Integration of Behavioral and Primary Medical Care Services and Systems

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The Criterion Health Management Briefing Series provides resource materials that allow quick overviews of the major factors influencing the industry as well as reference sources for more intensive investigation.

This paper is intended for leaders of community behavioral health organizations (CBHOs) who are already pursing, or exploring the possibility of launching, service integration initiatives. Specifically it seeks to provide the reader with:

1) A sense of the **Importance Of The Service Integration Movement** (p1) relative to the future of their organization and the current state of the integration movement,
2) Highlight **Emerging Best and/or Evidenced Based Practice Approaches** (p3),
3) **Suggested Action Steps** (p10) to exploit the opportunities and defend against associated risks, and
4) **Suggested Reference Materials and Sources** (p11) for the reader that wants to learn more.

Importance of the Service Integration Movement:

As asserted in 2002 by Charles Ray, then CEO of the National Council of Community Behavioral Health (NCCBH), *"both recent history and an emergent federal public health focus on state and federally endorsed community health centers suggest that for community mental health centers, the separate worlds of primary care and specialty care (such as mental health) are now in the process of rediscovering themselves. In an era of diminishing resources and increasing need, the ability to ignore each other and remain in comfortably isolated silos is no longer possible"*.

Now some eight plus years later it is clear, based on firsthand experience, that pro-active participation on the part of CBHOs in the movement is essential to their sustainability. There are two basic aspects for reflection.

First is the annual experience, shared by many CBHOs across the nation over the past five plus years, of:

1) Declines in funding to CBHOs from traditional public and private funding sources whether they are contracted or fee for service.
2) Changes in client/patient/customer [hereinafter referred to as patient(s)] eligibility reflecting the growing ineligibility of sub-groups of individuals historically served by CBHOs, while demand for service based on need has remained stable or increased,

3) Increases in regulatory oversight and cost increasing service protocols, and last but not least,
4) The growing number of federally qualified health centers (FQHCs), other non-federally qualified community health centers (CHCs), physician practices (PPs), that now offer behavioral health services directly. In some instances these organizations were motivated by their own service mission, values, and philosophies, and/or the availability of startup demonstration funding from the Health Resource and Services Administration (HRSA) in the case of FQHCs and/or private foundation or state based funding initiatives for CHCs, and PPs.

CBHO leaders must recognize the embedding of the integration of behavioral and primary medical care service development and expansion within the national health care reform initiative as represented in the Affordable Care Act passed by congress this past year. This fact coupled with the exclusion of CBHOs as designated service providers eligible to participate directly in any of the supporting federal grant offerings for organizational infrastructure (i.e. electronic record systems, etc.) and other direct service development initiatives specific to the integration of behavioral and primary health service is of critical importance. As a result, in its current form Affordable Care Act sets the stage for a) the number of additional FQHCs, CHCs, and PPs to grow significantly. They now have a financial incentive to join their more forward thinking and proactive counterparts that are already so engaged, and the number of surviving CBHOs will go down substantially.

Second is the current state of the integration movement relative to:

1) The work of early adopters, comprised of CBHO, FQHC, CHC, and PP based service providers has demonstrated the very real potential to meaningfully:
    a) Enhance the quality of care and resulting health outcomes experienced by patients through the use of more holistic health screening assessments resulting in better coordinated service/treatment [hereinafter referred to as service] plans and service delivery;
    b) Maximize service delivery efficiencies and cost effectiveness through the sharing of special knowledge and skill sets by service professionals such as physicians, nurses, psychologist, social workers, and other medical and behavioral specialists. Doing so has proven to alleviate perceived and real workforce shortages, while simultaneously increasing access to service, reducing waiting for service timelines, appointment “no show” rates, and reduced lengths of service in terms of frequency and duration without compromising service outcomes.
2) The alignment by many of the early adopters work with the Institute of Medicine’s (IOM) call for healthcare reform as articulated in its publication of Crossing the Quality Chasm: A New Health System for the 21st Century (March 2001) and a variety of other related publications subsequently, including and of specific interest to CBHO leaders, the publication of Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (July 2004).

3) There is a growing body of knowledge and skill that is emerging from these initiatives within the US and internationally. It is being written about in the professional literature and posted on websites of interested parties and stakeholders in the oversight, funding, delivery and/or use of behavioral and primary health care services. This literature supports and is building the case for integration of service which is broadly supported in national policy both here in the US and internationally.

Emerging Best and/or Evidenced Based Practice Approaches:

The IOM's call for change in our health care service system, as previously referenced, and its recommended framework and strategies has proved invaluable to the work of early adopters. The framework consists of:

- Six aims for improving health care: i.e., making health care more safe, effective, patient-centered, timely, efficient and equitable; and
- Ten rules to guide the redesign of healthcare; including:
  1) Care based on continuous healing relationships,
  2) Customization based on patient needs and values,
  3) The patient as the source of control,
  4) Shared knowledge and the free-flow of information,
  5) Evidence-based decision-making,
  6) Safety as a system priority,
  7) The need for transparency,
  8) Anticipation of needs,
  9) Continuous decrease in waste, and
  10) Cooperation among Clinicians [hereinafter referenced as practitioners].
- Specific internal organizational supports needed to achieve the aims and the rules; e.g., information technology, knowledge management strategies to support evidence-based practice, and
- Organizational supports from the external environment; e.g., public and private payment and purchasing strategies or regulatory actions to support and encourage healthcare organizations in undertaking change.

Most of the early adopters have utilized the IOM's framework to inform their design and implementation of integrated service initiatives. That said there still have been a wide variety of approaches to implementation and resulting outcomes experienced. The observed variations typically reflect unique differences in regional and/or local resources, politics, etc. Looking in on this work nationally and even locally it can appear to be chaotic and confusing as referenced in the Canadian Collaborative Mental Health Initiative (CCMHI), *"there are almost as many ways of 'doing' collaborative mental health care as there are people writing about it"* (Macfarlane 2005 p. 11).

As a result those interested in designing or replicating a given implementation initiative can be challenged by a wide variety of disparate and often times confusing approaches, which are further complicated by the fact that most of the existing models/approaches [hereinafter referenced as models], are implemented as hybrids blending one or more elements of the different models, and also vary significantly in the level collaboration and/or integration sought or achieved between practitioners and/or provider organization support systems relative to administrative structures and/or service delivery policy and procedures, and practice protocols.

This reality coupled with the additional complexity associated with varying state, regional, and local health policy, regulatory requirements, funding structures, available resources in terms of professional staffs and service settings, and area politics, endemic to a given geographic area underscores, in our opinion, the need to simplify this information and clarify the f terms used to describe the emerging models of integration.

We attempt to accomplish this, within the context of this paper, to support the reader in developing and understanding of how their organization can design or redesign an initiative to ensure it aligns with the emerging and best and/or evidenced based practices that may have an overarching future impact on future sustainabilityas well as be responsive to the current or transitional state, regional, and/or local issues. This approach is viewed as critical to maximizing the long-term potential for successful implementation of any service integration initiative undertaken.

The following terminology is commonly used within the movement and as presented here is intended to define the basic distinctions across the models that have emerged.

Practice Settings: Initially and still predominately practices are in the medically based settings of FQHCs, CHCs, and PPs. However increasingly this has been changing to include proactive CBHOs as well.

Practice Models: Typically referenced and differentiated in the literature as;

- Coordinated > services are typically provided in different practice settings and under separate or traditionally defined non-integrated practice protocols, policies, and/or regulations, and administrative structures and supports. Further the services are provided with "Minimal to Basic Level Collaboration" (as defined below under Collaboration Continuum presented below) occurring between referring practitioners.
- Co-located > service is provided in the same practice setting with either a BH specialist or Medical Primary Care (MPC) specialist being co-located in the setting typically with "Basic to Close level Collaboration" (as defined below under Collaboration Continuum) between practitioners. Note that this level or degree of collaboration experienced is not a given and varies significantly across implementation initiatives depending on the original intent, design, and level of commitment to achieve the goals and objectives of the initiative.
- Integrated > goals and objectives of the initiative are intended to achieve at least "partial" if not "full" service and system integration as defined below.
  - ✓ Partial Integration > meaning the provider organization(s) administrative structures etc. are partially aligned within the parameters of available

resources or regulations to support integration; that service practitioners experience routine face to face interaction and a greater sense of being a member of a service team with responsibility for providing coordinated services to a shared patient, under either one or separate, but coordinated, service plan(s) and record(s).

- Full integration > meaning the provider organization(s) administrative structures etc. are fully aligned to the extent possible within the available resources or allowed by regulations to support integration; that service practitioners are defined as members of a service team; and the patient experiences the service as one in which all of their health care needs are addressed and served by the team in a coordinated manner under a single integrated service plan and record.

Collaboration Continuum: Typically refers to the level of collaboration/consultation/ coordination [hereinafter referenced as collaboration] supporting the level of service integration sought or achieved between service practitioners and/or organizational support systems such as administrative structures and/or service delivery policy and procedures, practice protocols, etc. The continuum is represented as ranging from "minimal" to "basic" to "close" collaboration as defined below.

- Minimal > sharing of sufficient information to support a referral from one practitioner to another. Separate service plans and little to no collaboration during the course of continuing service to a mutual patient.
- Basic > sharing of detailed referral information and some collaboration between practitioners on recognized co-morbid conditions presented by the patient reflecting a higher degree of potential for coordinated service.
- Close > sharing results of clinical screening assessments supporting the development of a single integrated service plan which defines the roles and guides the interactions of the service practitioners with one another and with the shared patient.

Practice Service Delivery Protocols: such as, but not limited to those presented here, are frequently found to be embedded in the design of many implementation initiatives:

- Medical or Person Centered Healthcare Home [hereinafter referred to as Person Centered Healthcare Home] > originally developed within the sub-specialty of family practice medicine and now widely embraced by primary care practices as well, this approach is also a centerpiece in the current national healthcare reform efforts (Rittenhouse and Shortell 2009) and recognized as providing the basis for a more dynamic role for behavioral health in the patient centered health care home (Mauer 2009).
- Health Care Team [hereinafter referred to as Service Team] > initially introduced by the IOM and common to co-located and integrated models the doctor-patient relationship is replaced with a team-patient relationship (Strosahl 2005).
- Stepped Care > reflective of and not at odds with the historical service mission of BHOs this protocol defines that service provider organizations and practitioners are to offer services that:
  - ✓ Cause the least disruption in the person's life,
  - ✓ Are provided at the least:

  - ✓ Extensive level needed for positive results,
  - ✓ Expensive level needed for positive results and in terms of staff training required to provide effective service.
- Four Quadrant Clinical Integration > identifies patient populations to be served in the primary care versus behavioral health sub-specialties and has proven useful as a template for use in designing integration initiative relative to localized health care resources. (Mauer 2006; National Council for Community Behavioral Healthcare 2009; Parks et al. 2005)
- Chronic Care Plan or Planned Care [hereinafter referred to as Planned Care] > initially developed by Ed Wagner, MD, MPH, and promoted by Improving Chronic Illness Care (RWJF) and Group Health of Puget Sound, Seattle Washington is widely embraced within primary care practices and is consistent with its complementary several behavioral health evidence based practices such as:
  - ✓ Psychosocial Rehabilitation developed by Anthony at Boston University,
  - ✓ Co-occurring Mental Health and Substance Abuse treatment guideline developed by Kenneth Minkoff, MD and
  - ✓ Substance Abuse Relapse Prevention Plans guideline developed by Terrance Gorski
- Stanford University Chronic Disease Self-Management Program

Table 1: Service Integration Models presented on the next page utilizes the terminology as defined above to assist the reader in evaluating how well any existing implementation initiative they may be engaged in or planning aligns with the emerging body of knowledge, skill, and related direction of the service integration movement.

Table 1: Service Integration Models

Practice Settings	Service Elements or Process	Models defined relative to the Collaboration Continuum		
		Coordinated (Minimal to Basic Collaboration)	**Co-located (Basic to Close Collaboration)**	**Integrated (Basic to Close Collaboration)**
All (Initially and still predominately the practices are in the medically based settings of FQHCs, CHCs, and PPs. However increasingly this has been changing to include proactive CBHOs as well.)	Service Scheduling Planning Delivery & Recording	• Services are provided: ✓ In the separate existing practice settings traditional to the provider organizations and/or practitioners involved. ✓ Under their own unique and separate: ✓ Administrative structures and financing/re-imbursement systems. ✓ Service policy, procedures, practice protocols, patient service plans and records.	• Practitioners typically provide their respective services in the same practice setting, but may at least initially have separate systems reflecting a continuation of cultural differences and practice silos. • As the relationships evolve and mature overtime movement toward increased collaboration on the part of the provider organization(s) and/or practitioners involved frequently supports increased integration of service processes.	• A provider organization may develop an integrated service system either on its own or in partnership with another complementary organization or with individual or a group of practitioners to ensure: ✓ Access to needed knowledge and skill sets, and ✓ Service capacity. • The level of service integration sought and/or achieved is frequently referenced as "Partial" or "Full" as previously defined.
	Health Screening	• Situational to routine screening for medical and behavioral health problems.	• Situational to routine screening for medical and behavioral health problems.	• Routine screening for medical and behavioral health problems.
	Referral & Information Sharing or Exchange	• Situational to routine referral relationship and exchange of information between primary care and behavioral health practitioners.	• Enhanced potential for situational to routine referral relationship and informal exchange of information and consultation between primary care and behavioral health practitioners, but separate specialty related or defined service plans and records are typically maintained.	• Based on screening results, routine involvement and sharing of information by members of the service team (typically comprised of physicians, nurses, psychologist, social works, etc.) supporting the development of either coordinated or integrated service plan(s) and record(s).

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Table 1: Service Integration Models (Continued)

Practice Settings	Service Elements or Process	Models defined relative to the Collaboration Continuum		
		Coordinated (Minimal to Basic Collaboration)	**Co-located (Basic to Close Collaboration)**	**Integrated (Basic to Close Collaboration)**
All (Initially and still predominately the practices are in the medically based settings of FQHCs, CHCs, and PPs. However increasingly this has been changing to include proactive CBHOs as well.)	Health Services	• Primary care practitioners to deliver behavioral health interventions using brief algorithms. • Behavioral health practitioners deliver service recognizing and being sensitive to co-morbid conditions and presenting dynamics.	• Enhanced potential for use of: ✓ Coordinated and complementary service strategies responsive to co-morbid conditions and presenting dynamics ✓ Practice service delivery protocols such as: ✓ Health Care Home ✓ Health Care Team ✓ Step Care, and/or ✓ Four Quadrant Clinical Integration, etc.	• Demonstrated and consistent use of: ✓ Coordinated and complementary service strategies responsive to co-morbid conditions and presenting dynamics ✓ Practice service delivery protocols such as: ✓ Health Care Home ✓ Health Care Team ✓ Step Care, ✓ Four Quadrant Clinical Integration, etc.
	Outcomes	• Connections made between the patient and community resources thereby offering the potential for improved quality of care and related service outcomes. • The level of commitment toward increased communication and collaboration (i.e. from "minimal" to "basic") between practitioners relative to common patients is regarded as a positive step forward to improved quality of care.	• Enhanced potential for ✓ Reduced: ✓ No show rates for behavioral health specific services, and ✓ Improved: ✓ knowledge and skill level of practitioners, ✓ quality of service, and efficiency of care provided reflected in improved health outcomes	• Consistent documented experience of: ✓ Significant reduction in: ✓ No show rates for behavioral health specific services, and ✓ Patient non-compliance rates relative to physical health specific services ✓ Improved: ✓ Access to service through efficient differential use of existing service practitioner time, and ✓ Quality and efficiency of care provided reflected in improved health outcomes.

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<tr><th rowspan="2">Practice Settings</th><th rowspan="2">Service Elements or Process</th><th colspan="3">Models defined relative to the Collaboration Continuum</th></tr>
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(Initially and still predominately the practices are in the medically based settings of FQHCs, CHCs, and PPs. However increasingly this has been changing to include proactive CBHOs as well.)</td><td rowspan="2">Challenges Faced</td><td>• This model requires the least amount of change in the traditional practice on the part of sponsoring provider organization(s) and/or service practitioners involved.</td><td>• This model sets the stage to begin breaking down the cultural differences and practice silos of physical and behavioral health systems and practitioners.</td><td>• This model raises the bar of expectation on both the sponsoring provider organization(s) and practitioners to create a new culture of integrated service. It takes a concerted effort and a high level of commitment on the part of the sponsoring organization(s) to be successful.</td></tr>
<tr><td colspan="3">• All of these models experience these common challenges or barriers to integrating service. The difference in the degree to which they are experienced lies in the defined goals and objectives of the model being implemented by the sponsoring provider organization(s) and/or practitioners involved. This is particularly true in the case of the co-located and integrated models, which by definition seek higher levels of service and systems integration than is typically the case with the coordinated model, but can and do vary significantly in level of integration sought from one initiative to another.
✓ Confidentiality laws > pertaining to substance abuse (federal regulation CFR 42 and state) and mental health (state) are generally more restrictive than those pertaining to physical health and are frequently cited along with HIPPA (federal), albeit inaccurately, as a barrier to service coordination or integration.
✓ Service reimbursement and parity issues > issues are prevalent from both public and private sector payer sources. Current inequities include varying levels of reimbursement for covered services defined by practice setting and/or professional discipline of the practitioner for the same service; and variation in terms of covered versus non-covered services in general or again as defined by practice setting and/or professional discipline of the practitioner.
✓ Regulatory oversight > in the form of deferential state and/or federal regulations defined by practice setting. In some states this experience also reflects differential application by service setting of the very same regulation(s). Additionally, current regulations may impede the design and delivery of cost and quality efficient and effective services.
✓ Workforce shortages > real or perceived related to the number of appropriately trained and certificated/licensed practitioners available and willing to support and participate in such initiatives directly.
✓ Service Integration > of routine services such as health screening and long-term/chronic disease management protocols due to time constraints and/or practitioner willingness.
✓ Objective measurement of service outcomes > that speak to the concerns, desires, and needs of funding/payer sources, employers, regulators, patient advocates and patients themselves, practitioner satisfaction, and lastly the sponsoring provider organization(s).</td></tr>
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Suggested Next Steps:

1. **For Those Considering Participating:**
    a. Assess your organization's level of readiness by:
        i. Completing our readiness survey available to you online at (http://criterionhealth.net/checklist.html).
        ii. Contact us to explore how we may be of assistance in developing a strategic action plan using our proven Design or our full "3 D's" (Design, Development, and Delivery) process. For more information about this process use the following link (http://criterionhealth.net/pages/3d_process.html).
2. **For Those Already Participating:**
    a. Reassess your current initiative(s) relative your formal action plan if you have one and if you don't then complete our readiness survey available to you online at (http://criterionhealth.net/checklist.html)
    b. Contact us to explore how we may be of assistance in revitalizing your existing action plan or developing a new strategic action to plan using our proven Design or our full "3 D's" (Design, Development, and Delivery) process. For more information about this process use the following link (http://criterionhealth.net/pages/3d_process.html).
3. **For All Readers:**
    a. Consider and act on:
        i. The development and/or strengthening of existing strategic partnerships with FQHCs, CHCs, and/or PCPs if they are available and approachable in your geographic service area, or
        ii. Applying to become a FQHC or developing you own in-house primary medical care practice.
    b. Address common challenges both within your integration initiative plan and implementation strategies, and through advocacy efforts with area authorities as needed and appropriate:
        i. Confidentiality laws: > Recognize the inaccuracy of the citing these laws as a barrier to sharing information. While they do in different ways impose restrictions on the sharing of information they are manageable with the application of some common sense and effort by following procedural guidelines, presented in each law, for obtaining informed patient consent to allow for the sharing of information for specific purposes such as coordination of care across provider organizations and/or service practitioners.

            Additionally advocate for the continuation of current discussions striving to change the present laws to allow for less restrictive information sharing for the purposes of supporting service coordination and integration.
        ii. Service reimbursement and parity issues > Advocate for reform and redesign of public and private sector reimbursement policies, procedures, and practices to bring about:

1. Uniform coverage and rates of reimbursement across all practice settings for the same services as provided by practitioners of the same/or similar professional disciplines and levels of licensure and/or specialty certification.
2. Inclusion of coverage for the provision of same day service encounters with a patient by multiple practitioners consistent with an authorized service plan.

iii. Regulatory oversight > Advocate for relaxation of regulatory barriers that impede design and delivery of cost and quality efficient and effective services.

iv. Workforce shortages > Recognize the need to redefine the functional roles and accompany service duties and responsibilities of service practitioners by relative to their knowledge and skill sets to maximize their cost efficient and effective use across professional disciplines.

Additionally advocate for initiatives to enhance the training and incentivization of practitioners to serve in under-served communities.

i. Service Integration > Recognize the need for setting an organizational goal and supporting expectation that all health screening, and services related to long-term/chronic disease management and that of co-morbid conditions will be integrated through the use of best or evidenced based protocols such as:

1. Chronic Care Plan or Planned Care [hereinafter referred to as Planned Care] > initially developed by Ed Wagner, MD, MPH, and promoted by Improving Chronic Illness Care (RWJF) and Group Health of Puget Sound, Seattle Washington is widely embraced within primary care practices and is consistent with its complementary several behavioral health evidence based practices such as by the way of example:
    a. Psychosocial Rehabilitation Model > developed by Anthony at Boston University, and widely used on serving patients with severe and persistent mental illness.
    b. Co-occurring Mental Health and Substance Abuse Treatment Model > developed by Kenneth Minkoff, MD and Christie A. Cline, MD, MBA which is widely used by CBHOs.
2. Stanford University Chronic Disease Self-Management Program

ii. Objective measurement of service outcomes > Initiate and/or advocate for and participate in collaborative initiative at the state or, regional level such as the ones sponsored by Maine Health Access Foundation (MeHAF) and Quality Counts (QC) organizations, in the state of Maine, that are working to develop a culture of measurement with provider organizations and service practitioners

that address the interests of various stakeholders relative to reporting measurable outcomes in the areas of:

1. Patients in terms of life function,
2. Practitioners in terms of quality of work and related satisfaction,
3. Provider organizations in terms of enhanced service quality and cost containment or efficiency and effectiveness, and
4. Public and private sector payers, as well as employers, again in terms of enhanced service quality, efficiency and effectiveness, supporting and resulting in cost containment.

Suggested Reference Materials and Sources:

To learn more the reader is directed to "Evolving Models of Behavioral Health Integration in Primary Care" (available at http://criterionhealth.net/) published by the Milbank Memorial Fund, (2010), which we consider, given its alignment with our applied practice experience in reviewing and implementing practice approaches/models that are showing the greatest potential for s sustainability and therefore suitable for replication.

1. Institute of Medicine's publications:
   a. Crossing the Quality Chasm: A New Health System for the 21st Century (March 2001)
   b. Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (July 2004).
2. Milbank Memorial Fund publication: Evolving Models of Behavioral Health Integration in Primary Care (2010): available at (http://criterionhealth.net/),
3. Canadian Collaborative Mental Health Initiative publication: available at (http://www.ccmhi.ca/en/products/documents/04_BestPractices_EN.pdf) and related citations as follows:
   a. Macfarlane, D. 2005. Current State of Collaborative Mental Health Care. Mississauga: ON: Canadian Collaborative Mental Health Initiative; available at (http://www.ccmhi.ca/en/products/ documents/12_OverviewPaper_EN.pdf).
4. Mauer, B. 2009. Behavioral Health/Primary Care Integration and the Person-Centered Healthcare Home. Washington, DC: National Council for Community Behavioral Healthcare. Available at (http://www.allhealth.org/BriefingMaterials/BehavioralHealthandPrimaryCareIntegrationandthePerson-CenteredHealthcareHome-1547.pdf).
5. Rittenhouse, D., and S. Shortell. 2009. The Patient-Centered Medical Home: Will It Stand the Test of Health Reform? JAMA 301(19):2038–40. doi:10.1001/jama.2009.691. Available at (http://dx.doi.org/doi:10.1001/jama.2009.691).
6. Strosahl, K. 2005. Training Behavioral Health and Primary Care Providers for Integrated Care: A Core Competencies Approach. In Behavioral Integrative Care: Treatments That Work in the Primary Care Setting, edited by W. O'Donohue, M. Byrd, N. Cummings, and D. Henderson, pp. 15–52. New York: Brunner-Rutledge. Available at (http://www.amazon.com/Behavioral-Integrative-Care-Treatments-Primary/dp/0415949467).
7. The Chronic Care Model. Available at (http://www.improvingchroniccare.org/index.php?p=Chronic+Care+Model&s=124).
8. Psychosocial Rehabilitation Model. Available at (http://www.bu.edu/cpr/about/profiles/wanthony.html).

9. Co-occurring Mental Health and Substance Abuse Treatment Model. Available at (http://www.kenminkoff.com/resource.html).
10. Substance Abuse Relapse Prevention Plans. Available at (http://www.tgorski.com/gorski_articles/developing_a_relapse_prevention_plan.htm).
11. Stanford University Chronic Disease Self-Management Program. Available at (http://patienteducation.stanford.edu/programs/cdsmp.html)

Closing Thoughts:

In our assessment the integration of mental health and primary care is long overdue and that for CBHOs to survive in the face of the fast and ever changing arena of publicly funded primary healthcare the leaders of such organizations must take decisive, and proactive steps to fully participate in this movement or face significant inroads into their traditional roles if not complete obliteration.

Further we believe leaders of CBHOs that are concerned about remaining true to their founding missions of service to the community and the sustainability of their organizations, and also want to make meaningful contributions to the quality of service in their respective communities, have much to offer by taking proactive steps to position their organization participate directly in this movement.