CSAT TA Package

Working with Medical and Other Programs to Enhance Treatment Integration

The U.S. health care system is going through significant changes. These changes are prompted by the pressure to expand coverage to a greater proportion of the uninsured. They are also driven by the need to ensure quality services and minimize the cost of health care. These changes have implications for the delivery of all health services, including the treatment of substance use and mental health disorders.

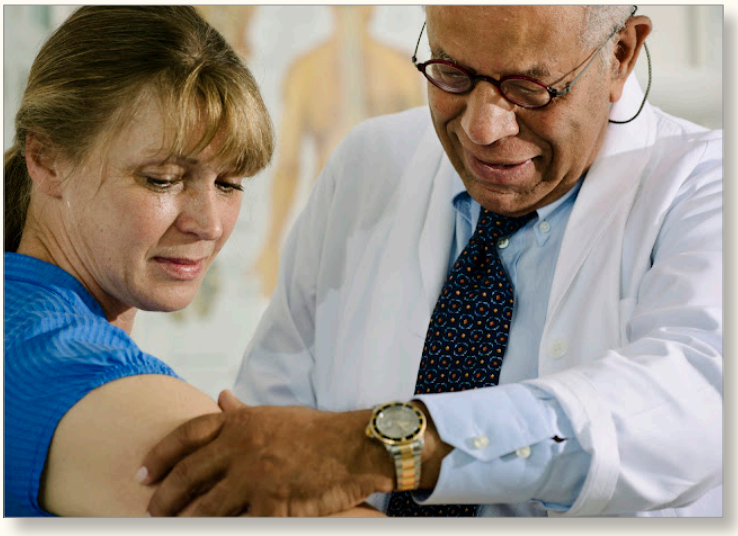
In response, there is an increased focus on the integration of general medical services and specialty services for substance abuse and mental health treatment. This integration of care can help to address comprehensively a broader range of client needs. Also, integration of care is financially efficient because it allows organizations to share specialized resources. The integration of behavioral health care and general medical care occurs along a continuum. It ranges from minimal collaboration to complete integration. There are many ways in which substance abuse treatment programs can increase integration of care.

About this Guide. This Technical Assistance (TA) Package was developed by the Center for Substance Abuse Treatment (CSAT). It was prepared for counselors and program managers to provide information and guidance about the integration of medical care and substance abuse and mental health treatment. It is designed to help addiction treatment professionals understand better how to work with primary care and other medical settings, health homes, accountable care organizations, federally qualified health centers, and similar entities.

What is in this Guide? This TA Package addresses key issues related to the integration of behavioral health care and medical care. It illustrates ways that you can tailor integration approaches for your program. Whatever your program's stage of readiness regarding integrated care, the TA Package seeks to provide you with useful information. This TA Package will address the following issues:

- The importance of integrated care
- What is integrated care?
- Models of integrated care
- Comparing collaboration options
- Understanding clients' needs
- Identifying potential partners

The Importance of Integrated Care



Among the 22 million Americans with a substance use disorder, only about 1 in 10 receives specialty substance abuse treatment. Untreated substance use disorders are associated with tremendous costs related to health care, society, social services, and criminal justice. In addition, many people use alcohol and illicit drugs in ways that are risky and dangerous, from unsafe sex to driving while intoxicated.

Despite the high incidence and cost of substance use, substance use disorders are often unrecognized in primary care settings. Similarly, clients treated in behavioral health settings often do not receive appropriate care for medical problems. Also, some clients may receive care for both medical and behavioral health problems in separate settings, but the respective providers may be unaware that other providers are involved in the treatment of their clients.

Substance abuse treatment programs have traditionally operated independently from the general medical care system. This separation of care can interfere with clients' treatment and recovery. Clients with substance use disorders have a high rate of medical comorbidity. Treatment is more successful if all of a client's health needs are addressed in a coordinated approach. Thus, programs should take steps to provide integrated and coordinated care.

The trend toward integration has begun. For example, Screening, Brief Intervention and Referral to Treatment (SBIRT) grantees are successfully identifying substance use disorders within primary care settings. The passage of the Affordable Care Act is serving as an impetus to increase integration of behavioral health and primary care. The Centers for Medicare and Medicaid Services is promoting new organizational approaches to integration of care.

Why Integration Matters to Treatment Programs

Integration has the potential for improving client outcomes and reducing care costs. It shifts the way providers work together and can change how providers are reimbursed. It is vital that substance abuse treatment providers become informed and proactive about integrated care and how they can have a seat at the table as the health system evolves.

Reasons for Integrated Care
• New ways are needed to increase screening for and treatment of substance use disorders. • Substance use and medical problems often co-occur, yet treatments often are not coordinated. • A holistic focus on a person's medical and behavioral health needs improves the quality of care. • The Affordable Care Act highlights integration as one way to improve access to care and outcomes.

Integration of care is also important because programs are likely to experience an increase in referrals from primary care and other medical practices. To handle that increase, programs should develop or strengthen linkages and relationships with community medical providers. In order to provide effective integrated care, health and behavioral health programs must be able to communicate in a shared language. Likewise, to participate effectively, programs should understand different models of integrated care, including patient-centered health homes, and how to operate within these models.

What Is Integrated Care?

The Substance Abuse and Mental Health Services Administration (SAMHSA) describes *integrated care* as the systematic coordination of general and behavioral health care. Integrated care is a continuum of collaboration. It ranges from minimal collaboration in which substance abuse and medical providers communicate only as needed to fully integrated collaboration, where primary care and substance abuse providers work as a co-located team with a single cohesive treatment plan. Integrated care refers to ways that treatment programs develop approaches to assess clients' health and behavioral health needs and manage clients across and within systems of care.

Treatment programs are at varying places along the continuum. Your program may be at the minimal level or closer to full integration. Whatever your stage, there are opportunities to improve collaboration with other providers. Care can be integrated by expanding referral networks. It can involve patient-centered medical homes or accountable care organizations. Collaboration is bi-directional. Your treatment program can become a medical home. There are important issues to consider, such as memoranda of understanding, sharing client information, specifications for provider payment, co-location, staffing and referral changes, and joint treatment plans.

Minimal. At the *minimal level of collaboration*, specialty behavioral health providers generally do not assess or provide referrals for medical care.

Basic at a Distance. At the *basic at a distance level of collaboration*, specialty providers may have a list of other providers they work with and feel comfortable referring the client. Generally, information is not shared between the providers and it is up to the client to make contact with the referred provider.

Basic On-site. Further along the continuum, *basic on-site level of collaboration* describes services that are usually co-located or on-site, where the behavioral health provider is at the same site as medical care. This arrangement makes referrals easier since providers know each other and clients can stay in one location for a variety of treatments. Usually, with *basic on-site* approaches, the providers maintain separate billing and administrative systems.

Partly Integrated. Situations in which medical and behavioral health providers share the same site and the same cases but are not on the same medical team can be characterized as *partly integrated collaboration*. In this case, the primary responsibility for the management of medical and behavioral conditions is negotiated between the specialist and primary care provider. This arrangement helps to ensure that lab tests are done, follow-up appointments are made, and all providers know what prescription medications clients receive and who prescribes them.

Fully Integrated. In *fully integrated care*, the behavioral health specialist is a member of the medical team. A fully integrated practice shares scheduling and medical records, develops integrated care plans, and confers about clients' treatment needs. This model works best with the most difficult cases, where chronic conditions challenge the clinical management of multiple diseases. This is helpful because there is one treatment plan for all aspects of a client's health needs.

To achieve efficiently integrated care, case managers may be used. Case managers can be part of a medical group or a behavioral health group. They work across care settings by working with clients and their providers and by facilitating other services that clients may need to support their recovery, such as housing. Case managers are well-suited to help overcome the challenges of implementing new models of care because they have experience with collaboration and transitions across levels of care.

Models of Integrated Care

Two emerging models of fully integrated health care are health homes and accountable care organizations.

Health Homes. *Health homes* are person-centered systems of care that facilitate access to and coordination with the full array of primary and acute medical health services, behavioral health care, and long-term community-based social and family services. Health homes are also called *medical homes* or *patient-centered medical homes*.

The health home is not a physical home but a team of health care professionals who directly provide or provide access to comprehensive care. This care ranges from primary care, dental care, and behavioral health care to social and family services.

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What is a Health Home?

4 DECEMBER 2010 4 COMMENTS

In talking with lots of folks—they are confused about the term "health homes". For some, when the term "health home" is used, they think it's a residential facility (like a nursing home). Others think it's a physical location where a person can go for health care needs, but really a health home is an approach to how health care is delivered.

A health home is a provider or a team of health care professionals that provide integrated health care. This means that if a person is participating in a health home, that person's health care, from primary care doctor to dentist to behavioral health professional, all share the same information and coordinate treatment based on that information. Health homes operate under a "whole-person" philosophy – caring not just for an individual's physical condition, but providing linkages to long-term community care services and supports, social services and family services. The integration of primary care and behavioral health services is critical to achievement of enhanced outcomes.

Under the Affordable Care Act, a health home provision [Sec. 2703 & Sec. 1945(e)] has been authorized that provides the opportunity for States to build a person-centered care system that results in improved outcomes for beneficiaries and better services and value for State Medicaid and other programs, including mental health and substance abuse agencies. The three types of health home provider arrangements described in the Act are:

1. Designated providers, (physician, clinic, behavioral health organization)
2. A health team which links to a designated provider
3. A health team (physicians, nurses, behavioral health professionals)

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Health homes, medical homes, or patient-centered medical homes are terms that describe how providers work together. They were established to better coordinate care supported by Medicaid and other payers to better meet the needs of people with multiple chronic conditions.

Health homes can be implemented in two ways. Specialty substance abuse programs can become a health home if you provide medical services in your program. Medical providers can become a health home if they integrate specialty services within their practices. In either case, one provider manages all aspects of clients' care, becoming accountable for patient-centered care. This includes managing and coordinating all services that clients receive, helping with transitions across settings, providing support to the client and family members, and referring to community and social support services.

Community health centers, also called *Federally Qualified Health Centers*, are medical homes that seek to enhance the provision of primary care services in underserved urban and rural communities. Services include primary care, dental care, prevention, pharmacy, mental health, and substance abuse and also supportive services, such as education and case management. Community health centers are open to all residents, regardless of insurance status, and provide free or reduced-cost care based on ability to pay.

Accountable Care Organizations. An *accountable care organization* is a formal network of health care providers that provides coordinated care, chronic disease management, and the full continuum of health care services.

Incorporating the functions of both an insurance company and an integrated delivery system, accountable care organizations were first called for as part of federal health care reform and recent changes to Medicare financing.

The accountable care organization receives a payment for all care provided to a client and is held accountable for the quality and cost of care. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings. Your program may be invited to join an accountable care organization in your community.

Comparing Collaboration Options

It is important to understand where your program currently fits on the continuum and what it might need to become more integrated. The table below illustrates some ways in which approaches across the continuum differ. Deciding whether and how to move along the collaboration continuum is helped by understanding two areas specific to your program: your clients' needs and your local delivery system.

Comparing Collaboration Options

	Minimal or Basic at a Distance	Basic On-site	Close Partly Integrated	Close Fully Integrated
With whom does the substance abuse provider work directly?	Staff within own program	Staff within own program and medical group	Staff within own program and medical group	Other providers within the integrated care network
Is there a memorandum of understanding?	No	Yes	Yes	No, because there is only one program
How do clients receive substance abuse treatment?	Through the substance abuse program	Through the substance abuse program	Through the substance abuse program or brief intervention at health care provider	Through the integrated care network by substance abuse specialists or brief intervention by medical providers, as appropriate
How do clients receive medical care?	Self-referred or referred to primary care provider	Referred to primary care provider within the same site	Referred to primary care provider at the same site or to a primary care provider located at the substance abuse program	Located within the same program
Who is in charge of substance abuse treatment planning?	Substance abuse program	Substance abuse program	Substance abuse program, with consultation between medical and substance abuse specialists	Substance abuse clinician who is on same treatment team as the medical staff
How is client information shared?	Separate health records are shared, on request, with releases of information	Separate health records are shared, on request, with releases of information	Separate health records are shared, on request, with releases of information	Health records are shared; there is no need for separate releases of information

Understand Clients' Needs

What are your clients' medical needs? Substance abuse treatment programs commonly see clients with hepatitis C, tuberculosis, diabetes, and HIV. Your program may treat special populations—such as pregnant women or homeless clients—who have similar medical needs. Thus, it is critical to understand the scope, type, severity, and frequency of your clients' medical needs in order to provide or arrange comprehensive treatment designed to meet those needs.

To do so, you can generate CSAT-GPRA reports to gather information about the overall level of medical needs of your clients. For instance, you can generate the *Frequency Report* to see how many clients have medical needs. You can generate the *Crosstabulation Report* to identify the characteristics of clients (such as gender, race, ethnicity, or age) who report those treatment needs. Because integrated care is relevant for the time in which a client is in treatment, it is best to use the intake CSAT-GPRA data. You can begin by examining clients' reports regarding receiving inpatient, outpatient, and emergency room treatment for physical complaints, which is gathered in Section F of the CSAT-GPRA Tool.

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY
F.2. During the past 30 days, did you receive: F.2.a. Inpatient Treatment for: (i. Physical complaint) F.2.b. Outpatient Treatment for: (i. Physical complaint) F.2.c. Emergency Room Treatment for: (i. Physical complaint)

Medical treatment in the past month suggests that an individual is currently receiving medical care. It also highlights the complexity of client needs. If many clients have received inpatient medical care or emergency room care in the past month, it suggests that your clients have complex medical needs, and it may suggest that they have problems accessing medical care. Both situations indicate that treatment integration and collaboration are important considerations for your clients.

A. RECORD MANAGEMENT—PLANNED SERVICES **Identify the services you plan to provide to the client during the client's course of treatment/recovery.** **Medical Services**
1. Medical Care 2. HIV/AIDS Medical Support & Testing 3. Other Medical Services (Specify)

The questions in Section A of the CSAT-GPRA Tool regarding planned medical services provide information about treatment needs identified at intake. Generate a CSAT-GPRA report to identify the proportion of your clients who have medical needs at intake. If the proportion is high, it is valuable information that you can use to seek ways to integrate medical services with your substance abuse treatment. Doing so will help you to better meet the overall treatment needs of your clients.

In much the same way, use questions from Section C of the CSAT-GPRA Tool to generate reports designed to identify the number and proportion of your female clients who are pregnant. Understanding the number and proportion of your clients who are pregnant provides valuable information about their treatment needs. A high proportion of pregnant women at your program suggests the need for integrated or close relationships with obstetrics and gynecology services, and a low proportion of pregnant women suggests that obstetrics and gynecology services provided through a well-known referral may be sufficient and cost-efficient.

C. FAMILY AND LIVING CONDITIONS

C.5. [IF NOT MALE] ARE YOU CURRENTLY PREGNANT?

- O YES
- O NO
- O REFUSED
- O DON'T KNOW

Self-reported health ratings are valid measures of health status. Thus, it is valuable to generate CSAT-GPRA reports based on questions in Section F, such as: "How would you rate your overall health right now?" Reports that note a high proportion of clients who report their current overall health as excellent, very good, or good suggests that a high proportion of your clients may be enjoying overall good health.

On the other hand, a report may indicate that a high proportion of clients report their overall health as only fair or poor. This provides valuable information that a high proportion of your clients are in poor health. With this information, your program may want to consider close collaboration or integration with general medical care to ensure that your clients are medically evaluated and receive the medical care that they need.

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY

F.1. How would you rate your overall health right now?

- O Excellent
- O Very good
- O Good
- O Fair
- O Poor
- O REFUSED
- O DON'T KNOW

You can use CSAT-GPRA data to identify various groups of clients who may have specific medical needs. For instance, answers to question 1 in Section C: Family and Living Conditions can help you to identify the number and proportion of your clients who are homeless or living in unstable situations. Since homeless individuals are at higher risk for numerous medical problems, you can use this information to determine their needs for primary care assessments, dental care, and prescription medication. Similarly, answers to question C.6 ("Do you have children?") can provide a basis to explore the health care needs of your clients' children and explore integrated care to meet their needs.

Likewise, answers to question B.3 ("In the past 30 days, have you injected drugs?") can help you to identify the proportion and number of your clients who inject drugs. Since needle-using clients are at risk for hepatitis, HIV, and other infections, this information can help you explore collaborations with providers who can evaluate and treat these conditions. Finally, question 4 in Section A asks, "What is your date of birth?" Analyzing birth date data can help you to identify the number and proportion of adolescents in your program and help you to explore their need for pediatric, adolescent, gynecologic, and primary care.

Identifying Potential Partners

Identify Local Resources. Once you have generated CSAT-GPRA reports to identify your clients' treatment needs, identify local providers that deliver needed treatment services that your program does not provide. Scan your local delivery system, and identify primary care and other physicians, medical practices, community health centers, pharmacies, dentists, urgent care centers, emergency rooms, hospitals, and medical specialists. Likewise, identify non-medical wraparound services, from social and family services to child care.

Get to Know Local Resources. Once you have identified local resources, meet with them. Understand their program goals and mission. Ask which clients they accept and do not accept. Understand their preferences or rules about making and accepting referrals. Learn about their payment requirements and about the types of insurance that they accept and don't accept. Discuss issues related to sharing client information. Inform local resources about the range of services that your program provides and how you can help them.

- Identify your existing referral or working relationships with primary care providers and other specialists, and learn what they are doing to integrate care.
- Gather information from your clients regarding where they access their medical care. You may want to strengthen relationships with providers that treat many of your clients.
- If local providers are serving as health homes or accountable care organizations, you may want to learn more about how to become involved with those providers.
- Obtain provider information that is available through provider organizations and your state Department of Public Health that licenses medical providers.

Participating in an Integrated Delivery System

This TA Package has described a continuum of collaboration and integration. But what is the best option for your program? What is the best option for your clients? There are many options. Your program can simply provide referrals to your clients. Your program can work collaboratively with other providers. Your program can join an integrated care network of providers. Also, your program can form an integrated care network and team with local resources.

Your program probably has relationships with other programs and agencies. One way to enhance care integration is to make existing relationships more formal and develop an agreement and a system to share client information. Importantly, such agreements must comply with Federal and local laws and regulations protecting the confidentiality, privacy, and security of health information, such as the Health Insurance Portability and Accountability Act and the Code of Federal Regulations (42 C.F.R. Part 2). Similarly, negotiations and agreements must comply with State and insurer credentialing and other requirements, such as staffing, for programs to participate in and be paid for integrated care.

Decisions about integrated care are not made in isolation from other aspects of your program. System change, such as increased integration, requires program resources and will change how your program functions.

You must take into consideration program staffing, finances, resources, and location when reviewing integration approach options that are best for your program and clients. For instance, you must consider whether your program requires additional staff to enhance integration.

Likewise, you must examine if integrated services such as case management can be reimbursed by your revenue sources. Because integration will change program operations and finances, it is critical to develop a business plan. Doing so will increase the likelihood of success and sustainability.

During this process, generate and make available data about your program, your clients, and your services. Be prepared to explain what your program can provide to the integrated care system. This may include providing consultation, program staff who may be relocated to the medical provider site, case management services, and the development of integrated care plans. In an integrated approach, all involved providers are active players. Thus, to become fully involved, consider what your program can contribute to the process and the system. Also, consider ways in which your program and clients can benefit.

Improve Your Referrals

Perhaps your clients' medical needs are relatively simple, or your program is not ready to become closely integrated with medical providers. You can still strengthen your approach to referrals in order to better serve your clients. A referral-based approach also exists on a continuum, such as simply providing referral information to clients, proactively helping clients follow through with referrals and providing follow-ups, and developing formal referral agreements with a network of providers.

If your program tends to provide nominal referrals, simply strengthening and enhancing your approach to referrals can greatly improve client care. Consider adopting an approach in which program staff work closely with clients to identify their unmet needs, identify the most appropriate resource to meet those needs, help clients make the referral and appointment, and provide follow-up contact to ensure follow-up and treatment progress.

As your program staff interact with other staff at other providers, professional relationships develop, referrals become easier, and clients receive better care. Enhance care integration by becoming proactive. Keep track of medical referrals. When your program refers clients, obtain signed releases of information to ensure that the medical provider is aware of the substance-related disorder. Maintain contact with clients about the referral and treatment so that you can assess progress. By taking these steps, your clients will have a more holistic approach to their care.

Consider Being a Health Home

Some substance abuse treatment programs decide to become a health home for their clients and bring medical care in-house. This can be ideal for programs who have clients with chronic substance use disorders and who also have complex medical needs. This can be helpful for clients who are disenfranchised from the medical system. The SAMHSA–Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions is a useful resource for programs that are considering becoming a health home. Please see the Resources section.

Next Steps

Achieving greater treatment integration is a complex process that affects the treatment program, program policies and procedures, and staff. The decision to do so should be thoughtful and requires careful reviews of processes, procedures, laws, and regulations.

The following questions should be taken into consideration as your program considers increased treatment integration.

- Do you need to expand your revenue streams? For example, should you become a Medicaid provider or become approved for specific insurance companies?
- Do you know which services your insurers will cover that facilitate integrated care, such as phone consultation or case management?
- In what ways would you need to modify your program's billing procedures? This is particularly important if you are currently a grant-funded program.
- Is your current program staffing sufficient to increase your integrated care activities?
- Does your staff have the licenses and credentials required to participate in integrated care? This includes credentials required by managed care plans and Medicaid.
- What processes, such as referrals or follow-up, would you need to change to participate in an integrated care approach?
- Do you understand the issues regarding confidentiality, the Health Insurance Portability and Accountability Act, and the Code of Federal Regulations (42 C.F.R. Part 2) so your efforts to improve information sharing are fully in compliance with relevant regulations?
- Do you need to educate your medical provider referral network about substance use, addiction, and specifically your clients and program?
- Do local medical providers know about your program and what you have to offer so that you have a place at the table as local integrated care networks are being formed?

Summary

In the U.S. health care system, there is an increased focus on the integration of medical services and specialty services for clients with substance use and mental health disorders. The integration of care helps to provide comprehensive services that meet the range of clients' treatment needs.

The integration of medical care and behavioral health care occurs along a continuum ranging from minimal collaboration to complete integration. At the *minimal level of collaboration*, specialty health providers do not assess or provide referrals for medical care. At the *basic at a distance level of collaboration*, specialty providers provide referrals to known providers, but client information is typically not shared. At the *basic on-site level of collaboration*, the behavioral health provider is at the same site as the medical care, although the providers maintain separate billing and administrative systems.

Partly integrated services describe situations in which the medical and behavioral health providers share the same site and cases but are not on the same medical team. In *fully integrated care*, the behavioral health specialist is a member of the medical team, and the fully integrated team shares scheduling and medical records, develops integrated care plans, and confers about clients' treatment needs.

Health homes and accountable care organizations are two models of fully integrated health care. Health homes are person-centered systems of care that facilitate access to and coordination with the full array of primary and acute medical health services, behavioral health care, and long-term community-based social and family services.

Accountable care organizations are formal networks of health care providers that provide coordinated care, chronic disease management, and the full continuum of health care services. In this model, the accountable care organization receives a payment for all care provided to a client and is held accountable for the quality and cost of care.

You can use CSAT-GPRA data to generate a variety of reports that provide valuable information about the medical needs of your clients. For example, you can generate reports regarding client receipt of treatment for physical complaints, planned medical services, and self-report of overall health. With this information, you can identify unmet treatment needs and seek ways to use integrated care to meet these needs.

To increase your program's integration of care, identify local resources, strengthen your relationships with other programs, and learn more about how other programs are participating in integrated care. Even if your program does not participate in integrated care, you can enhance client services by improving the ways in which your program provides referrals, such as working with clients to identify an appropriate treatment service, helping them make appointments, and providing follow-up regarding the referral. Substance abuse treatment programs can consider becoming a health home and bringing medical care in-house.

The focus on integrated behavioral and medical care offers great opportunities to improve the lives of your clients. This TA Package provides several key issues to consider regarding your program participating in integrated care. Many organizations, including SAMHSA, provide information and guidance about different models of integration and how to participate in integrated care.

Resources

General Resources

SAMHSA Blog: Articles in the Health Reform Category: http://blog.samhsa.gov/category/health-reform-2/

SAMHSA-HRSA Center for Integrated Health Solutions: http://www.integration.samhsa.gov

Evolving Models of Behavioral Health Integration in Primary Care: http://www.milbank.org/reports/10430EvolvingCare/EvolvingCare.pdf

SAMHSA Series: Understanding Health Reform: http://bit.ly/OmNbby

Integration

Integrated Care and Why You Should Care: http://store.samhsa.gov/list/series?name=Understanding-Health-Reform

Integration of Mental Health/Substance Abuse and Primary Care: http://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf

Health Homes

What is a Health Home?: http://blog.samhsa.gov/2010/12/04/what-is-a-health-home/

Health Homes and Primary and Behavioral Health Care Integration: http://www.samhsa.gov/healthreform/healthhomes/

Patient-Centered Medical Home: http://www.ncqa.org/tabid/631/default.aspx

Patient-Centered Medical Home Resource Center: http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483

Accountable Care Organizations

Improving Care Coordination for People with Medicare: http://www.healthcare.gov/news/factsheets/2011/03/accountablecare03312011a.html

FAQ On ACOs: Accountable Care Organizations, Explained: http://www.kaiserhealthnews.org/stories/2011/january/13/aco-accountable-care-organization-faq.aspx

What Are Accountable Care Organizations and How Could They Improve Healthcare Quality?: http://www.rwjf.org/files/research/Whatareaccountablecareorganizations.pdf

Local Resources

HRSA Find a Health Center website: http://findahealthcenter.hrsa.gov/Search_HCC.aspx

National Association of Community Health Centers: http://www.nachc.com/

Pioneer Accountable Care Organization Model: General Fact Sheet: http://innovations.cms.gov/Files/fact-sheet/Pioneer-ACO-General-Fact-Sheet.pdf

NCQA Patient-Centered Medical Home page: http://www.ncqa.org/tabid/631/default.aspx

Participation Tips

Integrated Care, Part 1: Securing Your Place at the Behavioral Healthcare Integration Table: http://www.attcnetwork.org/find/news/attcnews/epubs/addmsg/april2012article1.asp

Integrated Care, Part 2: Skills and Competencies for Succeeding in Integrated Healthcare: http://www.attcnetwork.org/find/news/attcnews/epubs/addmsg/may2012article.asp

NIATx Health Reform Readiness Index: http://www.niatx.net/hrri/Instructions.aspx