



State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan

**National Association of State Alcohol and Drug Abuse Directors, Inc.¹
September 2011**

Introduction

The national conversation about healthcare reform has placed a great deal of attention on integrating services, improving healthcare transitions, and promoting health homes, particularly to improve the quality of services for vulnerable populations and those suffering from chronic disorders, such as substance abuse (CMS, 2010). Individuals suffering from substance use disorders are often stigmatized in society and often lack access to quality health care. Moreover, substance use disorders add to overall healthcare costs, particularly to Medicaid (NCCBH, 2010). Advocates for healthcare integration believe that integration efforts, such as periodic screenings and brief interventions in primary care and the availability of on-site behavioral health providers in primary care settings are promising practices that can identify and intervene with health issues before they become more burdensome. It is expected that this can ultimately lower healthcare costs. This report identifies and summarizes published and “grey literature” studies about State efforts at the integration of substance use disorder services with primary healthcare. While particular emphasis is placed on integration efforts at the State Substance Abuse Agency (SSA) level, we have also very new reports on program initiatives.

As required by the Substance Abuse Prevention and Treatment (SAPT) Block Grant, SSAs have done considerable planning in the past years on how to integrate services for targeted

¹ Mr. Clifford Bersamira was the primary author of this report. He had significant assistance in writing and research from Ms. Emily Beardsley. Additional support was provided by Ms. Sarah Wurzburg, Ms. Marcia Trick and Ms. Jasmin Carmona. This work was done under the direction of Mr. Henrick Harwood, who also contributed to writing this report. This document would not have been possible without the cooperation from the Single State Authorities (SSAs) for Alcohol and Other Drug Services.

populations, such as intravenous drug users, pregnant women, and women with children. Some States have gone beyond the SAPT Block Grant's requirements and have made integration a State priority through systems and policy changes. Moreover, the Affordable Care Act has provided States an opportunity to consider how they intend to move forward with integration efforts. As of December 2010, nearly all States had given consideration to how to integrate behavioral health with primary care. Moreover, nearly half of all States described that they had no preferred approach to integration while 10 more States specified that they preferred the flexibility of multiple approaches to integration (SAMHSA, 2011). At the programmatic level, integration of substance use disorder and primary care services has been demonstrated in a variety of healthcare settings and in a spectrum of degrees of integration. Among the examples of integration that are discussed in this report are:

- Screening, Brief Intervention, and Referral to Treatment (SBIRT) in primary care settings;
- Substance abuse detoxification as an entry point to treatment and care;
- Medication assisted treatment (MAT) as integration for clients in primary care; and
- Person-centered healthcare homes.

Background

The Affordable Care Act (ACA) has made access to healthcare and the improvement of care delivery systems the center of focus, particularly among primary care and specialty care providers. Within the public system, community health centers that emphasize the coordination of primary and preventative services – also known as “medical homes” will play a critical role in promoting health service transitions and reducing health disparities, particularly among underserved and vulnerable populations of healthcare consumers (CMS, 2010).

While there is published literature that examines mental health and primary healthcare services integration (Butler et al., 2008; NCCBH, 2009; RAND, 2009), to date substance use disorder services and primary healthcare integration has been the subject of lesser focus. This assessment paid particular attention to State-level issues that are relevant to State Substance Abuse Agency Directors (SSAs) as they plan and implement the components of the ACA and as they consider how to provide quality services to clients.

One of the major components of ACA is the improvement of care transitions from one healthcare provider or setting to another. Medication errors, poor communication, and poor coordination among providers in various healthcare settings can lead to negative outcomes. However, individuals with chronic medical conditions, such as substance use disorder and mental health conditions are more likely to bare the negative effects of an uncoordinated system (Healthcare.gov, 2011). The ACA includes a provision to provide person-centered systems of care that improve outcomes for clients, otherwise known as medical homes. Medical homes serve as a locus for coordinating primary and specialty care, such as substance use disorder services. According to the Centers for Medicare and Medicaid Services (CMS), three goals are simultaneously pursued through medical homes: the improvement of the experience of care; the improvement of population health; and the reduction of per capita health costs (CMS, 2010).

It should be understood that some degree of integration already takes place in at least a minority of SUD providers. The 2009 National Survey of Substance Abuse Treatment Services (N-SSATS; a census of facilities that provide SUD care in the US) provides data on how certain high risk diseases are already being screened – and how ancillary health education is being offered – in substance use disorder treatment facilities in the United States. For example, 21.5% of treatment facilities offer Hepatitis B testing, 22.6% offer Hepatitis C testing, 28.5% offer HIV

testing, 19.9% test for sexually transmitted diseases, and 34.5% screen for Tuberculosis. In addition, 25.5% of treatment facilities provide HIV intervention, 55.8% provide HIV/AIDS education, and 50.8% provide ancillary health education. Moreover, 77.5% of treatment facilities provide case management, which plays a crucial role in coordinating substance abuse treatment services with other healthcare and social services (SAMHSA, 2009).

Methodology

The information reviewed in this document was gathered through a scan of academic and gray literature. We have particularly made an effort to identify “grey literature” documents, presentations and information available on Federal, State, academic, and nonprofit organization websites. Information from State SAPT Block Grant Applications (which are public documents) was made available to NASADAD by its members, the SSAs. The information and literature referenced in this report are very current and generally reflect services and initiatives that have yet to receive or are only now getting rigorous evaluations.

Selected Integration Efforts at the State Level

Insight can be gained into State requirements, initiatives, and future plans towards integrating care from the FY 2011 SAPT Block Grant Application and FY 2011 Block Grant Addendum for Health Care Reform, two documents that have been recently completed by State agencies that provide a great deal of information that is not otherwise generally available.

The FY 2011 SAPT Block Grant Application includes planning requirements for States in several components related to substance abuse, mental health, and primary care integration, including planning in domains such as: providing specialized services for pregnant women and women with dependent children (Goal #3); services to intravenous drug abusers (Goal #4); tuberculosis services (Goal #5); HIV services (Goal #6); establishing a process for client referral

to appropriate services (Goal #10); and coordinating substance abuse services with other appropriate services (Goal #11). The required planning goals of the SAPT Block Grant are an opportunity for States to consider policies for implementing the overall coordination and referral to primary health services as well as the screening, treatment, and early intervention for diseases such as HIV, TB, and other communicable diseases. Moreover, the referral of pregnant women and women with children to prenatal services and other health and social services might serve as a possible model for continued service integration.

NASADAD examined State plans for the implementation of these SAPT Block Grant mandated services and found that a handful of States went above and beyond in their integration of substance abuse services with primary healthcare and could serve as examples of promising practices of integration, particularly at the State systems level. The following descriptions of State initiatives serve as examples of State efforts towards systems integration. This is not intended to be an exhaustive listing of State efforts that were described in FY 2011 SAPT Block Grant Applications.

Maryland

One of Maryland's State Priorities in the FY 2011 SAPT Block Grant is the "Integration of Behavioral Health and Medical/Somatic Care." This includes integration efforts through SBIRT, office-based buprenorphine treatment, and improving the quality of services for co-occurring disorders (COD). In addition, the SSA collaborates with the State Infectious Disease and Environmental Health Administration in the training and implementation of HIV rapid testing procedures and in education on the following topics: HIV 101-Prevention Basics; HIV and Substance Abuse; the Graying of HIV; HIV, Hepatitis, and TB; and the Daily Challenges of Living with HIV (Maryland DHMH, 2010).

New Jersey

In New Jersey, clients entering substance abuse treatment are screened for HIV. Those who test positive are provided initial evaluations, including a physical examination, chest x-ray, TB test, CD4 count, pneumococcal vaccine, Hepatitis screening, viral load testing, and influenza vaccine. Women testing positive for HIV receive an Obstetrics and Gynecology (Ob/Gyn) examination, including a PAP smear and pregnancy test. The SSA partnered with three Federally Qualified Health Centers (FQHCs) to provide screening, brief intervention, brief treatment and referral to specialty care (SBIRT). In addition, recent efforts have been made to train staff at additional FQHC facilities and to promote SBIRT within select hospital emergency departments (New Jersey DHS, 2010).

New Mexico

All adults receiving substance abuse treatment services in New Mexico also receive TB, HIV, and Hepatitis C education through prevention media, including audio-visual productions and written pamphlets. Further, clients are accompanied to public health facilities, primary care providers, and other infectious disease experts for testing, follow-up appointments, and other medical interventions, when deemed necessary. In the spring of 2010, one of the State's initiatives was to promote SBIRT for alcohol. Moreover, the women's clinical treatment model emphasizes the integration of substance use disorder services with primary care (New Mexico HSD, 2010).

Vermont

One of Vermont's State priorities is the collaboration between primary care, behavioral health, and community-based prevention on chronic care strategies through a public health model. The SSA has been working on collaborations and relationships with local FQHCs.

Treatment providers who receive State grants are required to provide counseling, education, testing, and referral services for HIV and TB. While working with women and children, the State uses a care coordination/team approach. Further, all treatment providers have established capacities to work with pregnant women and women with children (Vermont DOH, 2010).

Wisconsin

Wisconsin has made efforts to create and strengthen linkages among public health agencies, AIDS service organizations, human service boards, treatment programs, and social service agencies. One of Wisconsin's State priorities is the integration of substance use disorder and mental health services in primary health care. In 2008, a Joint Statement was made by the SSA and the Department of Health Services to promote the integration of substance use, addiction, mental health, and primary health services. The Statement was distributed to public and private organizations across the State to set action planning steps towards integration (Wisconsin DHS, 2010).

FY 2011 Block Grant Addendum for Health Care Reform

In 2010, the Substance Abuse and Mental Health Services Administration (SAMHSA) requested that States complete an addendum to the FY 2011 Block Grant Applications to provide a description of their healthcare reform efforts (SAMHSA, 2011). The Addendum requested information pertaining to the integration of addiction and mental illness services into primary care; whether Medicaid agencies are taking planning efforts to promote integration; and whether States have preferred models for integration (see Appendix for Addendum Questions). The Block Grant Addendum was completed by all 50 States, the District of Columbia, and five Territories and Pacific Jurisdictions, which will be uniformly described below as States. Based on an analysis of all Addendum responses (SAMHSA, 2011), 54 of the 56 States indicated that

they were carrying out activities to integrate substance use disorder and mental health services with primary care.

Specifically, States were asked to provide information about whether they were taking on planning activities, such as convening workgroups and holding discussions with stakeholders:

- Twenty-two States indicated that they are making plans to integrate substance use disorder and mental health services.
- Twenty-three States indicated that they are currently undertaking planning activities to integrate behavioral health and primary care.
- Twenty-eight States indicated that they are using planning activities to promote the conversation between primary care and specialty care providers and include Medicaid officials in the planning and implementation of integrated care.

In addition, States provided examples of how policies were being revised and agency collaboration was being promoted in order to further integration efforts:

- Twenty-nine States specified that they were using practice reform activities to integrate substance use disorder and mental health services with primary care
- Sixteen States indicated that changes were being made to the Medicaid benefit to encourage care integration.
- Fifteen States were using practice reform activities to encourage conversations between primary care and specialty care providers.
- Thirty-five States indicated that interagency agreements had been established that were promoting partnerships among practices as well as co-located services.
- Twenty-one States had made formal partnerships between system providers and primary care providers.

States were asked to share which integration models they were implementing through grants and pilots. Twenty States specified SBIRT, 17 States specified Medical Home programs, eight States specified Co-Occurring State Incentive Grants (COSIG), and seven States specified managed care programs. When States were asked to indicate if they had preferred approaches to primary care and behavioral health integration, 23 States indicated no preferred integration approach and 10 additional States indicated they preferred the flexibility of multiple approaches.

Program Integration Case Studies

The literature on person-centered chronic care and behavioral health and primary healthcare integration is expansive (Collins et al., 2010; NCCBH, 2009; NCCBH, 2010; Wagner et al., 2001). Conceptual frameworks for integration vary, and includes models such as Alexander Blount's (2003) graded categories of *coordinated*, *co-located*, and *integrated* services to the National Council's Four Quadrant Model, which is categorically contingent upon substance use disorder and primary health risks and complexity (NCCBH, 2010).

The programs presented below are examples of integrated substance use disorder services with primary health care programs from a variety of States and populations. These programs were discovered through a review of presentations and gray literature on substance use disorder and primary healthcare integration. Whenever possible, the source of funding and billing mechanisms for these programs is discussed. However, this information was not available for all programs.

Apalachee Center, Florida

The Apalachee Center of Northern Florida is a private, non-profit behavioral health organization founded in 1948. The Center was primarily begun as a mental health and crisis stabilization care center, the organization now partners with many community entities to provide

substance use disorder, mental health, and legal services to its clients. The organization has a primary care center that provides medical detoxification and serves as an entry-point for further substance use disorder and mental health care as well as other specialty care services. Services offered with detoxification include psychiatric services, drug screening, social services, 12-step support groups, and aftercare planning.

Through a partnership with Leon County Health Clinics, Apalachee Center places behavioral health professionals in two free health clinics. Similarly, Apalachee Center has partnered with DISC Village, the largest local substance abuse treatment provider to have substance abuse treatment professionals at rural Apalachee center offices. While professionals communicate and coordinate at these locations, services are still within separate systems. Services offered at Apalachee Center locations, which span eight counties in Northern Florida, include crisis stabilization, inpatient psychiatric treatment, outpatient psychiatric and substance abuse treatment services, case management, supportive housing, and crisis support for children in families (Apalachee Center, Inc., 2011).

Beth Israel Medical Center, New York

The Methadone Maintenance Treatment Program (MMTP) at Beth Israel Medical Center began operating 40 years ago in order to support continuity and follow-up for medication assisted treatment. MMTP became an integrated part of the Beth Israel Medical Center and now operates 18 methadone clinics in Brooklyn and Manhattan. As a complete medical home, Beth Israel Medical Center offers substance abuse and mental health services, as well as a full spectrum of primary healthcare services. The MMTP provides health maintenance, disease prevention, and illness management services through Beth Israel's physicians and physician

assistants. All services are offered as part of a uniform system so information about patients can be shared and coordinated among providers (Continuum Health Partners, 2008).

Early Start – Kaiser Permanente, California

Early Start is a program through Kaiser Permanente of Northern California for pregnant women. The program uses screening and early intervention to reduce negative birth outcomes that result from substance abuse and drinking during pregnancy. The program also looks to reduce cost burden associated with these outcomes. The program operates as an access point for pregnant women who are “at risk” or in further need of substance abuse services during pregnancy. Early Start places a behavioral health professional in an Obstetrics and Gynecology (Ob/Gyn) office and provides a universal screening of all women. Early Start provides assessments, education, counseling, case management, motivational interviewing, and referral to further services. When at-risk women are identified, they work with the behavioral health provider to establish further assessments and follow-up appointments that coincide with Ob/Gyn appointments (Taillac, 2010).

La Clinica de la Raza, California

La Clinica de la Raza is a non-profit federally qualified health center (FQHC) based in Sacramento, CA. It began as a free clinic in 1971 in response to a community need for healthcare services. Today, La Clinica is the largest community healthcare center in the San Francisco Bay Area. La Clinica offers primary healthcare, dental and optical services, mental health services, alcohol and other drug (AOD) screenings and referral, and health education and prevention.

At La Clinica, a behavioral health specialist is housed within the primary care intake area and is part of the primary care team. The specialist issues an AOD screen at intake and refers the client to further treatment if necessary. La Clinica offers a full spectrum of primary healthcare

services and is funded in part by grants and MediCal (Medicaid). Behavioral health services provided include AOD screening, crisis stabilization, adult and child mental health services, and education and support groups for grief, trauma, anxiety and depression (La Clinica de La Raza, 2011).

Native American Rehabilitation Association, Inc. of the Northwest, Oregon

The Native American Rehabilitation Association (NARA), Inc. of the Northwest, located in Portland, Oregon, started in 1970 as an outpatient substance abuse treatment center. Today, NARA's mission is to provide culturally appropriate education, physical health, mental health, and substance abuse treatment to American Indians, Alaskan Natives, and other vulnerable populations. This program is another example of Blount's integrated category. NARA's physicians, nurse practitioners, substance abuse counselors and licensed clinical social workers coordinate care within the association. NARA offers residential family treatment, outpatient treatment, family resource programs, women-specific transitional housing, and primary care ranging from women-specific services to family medicine, HIV and diabetes care, and programs for infants and elders (NARANA Northwest, 2010).

Penobscot Community Health Care, Maine

Penobscot Community Health Care (PBHC) in Maine was incorporated in 1997 as a non-profit community health center. The majority (70%) of PBHC's clients include uninsured, low-income, or MaineCare (Medicaid) and Medicare populations. PBHC operates as a medical home, serving as a "one-stop shop" for a full continuum of substance use disorder, mental health, and primary care services. PBHC's staff, including a medical director, psychiatric nurse practitioner, director of addiction services, and director of homeless and primary care services, is structured within the same management team, making coordination of care and the use of electronic health

records fully available. PBHC offers addiction services, mental health and psychiatric services, and primary care services. More specifically, PBHC includes MAT with Suboxone, dental care, a pharmacy, disease management, chronic disease coaching, and services for the homeless (Penobscot Community Health Care, 2010).

Pretera Center, West Virginia

Pretera Center was created in 1967 as a regional mental health center and now serves nine counties in West Virginia. Pretera Center is funded through a blend of federal, State, and local tax funds, grants, contracts, Medicaid and Medicare, and some private pay. Addictions services at Pretera include outpatient services, specialized treatment for women, residential treatment, DUI safety education, and medically monitored detoxification services. During detox, clients are assessed for the appropriate level of addictions treatment, and referred and placed in continuing care. Pretera also offers residential mental health services, services for the homeless, and primary healthcare to all adult clients with a severe mental illness through a co-located primary healthcare provider, Valley Health. Services offered include healthcare screenings and referral to community healthcare providers when necessary (Pretera Center, n.d.).

SBIRT Colorado

SBIRT Colorado is an initiative funded by a five-year SAMHSA grant and its objective is to incorporate the process of screening, brief intervention and referral to treatment into primary care through the training and co-location of clinical staff and the standardization of screening throughout the State. Colorado SBIRT operates in 22 facilities, including rural and urban FQHCs, hospitals, and clinics, including HIV clinics and private physicians. The SBIRT Colorado initiative promoted interagency collaboration as its organizers partnered with many

stakeholders in the State, including the Colorado Department of Public Health and Environment (Improving Health Colorado, n.d.).

Tarzana Treatment Centers, California

Tarzana Treatment Centers (TTC) is located in Los Angeles County, CA. TTC offers primary care with substance use disorder, mental health, and HIV/AIDS treatment at a number of treatment sites, two community health centers, and three specialty HIV clinics. TTC also co-locates caseworkers in four San Fernando Valley hospital emergency departments. TTC provides inpatient psychiatric treatment, residential and outpatient substance use disorder treatment, mental health and co-occurring disorder treatment, sober living and transitional housing, MAT with methadone, buprenorphine, and Vivitrol, and psychiatric early intervention and stabilization services. These services are infused with TTC's primary health care services (Tarzana Treatment Centers, Inc., 2009).

VIP Community Services, New York

VIP Community Services (VIP) in the Bronx, New York provides an example of primary care integration through medication-assisted treatment (MAT). The program began as a church-based recovery support service for individuals with substance use disorders and then became a State-licensed substance abuse treatment program. In the early 1990s, the program began addressing and treating co-occurring substance use and mental health disorders, HIV/AIDS, Hepatitis C, and other health issues. Along with offering ambulatory and residential treatment, VIP provides medically-supervised methadone treatment. VIP is currently the only non-hospital based provider of its kind in the Bronx area and is staffed by physicians, physician assistants and other healthcare professionals who work collaboratively with substance use disorder

professionals. VIP utilizes a common database for all healthcare providers (VIP Community Services, 2009).

Conclusion

As the nation moves forward with health care reform and specialty services such as substance use disorder and mental health services progress in integration with primary health care, a greater understanding of current integration practices and State and local systems reform towards integration must be obtained. It appears that nearly all States are carrying out activities to integrate substance use disorder, mental health, and primary healthcare services based on information reported by States in the FY 2011 SAPT Block Grant Applications and Block Grant Addenda on Health Care Reform. In addition, State Substance Abuse Agencies (SSAs) have done considerable planning over the years on how to integrate services for targeted populations-- particularly intravenous drug users, pregnant women, and women with children. A handful of States have gone well beyond the requirements of the federal SAPT Block Grant and have made the integration of substance use disorder services, mental health care, and primary health care a State priority through broader systems and policy changes.

In December 2010, California's Forum on Integration was convened by the Integrated Substance Abuse Programs at the University of California, Los Angeles (Ober et al., 2010). The forum brought together State policy makers, program administrators, provider group representatives, and researchers. They discussed the experience with integration in the substance abuse field and concluded:

- One size does not fit all;
- Think big, start small, use data;
- Workforce and training issues loom large; and

- Barriers to substance use disorder/primary care integration exist but can be overcome.

Among the barriers that were discussed at the California Forum on Integration, the barriers that were more frequently mentioned by stakeholders included resistance – real or perceived – by primary care providers to integrate substance use disorder services, financial barriers from MediCal (Medicaid) billing restrictions, and limits to client file sharing due to privacy restrictions (Ober et al, 2010).

At the programmatic level, integration of substance use disorder and primary care services can take place through various models and in an array of healthcare settings. However, it is important to consider the factors that have made some programs more successful than others in their efforts to provide integrated care. What financial mechanisms permit for effective integration? What organizational and workforce-related issues should be addressed? Additionally, what transitional process works best in advancing a program towards integration? Substance use disorder service State agencies and providers should be attentive for funding opportunities that are likely to be made available to them in the future. These funding opportunities would offer the ability for providers to partner with local mental health service programs and community health centers to strengthen further integrative practices.

Moving forward, consideration should be made to the training, technical assistance, and funding needs of substance use disorder service and primary care providers as well as local and State-level agencies. Moreover, the collection and analysis of performance and outcomes data pertaining to integrated services and the coordinated efforts of health systems is more important now than ever before in order to ensure the promotion of person-centered quality care.

References

- Apalachee Center, Inc. (2011). *Apalachee Center Services*. Retrieved from <http://www.apalacheecenter.org/GeneralServices.htm>
- Blount, A. (2003). Integrated Primary Care: Organizing the Evidence. *Families, Systems, & Health*. 21(2):121-33. doi: 10.1037/1091-7527.21.2.121. Available at <http://dx.doi.org/doi:10.1037/1091-7527.21.2.121>
- Butler, M., R.L. Kane, D. McAlpine, R.G. Kathol, S.S. Fu, H. Hagedorn, T.J. Wilt. (2008 October). Integration of Mental Health/Substance Abuse and Primary Care No. 173 (Prepared by the Minnesota Evidence-based Practice Center under Contract No. 290-02-0009). AHRQ Publication No. 09-E003. Rockville, MD. Agency for Healthcare Research and Quality.
- Collins, C., D.L. Hewson, R. Munger, and T. Wade. (2010). *Evolving models of behavioral health integration and primary care*. New York, NY: Milbank Memorial Fund. Retrieved from <http://www.integratedprimarycare.com/Milbank%20Integrated%20Care%20Report.pdf>
- Continuum Health Partners. (2008). *Beth Israel methadone maintenance treatment program*. Retrieved from http://www.wehealny.org/services/bi_mmt/index.html
- Gleghorn, A. (2010 December). *Office-based opiate treatment (OBOT) and mobile methadone treatment in California*. [PowerPoint Presentation]. Retrieved from http://www.uclaisap.org/slides/cossr-encal/california-forum-on-integration/12_CFI_MAT_GLEGHORN.pdf
- Healthcare.gov. (2011, April 12). *Improving care transitions: background on care transitions*. http://www.healthcare.gov/center/programs/partnership/safer/transitions_.html#_Background_on_Care
- Improving Health Colorado. (n.d.) *SBIRT Colorado*. Retrieved from <http://www.improvinghealthcolorado.org/>
- La Clinica de La Raza. (2011). *La clinica*. <http://www.laclinica.org/index.html>
- Maryland Department of Health and Mental Hygiene, Alcohol and Drug Abuse Administration. (2010). Maryland Uniform Application FY2011, Substance Abuse Prevention and Treatment Block Grant. Retrieved from http://maryland-adaa.org/content_documents/BLOCKGRANT/Maryland2011FINAL_SAPT_BlockGrantApplication5_6_2011.pdf
- National Council for Community Behavioral Healthcare. (2010 March). *Substance Use Disorders and the Person-Centered Healthcare Home*. Retrieved from <http://www.thenationalcouncil.org/galleries/business-practice%20files/Substance%20Use%20Condition%20Report.pdf>

National Council for Community Behavioral Healthcare. (2009 April). *Behavioral Health/Primary Care Integration and the Person-Centered Healthcare Home*. Retrieved from <http://www.thenationalcouncil.org/galleries/resources-services%20files/Integration%20and%20Healthcare%20Home.pdf>

Native American Rehabilitation Association of the Northwest, Inc. (2010). *Native American Rehabilitation Association of the Northwest, Inc.* Retrieved from <http://www.naranorthwest.org/homepage.htm>

New Jersey Department of Human Services, Division of Addiction Services. (2010). New Jersey Uniform Application FY2011, Substance Abuse Prevention and Treatment Block Grant.

New Mexico Human Services Department, Behavioral Health Services Division. (2010). New Mexico Uniform Application FY2011, Substance Abuse Prevention and Treatment Block Grant.

Ober, A. J., Urada, D., Pearce, V., Padwa, H., Cousins, S., Lee, S., & Rawson, R.A. (2010 December 8-9). "California's Forum on Integration: Integrating Substance Use Disorder Services and Primary Care". California's Forum on Integration. Sacramento, CA. Conference Presentation. Retrieved from http://www.uclaisap.org/Affordable-Care-Act/assets/documents/CA%20Forum%20on%20Integration/CA%20Integration%20Forum%20Summary%20Report_FINAL.pdf

Penobscot Community Health Care. (2010). *Penobscot community health care*. Retrieved from <http://pchc.com/>

Pretera Center. (n.d.). *Pretera center*. Retrieved from <http://www.pretera.org/Pretera/Default.aspx>

RAND Corporation. (2009 May). *Integration of Primary Care and Behavioral Health: RAND Report to the Pennsylvania Health Funders' Collaborative*. Retrieved from http://npchf.org/community_reports/rand/RAND-report09.pdf

Stanford, M. (2010 December). *2 initiatives: the moorpark medical home and alexian health center*. [PowerPoint Presentation]. Retrieved from http://www.uclaisap.org/slides/cosr-encal/california-forum-on-integration/19_CFI%20COUNTY_%20SANTA%20CLARA.pdf

Stark, K.D. (2010 December). *Integration barriers: money or power and control*. [PowerPoint Presentation]. Retrieved from http://www.uclaisap.org/slides/cosr-encal/california-forum-on-integration/8_CFI_STARK.pdf

Taillac, C. (2010 December). *Early start outcomes and best practices, Kaiser Permanente, Northern California*. [PowerPoint Presentation]. Retrieved from http://www.uclaisap.org/slides/cosr-encal/california-forum-on-integration/7_CFI_SB%20IRT_TAILLAC_Early%20Start.pdf

Tarzana Treatment Centers, Inc. (2009). *Tarzana treatment centers, inc.* Retrieved from <https://www.tarzanatc.org/default.aspx>

United States Department of Health and Human Services, Centers for Medicare and Medicaid Services. (2010 November). *Health homes for enrollees with chronic conditions*. (DHHS Publication No. SMDL# 10-024). Baltimore, MD: Center for Medicaid, CHIP, and Survey & Certification. Retrieved from <https://www.cms.gov/smdl/downloads/SMD10024.pdf>

United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2011). *Report on State Responses to the FY 2011 Block Grant Addendum on Health Care Reform*. Retrieved from <http://www.samhsa.gov/grants/blockGrant/addendumrept5511.pdf>

United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2009). *National Survey of Substance Abuse Treatment Services* [Data file]. Retrieved from <http://www.icpsr.umich.edu/cgi-bin/SDA/SAMHDA/hsda?samhda+28781-0001>

Vermont Department of Health, Division of Alcohol and Drug Abuse Programs. (2010). Vermont Uniform Application FY2011, Substance Abuse Prevention and Treatment Block Grant.

VIP Community Services. (2009). *VIP community services*. Retrieved from <http://www.vipservices.org/>

Wagner, E., B. Austin, C. Davis, M. Hindmarsh, J. Schaefer, and A. Bonomi. (2001 November). Improving Chronic Illness Care: Translating Evidence Into Action. *Health Affairs*, 20, 64-78.

Wisconsin Department of Health Services, Division of Mental Health and Substance Abuse Services. (2010). Wisconsin Uniform Application FY2011, Substance Abuse Prevention and Treatment Block Grant. <http://www.dhs.wisconsin.gov/substabus/docs/sabg/sabg2011application.pdf>

Appendix

FY 2011 Block Grant Addendum on Health Care Reform

Integration

The Affordable Care Act includes provisions that emphasize an integrated perspective and approach to treatment and services as the standard -- especially between primary care and behavioral health. States need to determine:

- What current efforts are taking place to integrate mental illness and addiction services into primary care (or vice versa)?
- Is your Medicaid agency undertaking planning efforts to promote behavioral health and primary care integration?
- What activities do you have planned to promote conversations between specialty system providers and primary care (FQHCs, CHCs large primary care practices)?
- Do you have a preferred model(s) of primary care and behavioral health integration that you want your state to employ?
- Who is your “content” expert on primary care and behavioral health integration?
- What efforts are you employing to ensure integration/coordination between mental health and substance abuse?