## Appendix: One-Stop Shopping: Efforts to Integrate Physical and Behavioral Health Care in Five California Community Health Centers[a]

### Exhibit A Physical and Behavioral Health Assessment Tool

Exhibit A depicts the progression of the level of effort required for integration of physical and behavioral health care.

| SAHMSA-HRSA Model | | Coordinated | | Co-Located | | Integrated | |
|---|---|---|---|---|---|---|---|
| | | 1: Minimal collaboration | 2: Basic collaboration at a distance | 3: Basic collaboration on-site | 4: Close collaboration on-site with some system integration | 5: Close collaboration approaching an integrated practice | 6: Full collaboration in a transformed/ merged/ integrated practice |
| INFRASTRUCTURE | Physical proximity of primary care (PCP) and behavioral health providers (BHPs) | Separate facilities | Separate facilities | Same facility | Same practice space and facility | Organized in teams, in same practice space and facility | Organized in pods or same offices and teams, same practice space and facility |
| | Type and number of BHPs in primary care setting | None | None | Fewer than 1 full-time or temporary non-MD BHP (psychologist/ LCSW/intern) | 1 or more full-time non-MD BHPs and/or volunteer psychiatrist | 1 full- or part-time psychiatrist, 1 or more full-time non-MD BHPs | 2 or more full-time psychiatrists, 1 or more full-time non-MD BHPs |
| | Combined electronic health records (EHRs) and sharing of physical and behavioral health patient records | Separate EHRs, data not shared | Data not shared | Data shared on case-by-case basis, separate EHRs | BHP inputs of selected data in medical EHR, separate EHRs | Shared EHR, selected behavioral health data visible to PCP | Data fully shared in shared EHR |
| | Level and mode of communication or collaboration between PCPs and BHPs | Sporadically by email/phone for specific patients | Sporadically for shared patients | Occasionally for shared patients | As needed for shared patients, for consultation and coordination of treatment plans | BHPs occasionally attend team meetings, as needed for shared patients, for consultation and coordination of treatment plans | In regular PCP/ BHP team meetings and in morning huddles, as needed for shared patients, for consultation and coordination of treatment plans |
| CARE DELIVERY PROCESS | Behavioral health screening and assessment frequency | Assessment as needed | Assessment as needed | Occasional screening of new patients, assessment as needed | Regular screening of new patients, assessment as needed | As-needed screening of existing patients, regular screening of new patients, assessment as needed | Regular screening of existing patients, regular screening of new patients, assessment as needed |
| | Joint treatment planning by PCPs and BHPs | Separate plans | Limited sharing of plans, separate plans | Usual sharing of plans, separate plans | Some collaborative planning, separate plans | Frequent collaborative planning, separate plans | Single collaborative plan |
| | Referrals and transitions from primary care to behavioral care | Referrals to external BHP, no follow-up or feedback | Occasional follow-up and feedback, referrals to external BHP | Referrals to internal BHP, occasional follow-up and feedback | Follow-up and feedback through EHR messaging, occasional warm handoffs, referrals to internal BHP | PCP access to BHP records in EHR, frequent warm handoffs, referrals to internal BHP | Joint/same-day PCP and BHP visits, referrals to internal BHP, PCP access to BHP records in EHR, frequent warm handoffs |
| | Leadership support for behavioral health integration | None | For information sharing | For special projects, primarily | For mutual problem solving | Supportive but varies with funding availability | Unequivocally and strongly supportive |
| | PCP buy-in for behavioral health integration | Little | Some | For referrals | Inconsistent buy-in | Has not led to practice change | Active practice change |

Source: Adapted from the SAMHSA-HRSA *Standard Framework for Levels of Integrated Healthcare.* (*http://www.integration.samhsa.gov/integrated-care-models/CIHS_Framework_Final_charts.pdf*)

a *http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1364*

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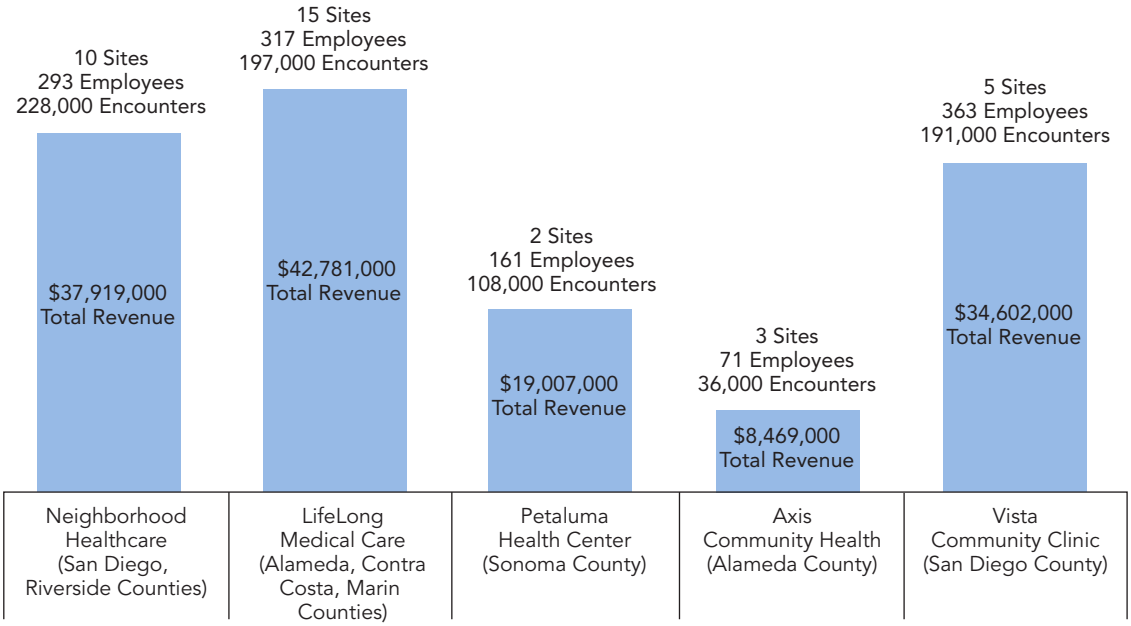
### Exhibit B Characteristics of Participating Community Health Centers, 2013

Exhibit B identified additional characteristics of CHCs. In addition, all five CHCs were recognized as PCMH level 2 or 3 between 2012 and 2014.[b]




Source: UCLA analysis of 2013 Office of Statewide Health Planning and Development primary care clinic utilization data.

a *http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1364*

b Neighborhood Healthcare: PCMH Level 2 (recognized 10/7/12)
LifeLong Medical Care: PCMH Level 3 (recognized 8/6/14)
Petaluma Health Center: PCMH Level 3 (recognized 1/28/13)
Axis Community Health: PCMH Level 2 (recognized 10/16/13)
Vista Community Clinic: PCMH Level 3 (recognized 2/12/13)

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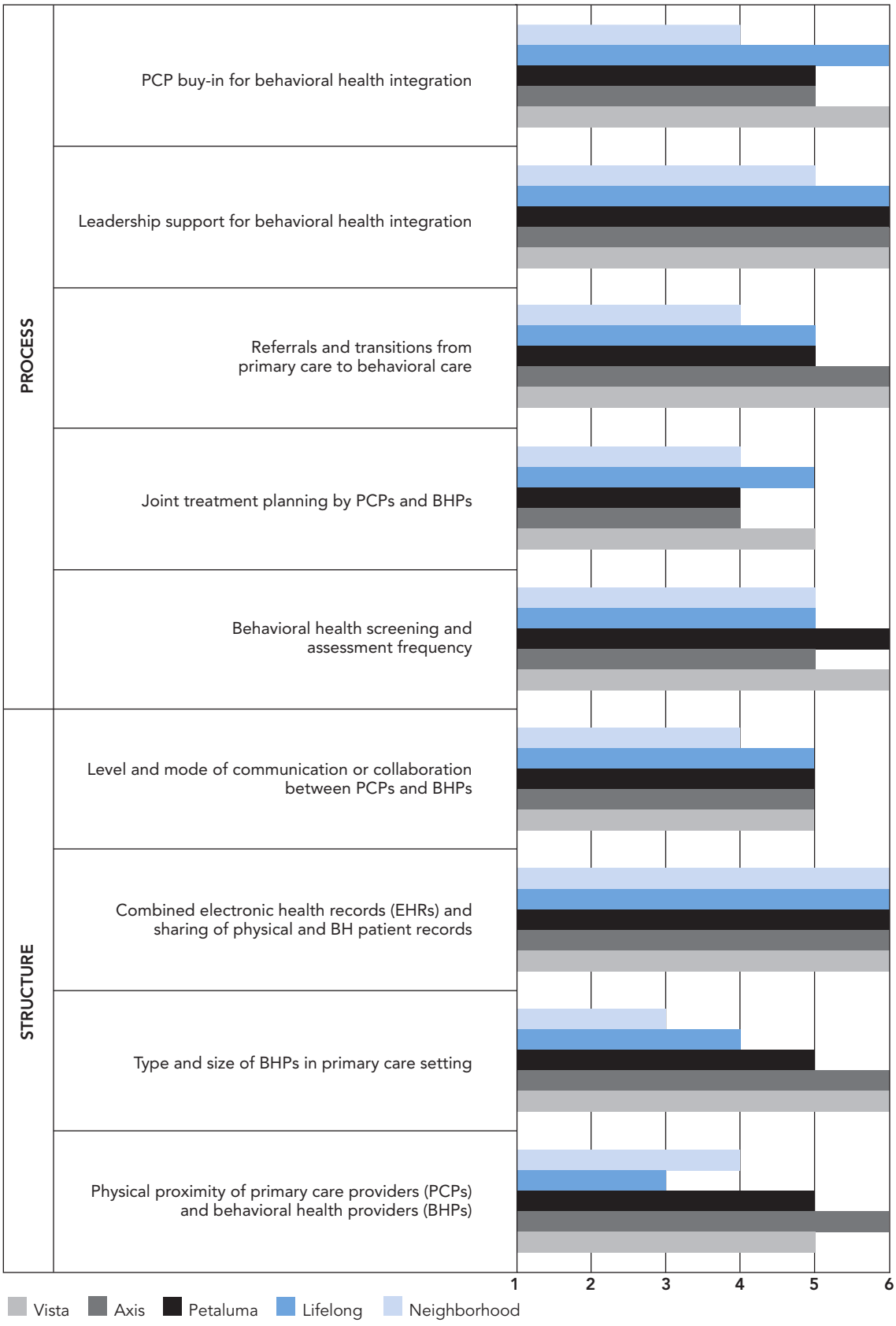
**Exhibit C**

## Evaluated Physical and Behavioral Health Integration Scores of Participating Community Health Centers by Structure and Process Measures, 2014

The progress of each CHC toward integration is shown below.




Source: UCLA interviews with participating community health centers, 2014

a *http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1364*