Executive Summary

In response to compelling evidence regarding the prevalence, cost, and burden of behavioral health (mental illness and/or substance abuse) conditions in the Finger Lakes region, the Regional Commission on Community Health Improvement convened the behavioral health workgroup. This group brought together expertise from a variety of domains including mental health providers, substance abuse providers, physical health and primary care providers, social services, hospital systems, and county planning agencies. After review of numerous data sources and thoughtful discussion, the workgroup identified two priority issues that represent key barriers to achieving good behavioral health for individuals in the Finger Lakes region: 1.) restricted access to behavioral health services and 2.) a lack of integration between the physical health and behavioral health care systems. In response to these priority areas, the workgroup developed a series of recommendations to help advance the its charge of improving the behavioral health of our community. These recommendation fall broadly into the categories of improving access to behavioral health services through the mitigation of existing barriers, improving the integration of behavioral and physical health, and ongoing measurement and monitoring to track progress and gain actionable feedback.

Introduction

Regional Commission on Community Health Improvement

Over the past several years, regional, state, and federal health care initiatives (e.g., the FLHSA 2020 Performance and Sage Commissions, CMS Care Transition Intervention initiatives, Health Homes (HH), Regional Behavioral Health Organizations (BHO), and Accountable Care Organizations (ACO)) have increasingly highlighted the need for a patient-centered, coordinated, and integrated system of care to best address patients' needs, optimize resources, and improve care. In alignment with these initiatives, the Finger Lakes Health Systems Agency (FLHSA) convened the Regional Commission on Community Health Improvement (RCCHI), a multi-stakeholder group, to develop community goals, recommendations, and measures to address the complex medical, behavioral, developmental and social needs of individuals.

RCCHI included representatives from a variety of fields, including: hospitals and health systems, long-term care and aging services, consumer representatives, school districts, primary care providers, social service providers, institutes of higher education, public health, and the business community. The Commission met 12 times between November 2013 and March 2015 to improve health outcomes by facilitating the integration and coordination of healthcare in the nine-county Finger Lakes region.

The Commission identified unlimited purview as too broad and ambitious to allow for meaningful recommendations. In order to narrow and ultimately define areas of focus, commission members requested additional information for several health care sectors. Existing research and local data informed commission members' selection of three areas of focus – Behavioral Health, Senior Health, and Prevention and Public Health – for development of community-wide goals and corresponding recommendations to achieve them.

Behavioral Health

Behavioral health (BH), which refers collectively to the often interrelated conditions of mental illness and substance use disorders, was selected by the full commission as a key area of focus. The evidence supporting this selection is considerable.

BH conditions are prevalent. National estimates suggest that between 26% and 32% of adults have a behavioral illness, with an estimated 6% having a serious mental illness that interferes with at least one major life activity (Bagalman & Napili, 2013). Locally, the results of a recently completed community needs assessment for a 14 county Finger Lakes region[1] indicated that over 12% of adults experienced poor mental health 14 or more days in the past month relative to about 10% of adults in New York State (Finger Lakes Health Systems Agency, 2014). Additionally, behavioral health conditions appear to be particularly common among Medicaid beneficiaries in

[1]This 14 county region encompasses that traditional 9 counties in the FLHSA's region

the same geography as the rates of diagnosed mental disorders and substance use disorders were found to be 40% and 14% higher than the New York State average, respectively.

The treatment of BH conditions is costly. One study estimated that mental disorders represent the most costly medical condition in the U.S., accounting for almost $150 billion in national spending (Roehrig, Miller, Lake, & Bryant, 2009). Consistent with this evidence, the FLHSA has found BH conditions to be leading causes of both inpatient and emergency department (ED) hospital use (both relatively expensive settings in which to receive), particularly among Medicaid recipients (Finger Lakes Health Systems Agency, 2014). Furthermore, individuals with BH conditions account for a significant portion of repeat hospital use, meaning individuals who are readmitted to an inpatient bed or have multiple ED visits within a given time frame. For example, the community needs assessment showed that among Medicaid recipients, BH disorders are the most frequent diagnoses present at the time of index admission for visits with a subsequent 30-day readmission.

Finally, BH disorders represent a significant burden on the individuals who live with them. National estimates indicate that BH disorders place individuals at increased risk of homelessness, imprisonment, disability, the development of a chronic physical health condition, and premature death (National Alliance on Mental Illness, 2015). Similar data at a regional level is difficult to obtain, but it appears that a substantial portion of premature death in the 14 county Finger Lakes region can be attributed to behavioral illness as suicide was the 5th leading cause of years of potential life lost (Finger Lakes Health Systems Agency, 2014).

In light of data such as these and numerous anecdotes described by commission members about the impacts and challenges of mental illness and substance use disorders, RCCHI moved to form the behavioral health workgroup to more fully explore the current behavioral health care system and ways in which it might be improved to better meet the needs of the Finger Lakes population.

Behavioral Health Workgroup

The BH workgroup was established by the Regional Commission on Community Health Improvement with the following vision:

To improve the behavioral health of adults and adolescents[2] throughout the Finger Lakes Region by supporting the integration of primary care and behavioral health services, prevention, and ensuring access to appropriate, quality behavioral health services so they will be more able to live their lives to the fullest.

[2] The workgroup was initially charged with focusing on the adult population. Yet, conversation and the first-hand experiences of workgroup members highlighted a need to address the BH needs of the region's adolescent and young adult population. Given the similarities in the clinical presentation of adolescents and young adults to those ages 18 and older, the workgroup agreed to include this population in the present work. It should be noted that there was also discussion about a

Of note is that the present workgroup did not include mental disorders due to traumatic brain injuries, dementias, and developmental disorders as they typically are considered to be organic mental disorders which require distinct approaches to treatment. Nevertheless, the workgroup recognizes that these disorders are also in need of future focus and may present with co-occurring behavioral health conditions.

Finally, the term behavioral health is used throughout this report to refer to mental health and/or substance abuse disorders. An individual may be affected by mental illness only, substance abuse only, or may have co-occurring mental illnesses and substance abuse disorders. In fact, estimates from national surveys suggest that about 7.7 million adults have co-occurring disorders, representing about 18% of all adults with any mental illness and about 38% of adults with a substance use disorder (Substance Abuse and Mental Health Services Administration, 2014).

WORKGROUP COMPOSITION AND PROCESS

The Behavioral Health Workgroup brought together planning processes from two distinct spheres of influence: mental hygiene and public health. Additionally, numerous stakeholders from across the region came to the table representing hospital systems, mental health providers, substance abuse providers, community service agencies, social services, and primary care providers.[3]

The workgroup met seven times over the span of eight months with support and planning from the FLHSA staff to discuss and set priorities for the region. The work was grounded in the Triple Aim, a framework for improving health care systems that focuses on improving the health of a population (including reducing disparities), delivering quality care to individuals, and reducing per capita costs (Berwick, Nolan, & Whittington, 2008). Themes from workgroup discussions were analyzed in conjunction with the 2014 mental hygiene plans for each of the counties in the Finger Lakes region,[4] the 19 county western regional planning process for the New York State Office of Mental Health's creation of Regional Centers of Excellence, and the recommendations of the New York State Medicaid Redesign Team BH reform workgroup.[5]

Priority Issues in the Behavioral Health Care System

The work of the BH workgroup resulted in the identification of the following issues as key barriers to achieving good behavioral health for adults and adolescents in the Finger Lakes region.

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need to examine BH issues in younger age groups. However, the workgroup believes that this population likely faces challenges that are sufficiently unique to warrant separate efforts in the future.

[3] Refer to the appendix for a full roster of workgroup participants
[4] These reports are available at: http://www.clmhd.org/contact_local_mental_hygiene_departments/
[5] Final report available at: https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf

According to national estimates, over 60% of adults with a diagnosable BH disorder do not receive treatment via mental health services (Druss et al., 2007). Meanwhile nearly 90% of individuals over the age of 12 with a substance use disorder received no specialty treatment for this condition (Levit et al., 2008). Collectively, these estimates indicate significant unmet needs for individuals with BH disorders. Discussion among workgroup members revealed consensus that similar unmet needs exist in the Finger Lakes. The reasons for these unmet needs are likely complex, however the issue of access consistently arose as an important explanatory factor during workgroup discussion.

Access can be restricted in a variety of ways. Some of these factors are related to the supply and location of available services, while others are related to consumers' demand for and awareness of such services. Conditional on sufficient supply and consumer demand, access may still be restricted by consumers' abilities to afford these services and/or navigate the systems in which they operate. The workgroup identified the following factors as important potential barriers to accessing BH services.

Adequate system capacity

Adequate system capacity refers to both clinical services, meaning those aimed at directly treating a BH disorder that are delivered by a clinician such as a psychiatrist or social worker, and social support services which address non-medical determinants of health that can exacerbate BH conditions and prevent health improvement, including a safe and stable living environment, adequate social support, and sufficient financial security.

Findings from the recently completed community needs assessment revealed a mix of quantitative and qualitative evidence that there is a shortage in the number and types of clinical BH services available in the Finger Lakes region (Finger Lakes Health Systems Agency, 2014). For instance, the report showed that there is less than one BH crisis intervention program, which provides assistance to individuals having a BH emergency who are unable to assist themselves, per 100,000 population in the 14 county evaluation area. What's more, many of the rural counties in the Finger Lakes region had no crisis intervention programs suggesting even greater potential shortages that are masked by region-wide measures. A need to increase clinical service capacity was also identified as a top priority by many of the county Mental Hygiene Directors in their 2014 Local Service Plans. These findings are largely consistent with the views of the BH workgroup

Shortages were also noted with regard to a variety social support services, including transportation to and from BH services, financial supports, social and peer supports, and assistance with navigating the health care system. The most frequently identified shortage area, however, was housing. A lack of stable and supportive housing for individuals with serious mental illness or in recovery from substance abuse may be key factors in explaining a patient's return to acute care settings (i.e. - inpatient hospital; emergency department) or relapse. For example, recent data from the Western Region Behavioral Health Organization indicated that about 15 percent of inpatient mental health or substance abuse admissions in their 18 county region (which includes the Finger Lakes region)

were for individuals who were homeless at the time of admission. On average, the housing status of these individuals was improved by the time of discharge in only about 62 percent of cases (Western Region Behavioral Health Organization, 2014). Discussion among workgroup members led to a consensus that a lack of housing providers is a crucial barrier to achieving good behavioral health.

Another important component of capacity, particularly with regard to clinical services, is the number of qualified professionals available to treat individuals with a BH condition. This appears to be another shortage area in the Finger Lakes region as all of its member counties have rates[6] of psychiatrists, psychologists, and social workers below the New York State average rate (Finger Lakes Health Systems Agency, 2014). Furthermore, much of the region has been identified as a Mental Health Provider Shortage Area (HPSA) by the federal Health Resources and Services Administration, particularly for the Medicaid population. As a result, the workgroup believes that addressing the current workforce will be another important step to improving access to BH services for all Finger Lakes residents.

Social barriers to access

Among individuals who reported unmet mental health needs in a national survey and *did not* receive treatment for their condition, 33% reported that they did not receive care because they believed they could handle the problem without treatment at the time. Twenty-eight percent cited fear of stigma attached with behavioral illness as a key reason for not receiving care (Substance Abuse and Mental Health Services Administration, 2013). A lack of understanding about the physiologic causes and nature of mental illness and substance abuse disorders have contributed to both public stigma, the negative reaction of the general population to people with behavioral illness, and self-stigma, the prejudice that individuals with behavioral illness project on to themselves (Corrigan & Watson, 2002). The workgroup agreed with national findings that both of these factors create restrictions in access to treatment for BH conditions. Individuals may avoid care due to a lack of awareness about the availability of services and their ability to help, or a fear of being judged negatively for having a BH diagnosis by friends, family, colleagues, or others may prevent them from seeking needed care.

A LACK OF INTEGRATION BETWEEN THE PHYSICAL HEALTH AND BEHAVIORAL HEALTH CARE SYSTEMS

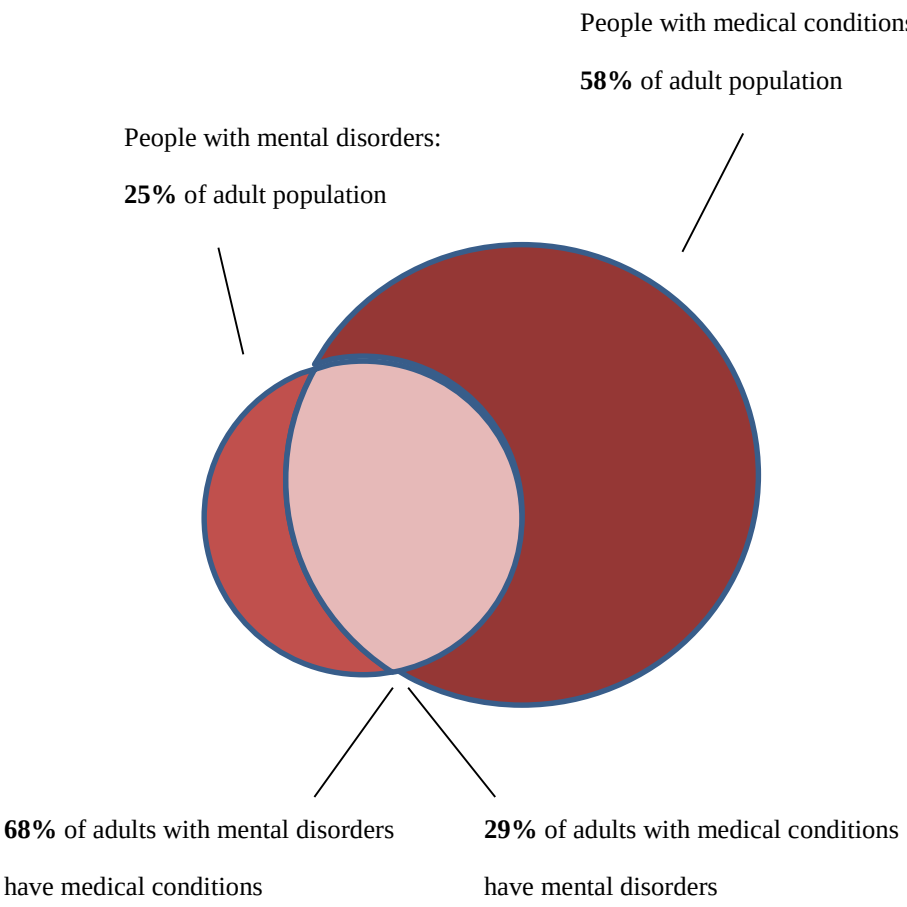
Individuals with serious mental illness are at increased risk for a variety of chronic physical health conditions that contribute to a life expectancy in this population that is on average 25 years shorter than the general population (Parks, Svendsen, Singer, Foti, & Mauer, 2006). Such evidence suggests that those with BH conditions face a complex set of health care needs that span both the physical and mental domains. This complexity appears to be bidirectional. Research has shown that the prevalence of BH conditions rises relative to the general population when the group under consideration is restricted to individuals receiving care in the general medicine outpatient setting and to those being treated in a medical inpatient setting (R. Kathol, Saravay,

[6] Number of licenses per 100,000 population

Lobo, & Ormel, 2006). In other words, BH conditions appear to be more common among people with co-occurring physical health care needs. Additionally, the number of individuals with both physical and mental health issues is sizeable. As Figure 1 demonstrates, it is estimated that 68 percent of adults with a mental illness have a comorbid medical condition and 29 percent of adults with a medical condition have a comorbid mental disorder (Druss & Walker, 2001).

Figure 1.

Percentages of People with Mental Disorders/ and/or Medical Conditions.



Despite the frequency with which physical and behavioral health needs co-occur, it appears that care for both aspects of well-being is often missing, sub-optimal, or delivered in isolation of each other. For instance, work done by the Western Region Behavioral Health Organization found that 77 percent of inpatient mental health or substance abuse admissions (in their 18 county region) had a physical health need identified during the inpatient stay. Only 42 percent of these discharges had an appointment scheduled with an outpatient physical health care provider at the time of discharge (Western Region Behavioral Health Organization, 2014). Analyses related to readmissions to the hospital within 30 days of discharge also provide evidence of potentially suboptimal care for individuals with comorbid conditions. For instance, work done by the FLHSA indicated that adult Medicaid recipients admitted to a medical inpatient bed with a documented comorbid serious mental illness (i.e. –

schizophrenia, episodic mood disorders, and personality disorders) had 22 percent higher odds of being readmitted compared to those without a serious mental illness secondary diagnosis after controlling for a variety of patient and facility characteristics. Furthermore, individuals admitted to an inpatient psychiatric bed in the Finger Lakes regionwith a secondary diagnosis of diabetes or heart disease had a 31 percent and 48 percent increase in the odds of being readmitted, respectively, relative to those without these comorbid conditions (Finger Lakes Health Systems Agency, 2014). Focus groups conducted with Medicaid recipients with a BH condition as part of the community needs assessment previously referenced also revealed considerable frustration with the apparent lack of integration and coordination between the physical and behavioral health systems in the Finger Lakes region. Specifically, consumers pointed to the unwillingness or inability of primary care physicians to address or discuss behavioral health needs, a lack of communication between physical and mental health care providers, and a general lack of understanding of the ways in which one's behavioral and physical illnesses are interrelated (Finger Lakes Health Systems Agency, 2014). Findings such as these highlight why calls for a more integrated and coordinated health care delivery system have received widespread attention, including substantial emphasis in the New York State Delivery System Reform Incentive Payment Program (DSRIP).

The workgroup came to a strong consensus that the need for such a system in the Finger Lakes region is clear. Yet, it recognizes that several barriers to achieving successful integration presently exist. These challenges include:

- Behavioral and physical health providers often operate in systems that are separate from each other with little opportunity for consultation or collaboration. As such care is typically siloed.
- The sharing of information and patient medical records between physical and behavioral health care providers is typically intermittent, unreliable and unpredictable. A framework to facilitate timely two-way communication does not currently exist.
- Confidentiality laws pertaining to the diagnosis of and treatment for substance abuse (federal and state) and mental health conditions (state) are generally more restrictive than those pertaining to physical health. HIPAA is often cited as a barrier to sharing information between primary care and mental health providers, but this is not entirely accurate. Sharing information for the purposes of care coordination is a permitted activity under HIPAA, not requiring formal consents. However, many states, including New York State, have mental health laws and regulations that are more restrictive and impede information sharing. These restrcitions may need to be reassessed.
- Current payment systems often do not directly compensate providers for efforts spent in collaborating with other providers and coordinating care. Furthermore, differences in the billing mechanisms between the physical and mental health systems create additional barriers by requiring greater administrative work and in some cases prohibiting same-day billing by both a physical and mental health care provider (R. G. Kathol, Butler, McAlpine, & Kane, 2010). Consequently, current financing mechanisms may not be aligned with an integrated approach to delivering care.

Despite these challenges, the workgroup believes that the present lack of integration remains a priority area that must be addressed to achieve good health for all community members living with BH conditions now and in the future.

Recommendations

ACCESS

In order to address barriers which prevent individuals with BH needs from accessing quality BH care, the workgroup endorses the following recommendations:

Access Recommendation #1: Expand Medicaid's Health Home care management service model to all populations, regardless of payer.

The workgroup believes that the Health Home model is a good example of what comprehensive quality care should look like for individuals with complex and chronic BH needs. However, this model is currently only available to Medicaid recipients, thereby restricting access for individuals with other forms of health insurance. As a result, the workgroup recommends expansion of this model, coupled with coordinated, targeted outreach for individuals who are not currently utilizing such services but could benefit from them.

Access Recommendation #2: Expand use of telepsychiatry and other forms of distance treatment and support.

The use of technology may help to alleviate shortages in capacity, both in terms of available programs and the number of qualified providers, particularly in some of the region's rural areas.

Access Recommendation #3: Develop and implement a regional social marketing strategy to reduce stigma around behavioral illness and raise awareness of available treatment and support resources.

As discussed previously, the workgroup views social stigma as a major impediment to this region's population accessing needed BH services. Consequently, the workgroup believes public education is needed. Mediums such as traditional and social media may be effective for spreading factual information about mental illness and substance abuse disorders and normalizing perceptions of seeking help for these conditions. Existing organizations, such as the Rochester Ad Council, may be important partners whose expertise should be leveraged when possible.

Access Recommendation #4: Increase the number and geographic availability of health care professional who are able to treat behavioral health conditions.

Looking strictly at the number of licensed providers in the Finger Lakes region suggests that there is a shortage of behavioral health care professionals. These simple rates mask deeper problems related to whether all providers accept all forms of insurance, the competency of general practitioners (like primary care physicians

and nurse practitioners) in addressing low-acuity BH issues, and the cultural competency of the existing workforce. The workgroup believes that while expanding and developing the ideal workforce is a daunting task, efforts in this area will be essential to ensuring access to quality BH care for the Finger Lakes population. Points of particular importance when considering the workforce of the future include:

- *Competency in the use of technology (e.g. telepsychiatry, social media, etc.) to promote access to and adherence to the treatment plan.*
- *Interprofessional collaboration and team care that helps to integrate behavioral health and primary care*
- *Awareness of community-based services and strategies for complex behavioral health populations.*
- *Knowledge of evidence-based practices in the integration of mental health and substance abuse services, and best practices for integrating behavioral services into primary care settings.*
- *Ability to deliver of person-centered care, including cultural and linguistic competence in the care provided to minority and/or non-English speaking populations*
- *Ability to effectively utilize and collaborate with peer recovery coaches and advocates.*

Access Recommendation #5: Develop new and expand existing models of social support to avert crises, maintain stability, and sustain recovery for individual with behavioral illness.

The workgroup believes that effective treatment of BH conditions cannot occur via medical means alone. Rather, adequate and accessible social supports are needed to address the multi-faceted determinants of good behavioral health, including one's living environment, economic conditions, and social support networks. Social programs can provide much needed support in these areas during times of crisis, transition, and recovery. These programs may include peer-run hospital diversion (ROSE house model), SAFE Haven, peer mental health and substance abuse recovery centers, warm lines and drop-in centers, access to peer advocates and recovery coaches, and ACT and ACT-Lite teams.

Access Recommendation #6: Improve access to supportive housing.

The workgroup believes that a lack of safe and stable housing options for individuals with behavioral illness is a major contributor to poor health outcomes and frequent hospital use in this population. The availability and accessibility of supportive housing can be achieved through several avenues, including:

- *Streamline the referral process while expanding the mental health single point of access (SPOA) for housing to include OASAS residential programs and non-behavioral health (community) affordable housing options.*
  - *A centralized point of access will maximize available resources across all types of housing for all individuals with BH conditions in need. Greater flexibility in regulatory and eligibility requirements is essential as the current requirements greatly limit the use of OMH funded*

housing for many populations. In addition, a greater focus on the needs of populations who are often excluded from current housing options, such as for those coming out of jail or prison, those fleeing interpersonal violence, those with special cultural and/or linguistic needs, families with children, and the medically compromised, is needed.

- *Increases in the funding of existing housing options for individuals with BH conditions.*
  - *According to the frontline experience of workgroup members, the acuity and complexity of the population served in residential settings has increased over time while the funding for these settings has largely not kept pace with such changes. In order to ensure that access remains for those currently in safe and stable living arrangements, the financing system and payment levels must be sustainable.*

Access Recommendation #7: Increase the availability of affordable, safe, reliable and timely transportation to BH programs and services.

Workgroup members from both urban and rural counties identified transportation as a key barrier to accessing needed services, particularly those necessary for maintaining recovery and preventing crises, despite important differences in the specific issues between these two geographies. (Transportation options are limited in rural areas and are often time-consuming and inefficient; in the urban center the options are often perceived as complex, dangerous, and/or prohibitively costly). The expansion and improvement of transportation options for individuals with BH needs, in conjunction with education efforts aimed at improving self-efficacy with the use of these resources, will be crucial to improving access in the Finger Lakes region.

INTEGRATION

In an effort to address the lack of integration between the physical and behavioral health care systems and its impacts on the quality of care delivered to Finger Lakes region residents with BH conditions, the workgroup endorses the following recommendations.

Integration recommendation #1*:* Integrate the current physical care and behavioral health care delivery systems.

Given the findings presented in the Priority Areas section of this report, the workgroup believes it is imperative for physical and behavioral health care to become more integrated in this region. While this recommendation is ambitious, incremental improvements may be best achieved through pilot programs implemented at the level of individual practices.

Pilots may focus on integrating mental health and/or addiction treatment into a primary care setting, using the evidence-based IMPACT or SBIRT models for example, integrating primary care into a behavioral health and/or addiction treatment setting, or simply integrating mental health and addiction treatment, using models such as IDDT or DDC/E. (For further details on these potential models, refer to this report's appendix). Additionally,

pilots may benefit from the use of the SAMHSA continuum of coordination scale to determine the appropriate level of integration to pursue (see appendix for details).

It is important to note that the workgroup believes care integration may have important implications for access and available capacity in the BH care system. As physical health providers, such as primary care practices, become better equipped to identify, treat, and monitor lower acuity BH conditions, BH specialists may gain capacity to see more acute patients. Overall, this would result in a more efficient health care system that is better suited to meet the needs of the population.

***Integration recommendation #2**:* Create standards and protocols for the sharing of protected electronic physical health and behavioral health information between physical health, behavioral health, and community service providers.

The efficient and timely communication of information is essential to effective integrated care. Referrals to a variety of treatment providers and community support programs should be done in a timely manner and communication should be provided back to the referrer in a timely way. As discussed in the Priority Areas section, the present system is not well suited to this type of communication. A standardized protocol will be an important first step towards improving the flow of information between physical health, behavioral health, and community service providers. Additionally, the identification of existing barriers to information sharing and advocacy for the mitigation of these barriers is likely needed to achieve an optimal level of information exchange.

Integration recommendation #3: Develop and implement community-wide guidelines regarding the integrated treatment of comorbid behavioral health and physical health conditions to promote consistency across the behavioral health care and primary care settings.

Consistent protocols for the treatment of comorbid BH and physical health conditions that have buy-in from providers in both sectors will help facilitate continuity of care for individuals living with these complex health needs while enhancing provider awareness of the need to collaborate. Guidelines for integrated care might include the use of talk therapy as a behavioral health intervention in addition to medication, recommendations on when an increase in the intensity or specialization of treatment is needed, and guidance on how and where a referral should be made.

Integration recommendation #4: Conduct formal community trainings and in-services for Behavioral Health and Primary Care providers to increase knowledge of the respective systems' cultures and practices, and available resources

Trainings would increase knowledge of the respective systems, including their cultures and practices, as well as train providers how to best use the available resources and treatment protocols to support patients. What's more, the workgroup believes that the community as a whole does not have a sufficient basic understanding of the regulations that exist around Behavioral Health and Substance Abuse treatment (i.e.- Article 28, Department

of Education, Office of Mental Health Article 31, etc.), making it difficult for concerned providers to advocate for changes needed to facilitate better integration between systems. These trainings can serve as a means for educating the workforce on these issues in hopes of facilitating better and more articulate advocacy in the future.

MEASUREMENT AND MONITORING

The Behavioral Health Workgroup recognizes that regular monitoring and evaluation of objective data related to the priority areas of access and integration are needed to track progress and ensure that these recommendations remain relevant. With this in mind, the workgroup endorses a final measurement recommendation.

Measurement recommendation #1: Leverage existing data sources (and explore the creation of new data sources to fill knowledge gaps) to evaluate the current state of behavioral health in the Finger Lakes region. This monitoring should be conducted as a partnership among local government units and agencies with expertise in the areas of behavioral health, such as county Offices of Mental Health, and the health care system as a whole, like the Fnger Lakes Health Systems Agency. Collaboration such as this will ensure that the unique assests and data resources of these organizations will be leveraged to the fullest. Areas of focus should include, but need not be limited to:

- *the prevalence of behavioral health conditions*
  - *CLMHD Behavioral Health Portal – Service Use*

- *access to care and the extent of unmet needs*
  - *ED visits with a behavioral health diagnosis as a percent of total ED visits*

- *the degree of care coordination and integration*
  - *Percentage of Medicaid patients with 7 and 30 day follow up vists with a mental health professional*
  - *Percent of 30 day hospital readmits among those with a BH diagnosis*

- *the prevalence of comorbid physical health conditions among people with BH conditions*
  - *Percentage of admitted BH patients with 1 or more comorbid condition*

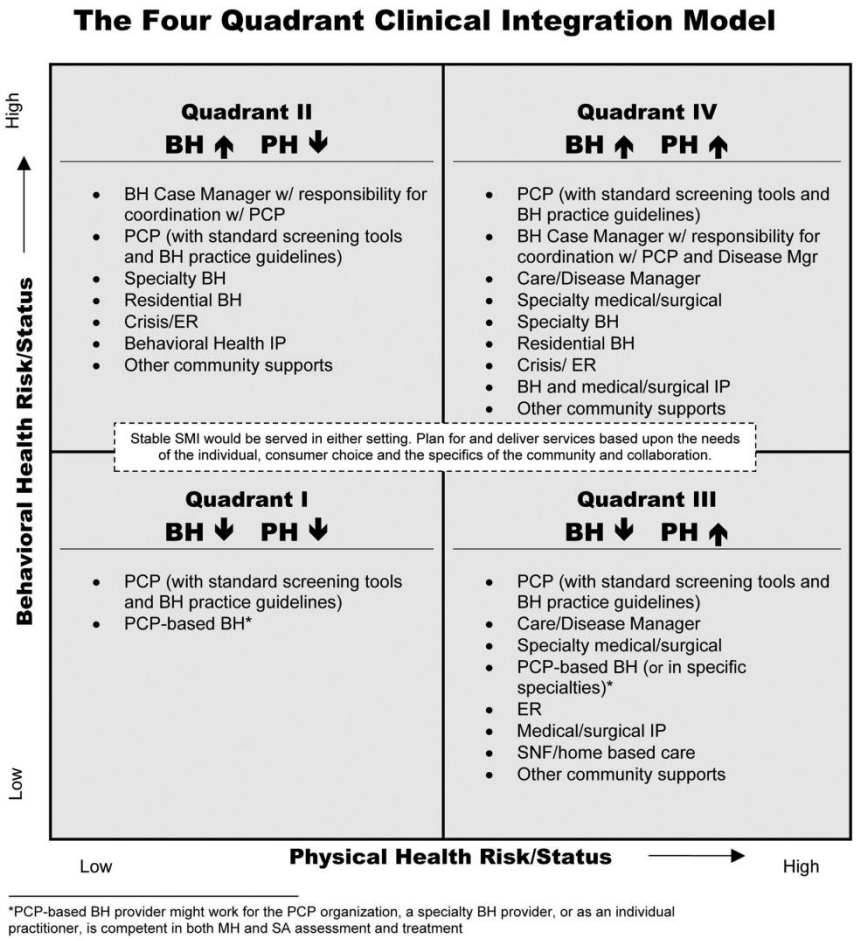
Further investigation into the data sources currently available and the identification of areas where development is needed should occur as part of the creation of the RCCHI blueprint.

Appendix

INTEGRATION RESOURCES

There are some concepts common to all models of integrated care, including the health care team, stepped care, and the four-quadrant clinical integration model. In the health care team, the provider-patient relationship is replaced with a team-based care approach. Applied to integrated care, members of the health care team share responsibility for a patient's care. Stepped care is widely used in integrated care models. This concept holds that, except for acutely ill patients, health care providers should offer care that causes the least disruption in the person's life, and is the least extensive and expensive in order to achieve desired outcomes. If the patient's functioning does not improve through the usual course of care, the intensity of service is "stepped up" according to the patient's needs. The four quadrant model of clinical integration identifies the types of populations served in primary care versus specialty behavioral health care settings. Figure A.1 summarizes the settings where an individual receives care—based on the complexity of his or her physical and behavioral health care needs.

Figure A.1



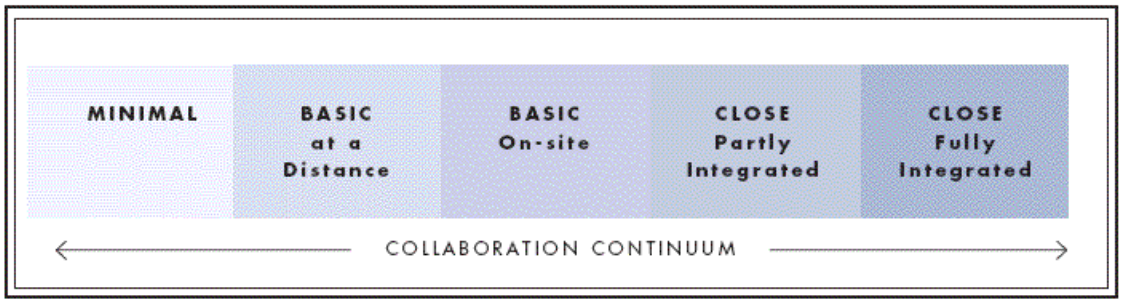
SAMHSA has created five levels are of integration or collaboration that help to describe the degree to which behavioral health and physical health care are integrated. This concept is not based entirely on population characteristics but on the level of collaboration between primary care and behavioral health providers. It is a way for providers to assess how they can and should integrate based on their patient populations. They are as follows:

1. *Minimal collaboration.* Behavioral health and primary care providers work in separate facilities have separate systems and communicate sporadically.
2. *Basic collaboration at a distance.* Primary care and behavioral health providers have separate systems at separate sites, but engage in periodic communication about shared patients. Communication occurs typically by telephone, letter or electronically.
3. *Basic collaboration on-site.* Behavioral health and primary care providers have separate systems but share the same facility. Proximity allows for more communication, but each provider remains in his or her own professional culture.

4. *Close collaboration in a partly integrated system.* Behavioral health professionals and primary care providers share the same facility and have some systems in common, such as scheduling appointments or medical records. Physical proximity allows for regular face-to-face communication among behavioral health and physical health providers. There is a sense of being part of a larger team in which each professional appreciates his or her role in working together to treat a shared patient.
5. *Close collaboration in a fully integrated system.* The behavioral health provider and primary care provider are part of the same team. The patient experiences the mental health treatment as part of his or her regular primary care.

Figure A.2 summarizes the levels as a continuum.

Figure A.2- Levels of Collaboration



Models of Integrated Care

IMPACT (Improving Mood – Providing Access to Collaborative Treatment) is an evidence-based practice for the treatment of depression in a primary care setting from the University of Washington's AIMS Center. This model integrates depression treatment into primary care and other medical settings and has been shown to be more than twice as effective as traditional depression care. IMPACT also improves physical and social functioning and patients' quality of life while reducing overall healthcare costs. The model has been adapted and proves effective in treating depression and other mental disorders in a wide range of patients, including those with diabetes and cancer. Refer to http://impact-uw.org/ for more information.

SBIRT (Screening, Brief Intervention, Referral to Treatment) is an evidence-based model for use in primary care and non-behavioral health settings. This model assists practitioners in identifying and successfully referring individuals with substance abuse disorders to specialized treatments. Further details can be found at http://www.ncbi.nlm.nih.gov/pubmed/18929451.

DDC (Dual Diagnosis Capable) programs have a primary focus on the treatment of substance-related disorders, but also are capable of treating patients who have relatively stable diagnostic or sub-diagnostic co-occurring mental health problems related to an emotional, behavioral, or cognitive disorder.

DDE (Dual Diagnosis Enhanced) programs are designed to treat patients who have more unstable or disabling co-occurring mental disorders in addition to their substance-related disorders. For more information, refer to (http://kenminkoff.com/articles/dualdx2006-2-dualdxcapability.pdf).

IDDT (Integrated Dual Diagnosis Treatment) is an evidence-based practice that improves the quality of life for people with co-occurring severe mental illness and substance use disorders by combining substance abuse services with mental health services. It helps people address both disorders at the same time—in the same service organization by the same team of treatment providers. It is multidisciplinary and combines pharmacological (medication), psychological, educational, and social interventions to address the needs of consumers and their family members. IDDT also promotes consumer and family involvement in service delivery, stable housing as a necessary condition for recovery, and employment as an expectation for many. See (http://www.centerforebp.case.edu/practices/sami/iddt) for more information.

REGIONAL COMMISSION ON COMMUNITY HEALTH IMPROVEMENT
BEHAVIORAL HEALTH WORK GROUP

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