues/view.php?id=5

11. Support wellness programs which include health education and appropriate self-management programs.

Rationale: Wellness programs provide the tools for consumers to practice self-care and gain control over their health care decisions. These programs may include consumer-specific health education and the development and maintenance of a self-care action plan.[39] The Pathway to Care Model (see Appendix B) identifies patient self-management as a key component of active treatment and recovery. Self-management education teaches consumers problem-solving skills which allow them to attain the best possible quality of life while living with their health condition(s)[40].

Action Steps:

a) Encourage the utilization of collaborative tools such as patient-guided short term action plans for improved wellness.[41]
b) Promote alternative therapies that emphasize "healthy living" principles such as nutrition, exercise, and tobacco cessation. It has been noted within the consumer community that modalities other than those employed in traditional Western medicine are also a vital part of the recovery process that should be integrated into comprehensive wellness programs.

12. Develop a medical advocacy system aimed at improving access to primary and preventive care for individuals with behavioral health problems. Advocates should be trained to understand patient needs, identify services and link consumers to appropriate care.

Rationale: Medical patient advocates are peers that would be available to link people to needed services, assist with filling out forms, arrange transportation and other needed services, as well as protect patient rights. They would not provide medical advice, but instead would advocate on behalf of the consumer to ensure that barriers to access are removed and the consumer is treated with dignity and respect. Access to advocates could also potentially reduce the over-reliance of some patients on health care professionals when what actually may be needed at a given time is a sense of stability and connection.

Action Steps:

a) Place medical patient advocates in mental health care settings to ensure that consumers have access to various health care services (including primary care, oral health, and complementary care).
b) Connect emergency rooms with an on-call mental health patient advocate for intervention at the point of crisis.
c) Develop training and certification processes for advocates to ensure that quality assistance is provided.

Self-Sufficiency Services and Supports

13. Promote supported housing in order to assist consumers with severe mental illness and/or substance abuse issues in obtaining or retaining housing within their community.

Rationale: Studies have shown that access to safe and affordable housing is vital to the recovery process because it increases long-term integration with the community.[42, 43] A consumer with stable housing is less likely to end up homeless or incarcerated and more likely to avoid inpatient and institutional settings.[44] Mental health housing encompasses a range of options with graduated care and services including secure residential treatment facilities and supported housing with integrated mental health services. Consumers with substance abuse disorders can benefit from "clean and sober" living arrangements and/or informal peer-governed recovery housing such as Oxford Homes.[45]

Action Steps:

a) Actively coordinate and collaborate with existing supported housing and public assistance programs to work towards eliminating the barriers to securing appropriate housing faced by consumers.
b) Partner with providers and health plans to identify:
   i) Consumers in recovery who could benefit from supported housing, and
   ii) Sources of available supported housing funds.
c) Develop educational materials using "people first" language to reduce stigma and facilitate seamless integration of supported housing into existing communities. [46]

14. Promote supported employment programs that emphasize a "place and then train model" which teaches needed skills and technical abilities on the job. This model focuses on individualized job development and time-unlimited individual job coaching.

Rationale: Supported employment is a validated evidence-based practice for consumers with serious mental illness.[47] Viable employment can be as vital to the recovery process as housing and health care. Some consumers enter recovery after years of chaos and transition, and the opportunity to be responsible and stable while earning a living is extremely valuable. Several people who testified before the MAC expressed true pride in maintaining and thriving in a job. Work allows consumers in recovery to increase their tenure in the community and share a feeling of civic engagement and contribution. A job also provides a feeling of hope, a reason to get up and stay healthy each morning. Employment is another natural support within the community that helps those in recovery move towards a life that works for them.

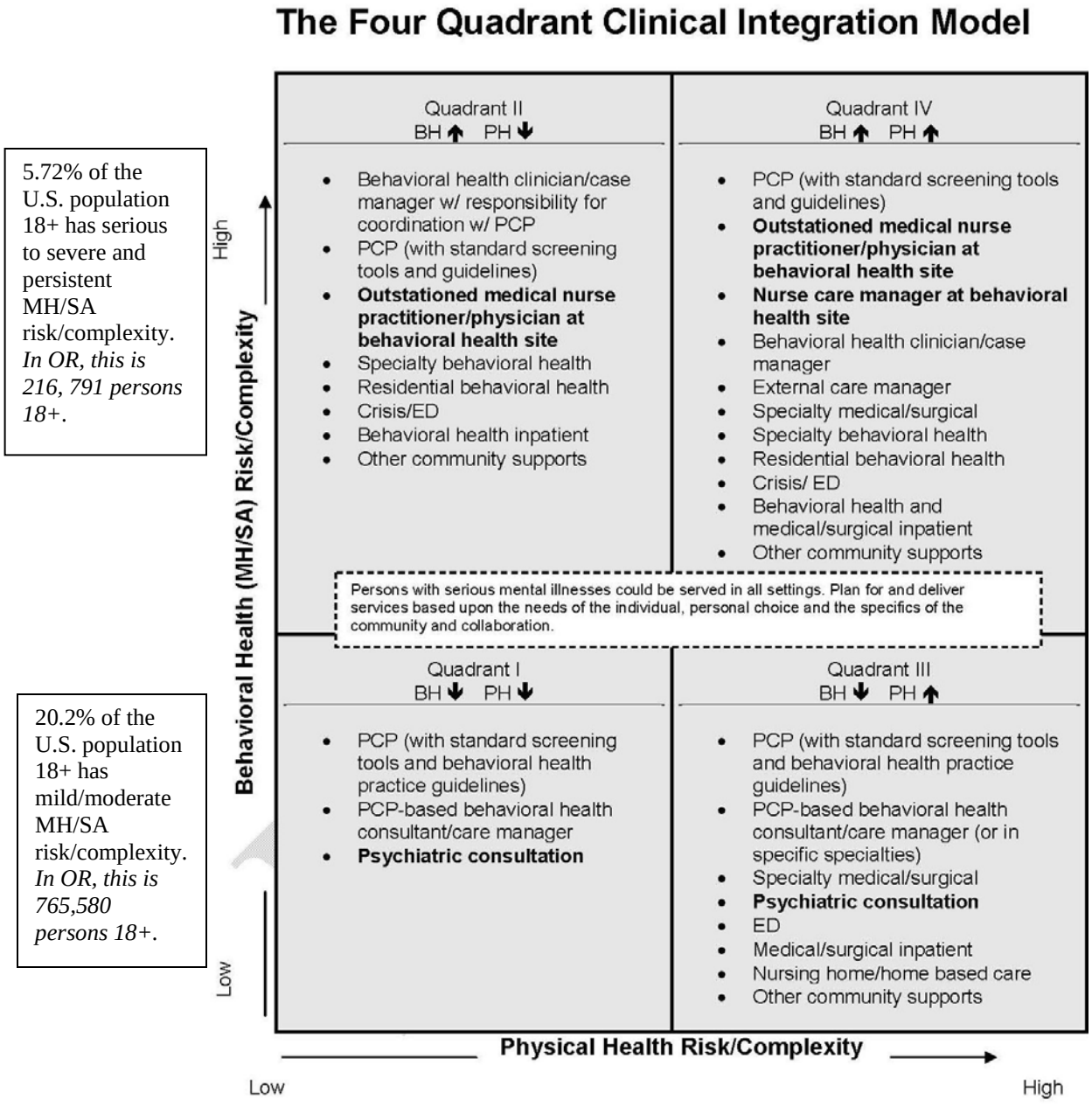
A critical component of supported employment is addressing barriers to employment with both the employee and the employer. This engagement can occur through actively recruiting potential employers who are willing to extend an opportunity for employment to an individual in recovery. In order for the placement to be successful,

communication with and support of the employee and the employer must continue to occur for a length of time after the employee begins work. Rather than a sheltered workshop or enclaves, supported employment programs promote work within existing employment opportunities at the same salary that any employee would obtain.

Action Steps:

a) Actively coordinate and collaborate with existing supported employment and public assistance programs to work towards eliminating the barriers to securing stable employment faced by consumers. This collaboration could be coordinated, for example, through the Oregon Employment Department, the Addictions and Mental Health Division, and/or the Vocational Rehabilitation Division.
b) Remove barriers to maintaining Medicaid coverage after gaining employment. Assist consumers in recovery in securing private health insurance as they transition off of the OHP.
c) Link supported employment programs with funding from state employment transition programs such as the Oregon Food Stamp Employment Transition Program (OFSET) to give consumers in recovery the tools and assistance they need to remain stable while pursuing viable employment. These tools may include food stamps, daycare support and transportation assistance.[48]

Appendix A
Four Quadrant Clinical Integration Model[49, 50]



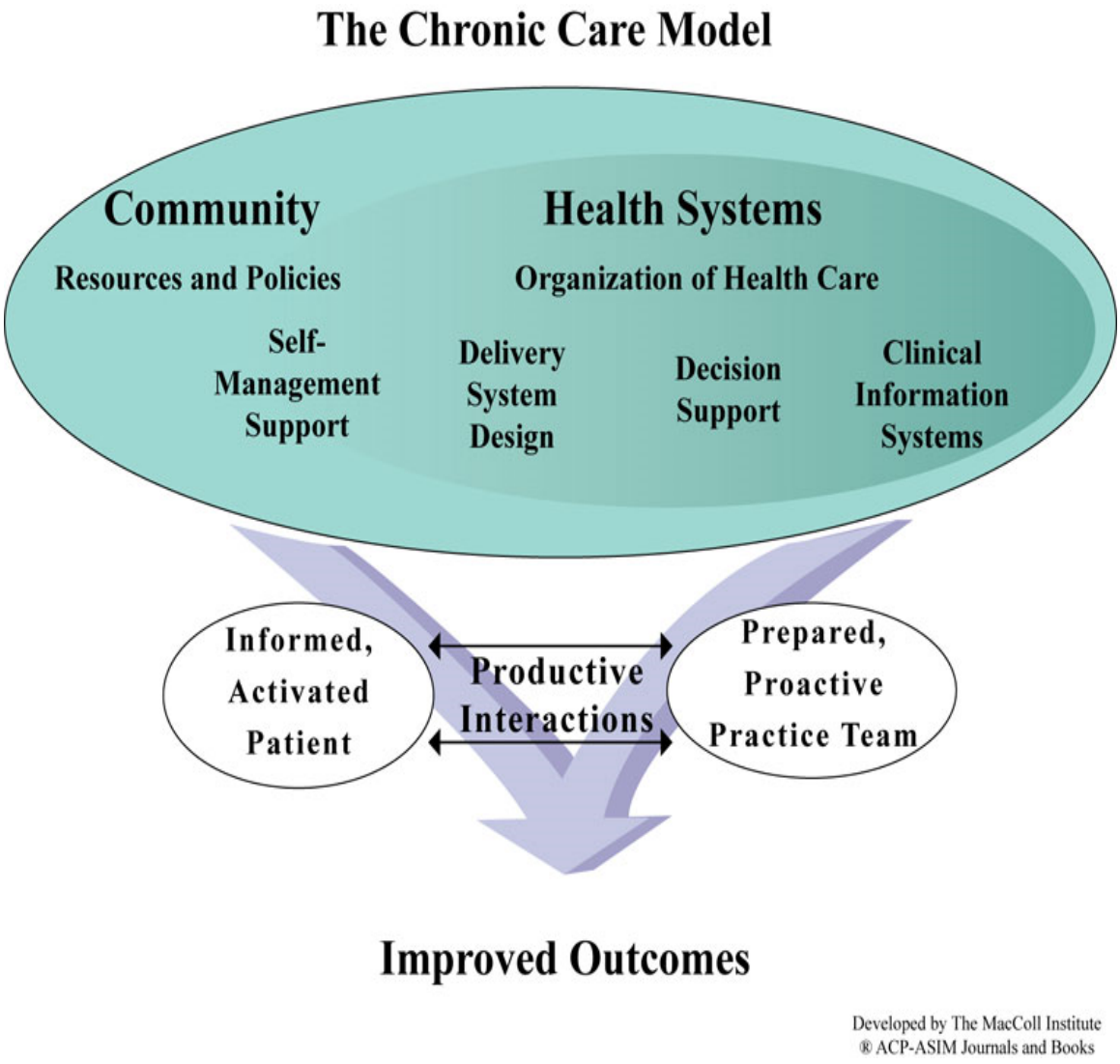
5.72% of the U.S. population 18+ has serious to severe and persistent MH/SA risk/complexity. *In OR, this is 216, 791 persons 18+.*

20.2% of the U.S. population 18+ has mild/moderate MH/SA risk/complexity. *In OR, this is 765,580 persons 18+.*

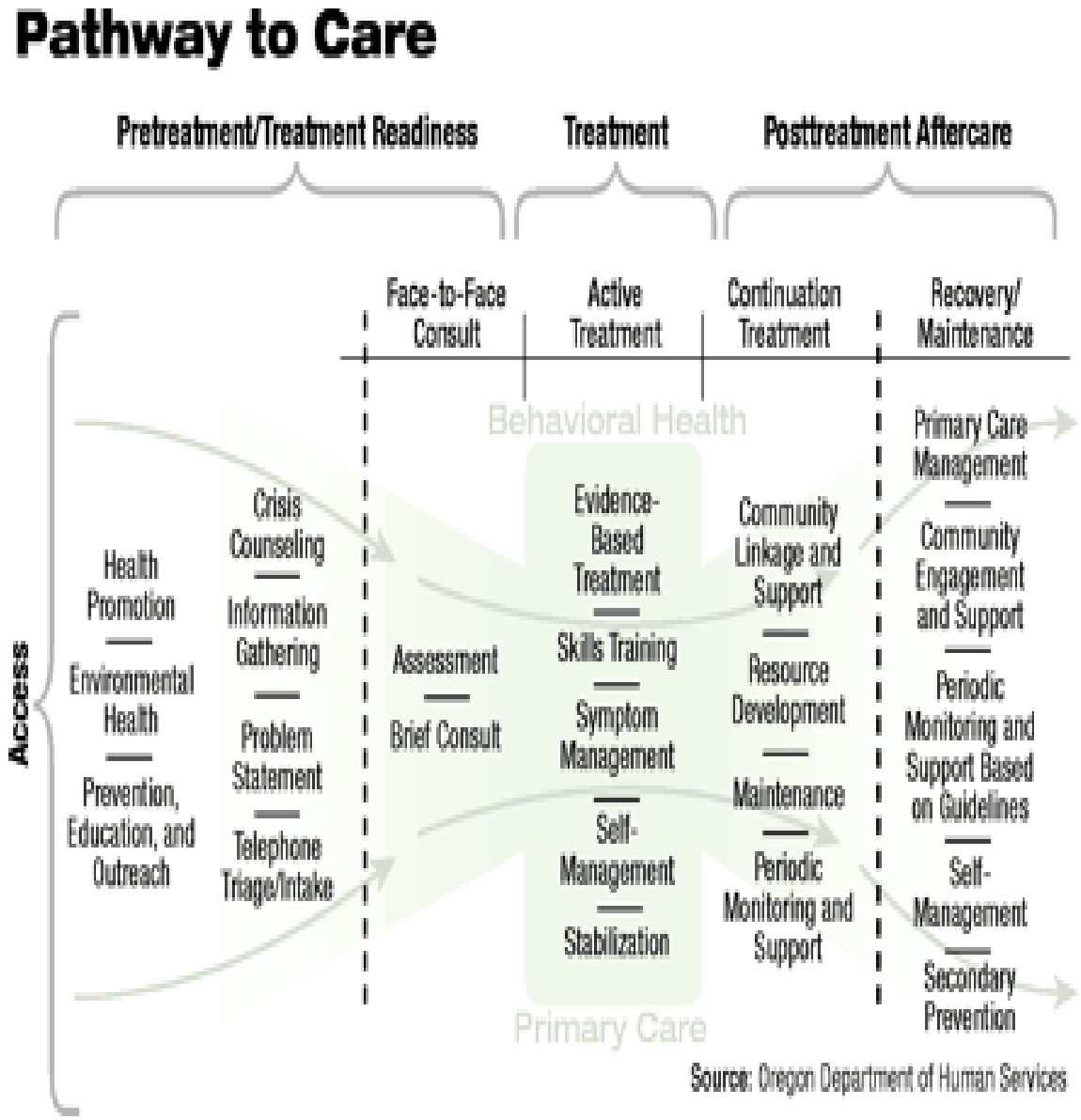
According to the 2007 Oregon Behavioral Risk Factor Surveillance Survey, over 87% (3.3 million) of Oregon's population 18+ reported being in good to excellent health.

According to the 2007 Oregon Behavioral Risk Factor Surveillance Survey, 12.8% (485,128) of Oregon's population 18+ is at risk for fair or poor health.

Appendix B[51]
Chronic Care Model



Appendix C[52]
Pathway to Care Model



Appendix D
Oregon Health Reform Legislation and Integration Efforts:
Comparison of HB 2009 directives and the Medicaid Advisory Committee Recommendations

HB 2009 Directives[53]	**MAC Recommendation Action Steps**
Define core attributes of the PCPCH. § 1163 (1) (a)	**1. b)** Promote integration of behavioral health consultants within primary care organizations and integration of primary care providers such as MDs, NPs, and PAs within behavioral health organizations. **1. c)** Support utilization of "virtual" co-location techniques such as telemedicine to increase efficiency and provide patients with access to a wider array of health care professionals. **1. d)** Require integration of oral health care services in PCPCHs to promote wellness and prevent costly oral health conditions from developing. **2. a)** Require health plans to identify members with serious mental illness and/or other behavioral health problems that are at-risk of having or developing physical health issues. **10. d)** Encourage health care organizations to use licensed professionals when necessary, and also encourage the use of non-licensed peers to provide services such as wellness programs and psycho-education activities.
Establish a simple and uniform process to identify PCPCH that meet the core attributes defined in (1) (a). § 1163 (1) (b)	**1. a)** Create a PCPCH designation based on a nationally-accepted certification process, such as the NCQA guidelines, designed to facilitate communication and collaboration among providers.
Develop uniform quality measures that build from nationally accepted measures and allow for standard measurement of PCPCH performance, and develop uniform quality measures for acute care hospital and ambulatory services that align with the PCPCH measures. § 1163 (1) (c) and (d)	**1. e)** Develop tools to measure the outcomes of integration for consumers of behavioral health services. Specifically focus on indicators that have historically led to elevated morbidity in the behavioral health consumer population. **2. b)** Pursue quality improvement efforts related to health status of individuals identified with severe behavioral health issues. **6. a)** In collaboration with the Oregon Health

	Care Quality Corporation, define a set of measurable health outcomes which providers should aim to achieve.
The office will establish a learning collaborative to share information and best practices and coordinate efforts around PCPCH development. § 1163 (3) (a - g)	**4.** Foster coordination between behavioral and physical health providers and health plans to achieve effective and safe medication management for consumers. **8. a)** Develop an educational campaign to increase providers' awareness of available screening tools and appropriate utilization.
The Oregon Health Authority shall develop, test and evaluate strategies that reward enrollees in publicly funded health plans for receiving care through PCPCHs, seeking preventative and wellness services, practicing health behaviors, and effectively managing chronic disease. § 1165 (1) (a) (A – D)	**1.** Establish PCPCHs which integrate behavioral, physical, and oral health care services and provide incentives for OHP clients to utilize PCPCHs. (see action steps 1a – 1e)
The Oregon Health Authority shall develop, test and evaluate community-based strategies that utilize community health workers to enhance the culturally competent and linguistically appropriate health services provided by PCPCHs in underserved communities. § 1165 (1) (b)	**9. b)** Implement intensive treatment programs, such as the "Wraparound Model", which facilitate identification and integration of natural supports into a child's care team. **10.** Support peer-delivered services such as mentoring programs. (see action steps 10a – 10e)
The Authority shall focus on patients with chronic health conditions in developing strategies in this section. § 1165 (2)	**2.** Encourage providers and health care organizations to utilize the Four Quadrant Clinical Integration Model as a strategic planning tool for provision of care. (see action steps 2a & b)
There is created in the Oregon Health Authority the Statewide Health Improvement Program to support evidence-based community efforts to prevent chronic disease and reduce the utilization of expensive and invasive acute treatment. § 1166 (1)	**10.** Support peer-delivered services such as mentoring programs. (see action steps 10 a – 10e).
Set specific health information technology goals and develop a strategic health information technology plan for this state. § 1171 (1)	**3.** Support development and implementation of electronic integrated information systems to facilitate integration of all aspects of health care including medication monitoring, chronic care management, and treatment

	outcomes.
Create and provide oversight for a public-private purchasing collaborative or alternative mechanism to help small health care practices, primary care providers, rural providers and providers whose practices include a large percentage of medical assistance recipients to obtain affordable rates for high-quality electronic health records hardware, software and technical support for planning, installation, use and maintenance of health information technology. § 1171 (4)	**3. a)** Provide guidance and resources to help practices select appropriate and affordable electronic health record vendors and service companies that meet quality standards.
Determine a fair, appropriate method to reimburse providers for their use of electronic health records to improve patient care, starting with providers whose practices consist of a large percentage of medical assistance recipients. § 1171 (10)	**3. b)** Provide subsidies for the purchase and maintenance of these products (EHR) to primary care, rural, and other providers who may not have the resources to do so on their own. **3. c)** Provide incentives and compensation to providers that utilize integrated information systems to track and improve consumer health outcomes.
Determine whether to establish a health information technology loan program and if so, implement the program. § 1171 (11)	**3. b)** Provide subsidies for the purchase and maintenance of these products (EHR) to primary care, rural, and other providers who may not have the resources to do so on their own. **3. c)** Provide incentives and compensation to providers that utilize integrated information systems to track and improve consumer health outcomes.

Appendix E
Oregon Behavioral Health Integration Efforts:
Comparison of DHS Behavioral Health – Primary Care Integration Core Team Goals and the Medicaid Advisory Committee Recommendations

MAC Recommendation	DHS BH – PC Integration Core Team Goals
1. Establish patient-centered primary care homes (PCPCH) which integrate behavioral, physical and oral health care services and provide incentives for OHP clients to utilize PCPCHs.	• Develop DHS Integration Toolkit with screening tools, coding information and confidentiality information (Complete) • Establish website for integration project. (Complete: http://www.oregon.gov/DHS/hsi/index.shtml) • Continuously update and analyze existing integration projects catalog.
2. Encourage providers and health care organizations to utilize the Four Quadrant Clinical Integration Model (see Appendix A) as a strategic planning tool for provision of care.	• Develop DHS Integration Toolkit with screening tools, coding information and confidentiality information (Complete) • Develop comprehensive DHS plan for integrating OHP, community mental health & addictions and physical health services on a statewide basis.
3. Support development and implementation of electronic integrated information systems to facilitate integration of all aspects of health care including medication monitoring, chronic care management, and treatment outcomes.	• Monitor OCHIN EMR initiative and review other potential options for providers.
4. Foster coordination between behavioral and physical health providers and health plans to achieve effective and safe medication management for consumers.	• Develop comprehensive DHS plan for integrating OHP, community mental health & addictions and physical health services on a statewide basis. • Review needs for integration training on medication and other issues using clinical training subcommittee.
5. Expand coverage under the Oregon Health Plan with the goal of increasing access to physical and behavioral health services for all Oregonians.	• Monitor opportunities for implementation of comprehensive plan for integration.
6. As opposed to the traditional fee-for-service payment system, the reimbursement framework should reward holistic care.	• Recommend potential Medicaid waiver requests and monitor AMH amendments to Integrated Services and Supports OAR • Identify other administrative actions to remove and reduce barriers to integration.

7. Promote the "Services and Supports" outlined in this report through the reimbursement structure.	• Develop comprehensive plan for integrating OHP community mental health & addictions and physical health services on a statewide basis. • Review rate-setting processes and administrative actions to remove and reduce barriers to integration.
8. Implement consistent mental health and substance abuse screening procedures throughout the OHP using standardized assessment tools that reach people in the health care setting of their choice.	• Develop DHS Integration Toolkit with screening tools. (Complete) • Survey degree of integration using informal surveys of programs statewide. • Implement administrative actions to remove and reduce barriers to integration.
9. Require providers to regularly use early intervention and screening mechanisms to facilitate identification and prevention of mental health issues in children.	• Develop DHS Integration Toolkit. (Complete) • Add contractual requirements after negotiation with MHOs and FCHPs for next contract. (CMHPs have already agreed to amendment in intergovernmental agreements.)
10. Support peer-delivered services such as mentoring programs.	• Apply SB 364 from 2007 legislative session to include consumer representation (comprising at least 20% of the membership) on all committees for DHS integration. (Complete/On-going) • Develop proposed contract changes to drive integration for 2009-11 contracts with MCOs. • Identify consumers for participation in AMH wellness initiative.
11. Support wellness programs which include health education and appropriate self-management programs.	• Review opportunities for immediate improvements in financing and practice of integration. • Analyze Performance Improvement Projects to look for trends that result in improved outcomes. • Support AMH Wellness work group and add Oregon State Hospital and Blue Mountain Recovery Center to activities.
12. Develop a medical advocacy system aimed at improving access to primary and preventative care for individuals with behavioral health problems. These advocates should be trained to	• Review and make recommendations regarding children and adolescent services with work group led by the Oregon Pediatric Society and Oregon's chapter of the American Academy of Child and

understand patient needs, identify services, and link consumers to appropriate care.	Adolescent Psychiatry • Develop toolkit to assist primary care and mental health/addiction providers to remove and reduce barriers to integration for children and adolescents. • Work with Wraparound Initiative created by HB 2144.
13. Promote supported housing in order to assist consumers with severe mental illness and/or substance abuse issues in obtaining or retaining housing within their community.	• Develop **comprehensive** plan for integrating OHP, community mental health & addictions and physical health services on a statewide basis.
14. Promote supported employment programs that emphasize a "place and then train model" which teaches needed skills and technical abilities on the job. This model focuses on individualized job development and time-unlimited individual job coaching.	• Develop **comprehensive** plan for integrating OHP, community mental health & addictions and physical health services on a statewide basis.

Appendix F
DHS Addictions Services Presentation to the MAC: February 2009

DHS
Oregon Department of Human Services

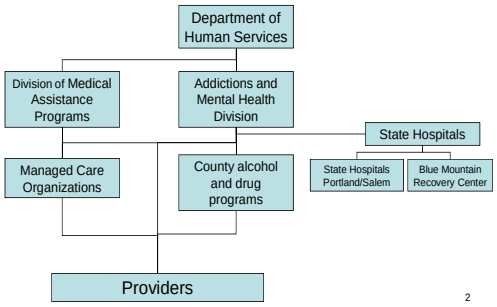
Addictions Services Overview for Medicaid Advisory Committee

Karen Wheeler, Addictions Program Administrator

February 2009

DHS

Oregon's addictions and mental health system



2

DHS

Oregon's Alcohol and Drug Prevalence is 8.3%.

- **8.8%** of children abuse or are dependent on alcohol or other drugs.
- **20.1%** of young adults abuse or are dependent on alcohol or other drugs.
- **6.2%** of adults abuse or are dependent on alcohol or other drugs.

Children 12-17
Young Adults 18-25
Adults over 25

3

DHS

Need for addiction services

Age/ Category	Need for service	People served in public system	% of need met
Addiction			
17 & under	**26,765**	**6,635**	**25%**
Over 17	**235,516**	**56,138**	**24%**
Mental Health			
17 & under	105,306	34,617	33%
Over 17	154,867	71,204	46%
Problem Gambling			
All	76,839	4,743	6%

Fiscal Year 2007 – 2008

4

DHS

Economic Costs of Substance Abuse

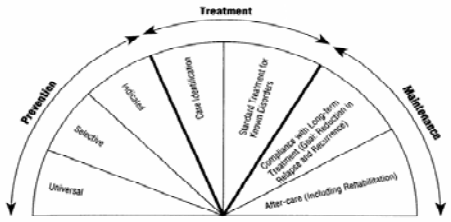
- Untreated substance abuse costs Oregon $5.93 billion each year:
  - $813 million for health care;
  - $4.15 billion in lost earnings; and
  - $967 million for:
    - Law enforcement,
    - Criminal justice, and
    - Social welfare.

Data source: EcoNorthwest

5

DHS

Institute of Medicine
Model for Addiction Services



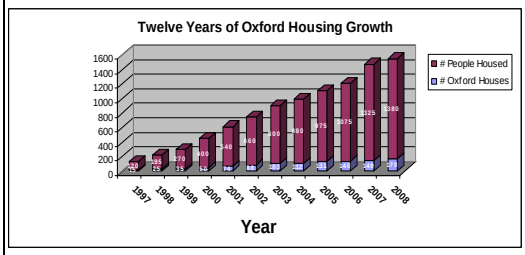
6

Recovery Paradigm

- "Recovery" is a process of healing and transformation for a person to achieve full human potential and personhood in leading a meaningful life in communities of his or her choice.
- Recovery means acknowledging that addictions is a chronic disease that takes lifetime management and support.
- Recovery is the common goal of all addiction services administered by AMH.

7

Oregon Recovery Homes



11

Treating Addiction as a Chronic Condition

- Addiction is best treated via models of sustained medical monitoring and continuing care.
  - Resembles chronic disorders such as type 2 diabetes mellitus, hypertension, and asthma in etiology, course, and clinical outcomes.
- Personal choice and lifestyle decisions affect the outcomes of all chronic disorders.
- Treating addiction via repeated episodes of detoxification, and brief stabilization, is ineffective and contributes to skepticism and pessimism of clients, providers, policymakers and the public.

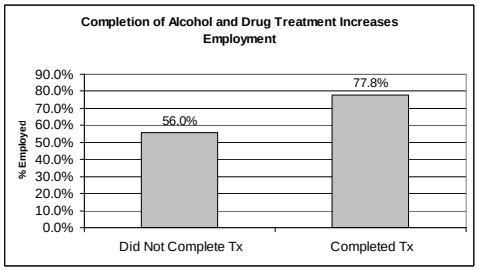
18

Screening, Brief Intervention and Referral to Treatment - SBIRT

- SBIRT is a preventative service under the Oregon Health Plan. The SBIRT codes (99408 and 99409) allow health care professionals to screen, provide brief interventions, and refer to specialty services for Substance User Disorders. These codes are billed to the physical health plans or Department of Medical Assistance Programs (DMAP).

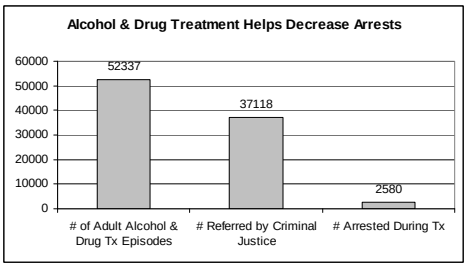
19

Addictions Services Outcomes - Employment



22

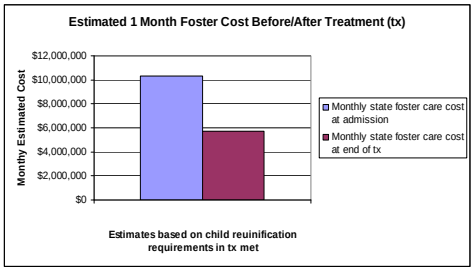
Addictions Services Outcomes - Arrests Reduction



23

DHS

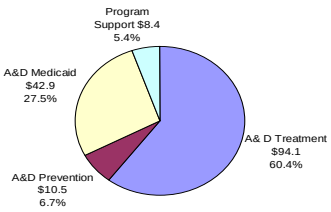
Addictions Services Outcomes Child Welfare



24

DHS

Oregon's Public Addictions Investment



Total Funds - $155.9 M

2007-09 LAB

25

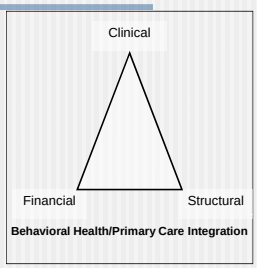
Appendix G
Presentation to the MAC by David Pollack, MD, April 2009

Models for Integrating Behavioral Health & Primary Care

LASACT Conference
August 5, 2008
David A. Pollack, M.D.
Professor for Public Policy
Oregon Health and Science University

What Is Integration?

- Can be any/all elements of care system, but not meaningful without clinical integration
- Requires financial & structural support to be effective



Barriers to Integration

- Medicaid funding crisis
- Severe MH/SA budget cuts
- Fragmentation of care
- Difficulty in matching provider skills and patient needs
- Lack of a coherent process for change
- Financial (revenue/billing) impediments

Why Pursue Linkage/Integration?

- Many pts receive BH care in PC system
- Many pts w/ BH conditions also need quality PC access/services
- Pts in community-based health settings need access to BH specialty services
- Opportunities for QI w/in PC and BH systems

Why Pursue Linkage/Integration?

- BH clinicians can effectively collaborate in care of persons w/ chronic health conditions
- Changes in financing of health and BH service systems/care on the horizon
- Federal initiatives providing TA and funding for linkage/integration
- It's the right thing to do!

Self-Management Support

- Emphasize the patient's central role
- Use effective self-management support strategies
- Organize resources to provide support

Delivery System Design

- Define roles and distribute tasks amongst team members
- Use planned interactions to support evidence-based care
- Provide clinical case management services
- Ensure regular follow-up
- Give care that patients understand and that fits their culture

Decision Support

- Embed evidence-based guidelines into daily clinical practice
- Integrate specialist expertise and primary care
- Use proven provider education methods
- Share guidelines and information with patients

Clinical Information System

- Provide reminders for providers and patients
- Identify relevant patient subpopulations for proactive care
- Facilitate individual patient care planning
- Share information with providers and patients
- Monitor performance of team and system

Health Care Organization

- Visibly support improvement at all levels, starting with senior leaders
- Promote effective improvement strategies aimed at comprehensive system change
- Encourage open and systematic handling of problems
- Provide incentives based on quality of care
- Develop agreements for care coordination

Community Resources/Policies

- Encourage patients to participate in effective programs
- Form partnerships with community organizations to support or develop programs
- Advocate for policies to improve care

Implementation Tasks

- Complete environmental scan
- Determine program's capacity and "filters"
- Establish administrative and clinical leadership "buy-in"
- Decide whether to rent or own BH staff
- Determine staffing pattern and BH tasks
- Define BH specialist skills

Clinical Tasks

- Triage
- Comprehensive assessment
- On-site treatment
- Referral
- Consultation
- Care monitoring & condition management
- **The key is balanced management of these tasks!**

Staffing the Model

- Behavioral health professional (Masters or higher)
- Psychiatric provider (for diagnostic and tx insights, not just for meds)
- Non-BH personnel trained to provide specific support functions

Clinician Characteristics

- Comfortable with primary care pace and treatment culture
- Respectful of cultural differences
- Bi-lingual language skills
- Flexible and adaptable
- Experience working in the public sector

Clinician Skills

- Adept with SPMI and addiction treatment issues
- Able to provide brief, creative, and effective treatment
- Evidence-based treatment experience
- Prevention & patient education skills
- Experience w/ triage, crisis interventions, & commitment process

Skills: continued

- Knowledge of Biopsychosocial and Care Models
- Curious & interested in medication and medical illness, labs etc.
- Computer competent and able to document clinical activities succinctly
- Understands the impact of stigma on client and providers

System Transformation Goals

- Through state and local leadership, create local safety net capacity and incentives to integrate behavioral health and primary care services.
- Provide adequate funding, administrative support and properly aligned risks.

System Transformation Goals

- Create an integrated health system that is accessible, continuous, comprehensive and available to all.
- System is adaptable and coordinated to each individual, setting, and specific community needs.
- System is evaluated and improved through outcome measures.

System Transformation Goals

- Co-locate services in all directions (PC/MH/SA).
- Patients are screened and provided the care they need in the setting of their choice
- Patients are served where they need and want to be served with culturally appropriate care.

Key Strategy I

Establish a cooperative partnership to identify:

- Preferred clinical models
- Dimensions of care (who does what with whom and where)
- Comprehensive screening tools, practice guidelines, & other decision supports
- Financial and administrative barriers

Key Strategy II

- Provide state level guidance and framework to support effective and flexible integration models.
- Guidance areas include: financing models, billing methods, program certification, QA/credentialing, documentation rules/regulations, Federal-State cooperation

Key Strategy III

- Implement regulatory changes to reduce paperwork and other administrative barriers to integration, especially clinical record and enrollment requirements.

Key Strategy IV

- Develop framework for full and partial integration pilots for the safety net system (FQHCs, RHCs, etc.), while working on setting policies that go beyond the safety net

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