



ISSUE BRIEF

NO WRONG DOOR:

BRIDGING MENTAL HEALTH AND PRIMARY CARE SILOS IN KENTUCKY

JULY, 2010

EXECUTIVE SUMMARY

This document is a work product of the Integrated Care Action Team (ICAT) – a group of health care professionals interested in increasing access to a health care service delivery model in Kentucky that integrates mental health services and medical services in one setting.

The purpose of this document is to bring attention to key obstacles preventing low-income Kentuckians with mental health needs from receiving diagnosis and treatment for those needs in primary care centers and conversely, for persons entering the community mental health system who need medical care.

Primary Care is the “de facto mental health system” – typically the first place a patient presents with a psychological problem. Primary Care manages either directly or indirectly 80% of patients with psychological disorders. So why not put mental health services in primary care?

Individuals with serious mental disorders receive most of their care in the public mental health systems and are dying 25 years earlier than the general population mostly due to preventable conditions such as cardiovascular disease and diabetes. So why not put medical services in the community mental health centers?

The Foundation for a Healthy Kentucky has funded several projects around the state to explore models of integrating mental health and medical services. In their work, these dedicated providers have come against a number of barriers that are preventing their patients from accessing care. Through their work in the ICAT, these providers have identified 5 key obstacles and recommendations to: assure the appropriate provision of primary care in community mental health centers; assure the appropriate provisions of mental health assessments in primary care settings and promote the effective delivery of care in the face of professional staffing shortages:

Recommendations:

1. Medicaid reimbursement for physician care at Community Mental Health Centers

- That Kentucky review its Community Mental Health Center (CMHC) scope of service regulations to ensure that primary care can be delivered within the CMHC setting.
- That services delivered by a non-psychiatrist physician or primary care physician within the CMHC setting be reimbursed adequately and on par with reimbursement rates for those services at other locations. Specifically, non-psychiatrist physician employed by a Community Mental Health Center should be paid the same fee for like services provided by physicians in private practice.

2. Offsite Provision of Primary Care Services

- That Medicaid payment (907 KAR 1:054) and OIG licensure (902 KAR 20:058) regulations or revision of KRS 216(B), if deemed necessary, be instituted to permit provision for

physical health services at community mental health centers by partnering with licensed primary care centers in a fashion similar to what is currently allowed in school health services.

3. Medicaid reimbursement for mental health consultation in primary care

- That applicable codes and appropriate Medicaid reimbursement levels be determined to support mental health screening and consultation in a medical setting, even in circumstances when the clinical assessment rules out a psychiatric diagnosis.

4. Medicaid reimbursement for telemedicine collaboration

- That the expanded use of telemedicine reimbursement be addressed by moving forward with a new regulation currently in development, its filing as a state plan amendment and provisions for payments for mental health and primary care services delivered via telemedicine, with implementation as soon as is practical. This would assure that Medicaid reimburses both for the provider of service where the patient is located and for services provided via telemedicine by the offsite consulting provider.

5. Medicaid reimbursement for Peer Support Specialists

- That the Commonwealth complete a state plan amendment, to permit training and licensing of peer support specialists throughout Kentucky.

Uncoordinated health care is inefficient and costly, both in lives and in resources, to the taxpayers of Kentucky. Now, when we face daunting shortfalls in revenue at the state and federal levels, it is more important than ever to “work smart” with the prudent use of limited health care resources, and Medicaid funds.

We hope this document will bring more attention to the kinds of policy change needed to improve access to more integrated care in Kentucky.

INTRODUCTION

This document is a work product of the Integrated Care Action Team (ICAT) – a group of health care professionals interested in increasing access to a health care service delivery model in Kentucky that integrates mental health services and medical services in one setting.

The ICAT was formed in February 2009 with representatives of grantee organizations who were funded by the Foundation for a Healthy Kentucky to explore strategies for integrating mental health and medical services in a variety of health care settings: school-based health centers, hospital outreach clinics, public health department clinic, primary care centers and community mental health centers. In undertaking these projects, ICAT members frequently encountered barriers associated with provision of and payment for services. The ICAT was formed in response to these challenges with the purpose to: (1) share experiences, protocols and data on their integrated care models; (2) discuss the policy and regulatory barriers hindering the advancement of integrated care in Kentucky and (3) devise an action plan for addressing these barriers. These demonstration projects have also developed and tested a number of collaborative relationships, in particular, partnerships between community mental health centers and primary care.

The ICAT has since grown to include representatives of the Kentucky Primary Care Association, the Kentucky Association of Regional Programs, and Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities.

This document aims to address the barriers identified by the experience of organizations working to integrate mental health and medical services and that may be relieved by changes to Kentucky law or regulation, or institutional practices.

WHAT IS INTEGRATED HEALTH CARE?

The Hogg Foundation for Mental Health offered this definition, in their 2008 publication, *Connecting Mind and Body: A resource guide to integrated health care in Texas and the United States*:

“[I]n essence integrated healthcare is the systemic coordination of physical and behavioral health care. The idea is that physical and behavioral health problems often occur at the same time. Integrating services to treat both will yield the best results and be the most acceptable and effective approach for those being served.”

The Collaborative Family Health Association – www.cfha.net – defines integrated primary care in this way:

Integrated Primary Care (IPC) combines medical and behavioral health services to more fully address the spectrum of problems that patients bring to primary medical care.

Because the vast majority of patients in primary care have either a physical ailment that is affected by stress, problems maintaining healthy lifestyles or a psychological disorder, it is clinically effective and cost effective to make behavioral health providers part of primary medical care.

IPC allows patients to feel that for any problem they bring, they have come to the right place. By teaming mental health and medical providers, IPC is the structural realization of the biopsychosocial model advocated so broadly in Family Medicine and Psychiatry.

The aims of integrated health care are closely aligned with larger efforts across the nation to affect person-centered care. The Patient-Centered Primary Care Collaborative – www.pcpcc.org – issued a set of joint principles of the patient-centered medical home, endorsed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association in February 2007. While calling for a personal physician to be the team leader and point of first contact, it recognizes the need for a “whole person orientation” throughout the life cycle and coordination or integration of care “across all elements of the complex health care system.

Speaking to a Working Meeting on the Integration of Mental Health Services and Primary Care in Atlanta in 2000, then Surgeon General David Satcher called for a “balanced partnership” among care providers, patients and families, and communities. Quoting from the 2001 report of this meeting - www.surgeongeneral.gov/library/mentalhealthservices/mentalhealthservices.html:

“Dr. Satcher addressed specifically the lack of time in primary care that providers have to adequately attend to the many responsibilities that our health care systems require of them. He urged primary care providers to remember that they are not alone. In fact, he challenged the primary care provider to be the quarterback of the health care team that collaboratively makes the system work for the patients and their families. He spoke of our negligence of the health care system for not engaging the potential resources available within families. Not only is family involvement therapeutic for the patient, but it is the key to sustaining continuity of care and providing high-quality care.....He emphasized that without good mental health one cannot have good health and well being. Therefore the primary care and mental health partnership is crucial for overall balanced health.

The good news in the mental health report, he indicated, is that we have the ability, perhaps 80 to 90 percent of the time, to treat mental disorders with a range of different treatments. However, the bad news is that less than half who suffer each year seek treatment. And many who make contact with the health system don’t necessarily make contact with the mental health system because they are experiencing mental illness, because they are unaware or because of the stigma surrounding mental illness.”

In addition to the Surgeon General, many national and international organizations have called for the adoption and cited the principals of integrating services as a must in health care today – among them, the President’s New Freedom Commission on Mental Health (2003), the Institute of Medicine (2004) and the World Health Organization (2008).

And in Kentucky, a 2006 report by the then Department for Mental Health and Mental Retardation Services, entitled “Best Practice Implementation in Kentucky’s Public Mental Health System”, sites the “integration of services” and the “breaking down of silos” as a best practices being attempted by CMHCs in Kentucky. The report recommends to “strengthen relationships across agencies that serve mutual clientele around specific transformation activities, e.g., physical/behavioral health interface, cross-agency information and data sharing, development of model protocols among community agencies...”

WHY DOES IT MATTER?

Nearly a decade has passed since the Surgeon general’s meeting in Atlanta, yet in Kentucky today we still see the impact of a nation’s slow response.

A research study published in the September 2009 issue of *Psychiatric Services*, conducted by researchers from Thomson Reuters and the federal Substance Abuse and Mental Health Services Administration (SAMHSA), analyzed prescribing patterns for psychotropic drugs from August 2006 through July 2007.

Of the 472 million prescriptions written for psychotropic medications during the study period, the researchers found that general practitioners prescribed 62 percent of antidepressants, 52 percent of stimulants (mainly drugs to treat attention deficit hyperactivity disorder), 37 percent of antipsychotics, and 22 percent of anti-mania medications. Pediatricians were included as general practitioners and wrote 25 percent of all stimulant prescriptions. ***In all, more than half the psychotropic drugs prescribed in America in the research period were prescribed by general practitioners.*** Many of these patients may never see a behavioral health professional.

For patients in the mental health service system, many will have health problems that go unaddressed, even though some psychotropic medications have been found to contribute to overweight and diabetes. A 2006 report of the National Association of State Mental Health Program Directors – www.nasmhpd.org – *Morbidity and Mortality in People with Serious Mental Illness*, found that ***people with serious mental illness die, on average 25 years earlier than the general population.*** State studies document recent increases in death rates over those previously reported. While suicide and injury account for 30-40% of excess mortality “60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases.”

In short, slow response to these well-documented concerns is keeping many Americans – including many Kentuckians – from obtaining needed care.

OBSTACLES AND SOLUTIONS

The obstacles to effective integration, identified by the ICAT, are similar to those identified by our colleagues in other states and include:

- Professional training of physicians that has not fostered a team approach to care; professional training for psychologists and social workers that has not accustomed these professionals to the rapid-pace, brief encounter strategy that works best in co-located care settings.
- Reimbursement and licensing practices that raise barriers to providing and paying for coordinated care.

While the first set of problems calls for long-term solutions, problems arising from reimbursement practices hold promise of rapid high-impact responses. Licensing changes may take the middle ground, in terms of timing of implementation. The following are 5 obstacles and subsequent recommendations prioritized by the ICAT as ways to increase immediate access to mental health and medical services.

1. MEDICAID REIMBURSEMENT FOR PHYSICIAN CARE AT COMMUNITY MENTAL HEALTH CENTERS

For people with a serious mental illness, the community mental health center is often perceived as their “medical home” – the place they turn to for the majority of their health care needs such as prescriptions and medication management, case management and coordination with specialty services, and other rehabilitative services needed to maintain a life in the community. In a fully integrated system, people with mental illness can access routine physical health care services at this location as well, if they so choose.

Currently in Kentucky, primary care providers such as physicians and nurse practitioners generally do not provide routine physical health care at CMHCs. Providing primary care at a CMHC in Kentucky is problematic: although physicians – internists, psychiatric residents, and other non-psychiatric physician specialists - may provide care for patients at Community Mental Health Centers, Medicaid will only reimburse them at the approved rate for “therapists” – a rate below the rate afforded nurse practitioners. In addition, provision of primary care is currently outside the described scope of practice for a community mental health center in Kentucky.

Other states have identified the value of integrating care for people with serious mental illness by creating opportunities for primary care physicians to deliver care within the community mental health center. This can take a variety of forms:

In Tennessee, dual licensure and a negotiated, bundled rate allows Cherokee Health Systems to provide fully integrated, mental health and primary care services to its patients. (Although Tennessee currently

has a carved-in Medicaid mental health model, Cherokee Health System's integrated model was supported for many years under the previous carve-out system as well).

Missouri has different Medicaid delivery models throughout the state, depending on the rural or urban concentrations of its population. Mental health services are largely fee-for-service. The state has used a variety of resources and tools to specifically promote physical health care within CMHCs:

- State grant funds were used to build examination rooms at Community Mental Health Centers appropriate for the delivery of primary care services.
- CMHCs "lease" physicians or nurse practitioners from FQHCs; FQHCs bill Medicaid for the services provided
- CMHCs also have nurse practitioners on staff who provide routine physical health screening and bill Medicaid for the service.

In Oregon, state policymakers are embarking on a major system reform that will pool all state dollars at the regional level to promote fully integrated care.

Recommendations:

- **That Kentucky review its Community Mental Health Center scope of service regulations to ensure that primary care can be delivered within the CMHC setting;**
- **That services delivered by a non-psychiatrist physician or primary care physician within the CMHC setting be reimbursed adequately and on par with reimbursement rates for those services at other locations. Specifically, non-psychiatrist physician employed by a Community Mental Health Center should be paid the same fee for like services provided by physicians in private practice.**

2. OFF-SITE PROVISION OF PRIMARY CARE SERVICES

Currently, the State of Kentucky permits health care providers from licensed primary care sites to provide and receive compensation for medical services at school-based sites. The I-CAT recommends that either through administrative regulation, or revision to KRS 216(b), payment be extended to include provision of and compensation for care by physicians, nurse practitioners or physician assistants employed by licensed primary care centers or Federally Qualified Health Centers, provided at community mental health centers. This would relieve community mental health centers of the need to duplicate the services of other safety-net providers in areas of scarce resources, provide assurance of a medical home for the patients and provide integrated patient care on site where the patients are being treated for other health care needs. Larger CMHCs may be able to support hiring a physician in their center, particularly with the reimbursement allowances as described in recommendation #1 above. However, for smaller CMHCs, hiring a physician still may be prohibitive. Authorizing "Offsite Service

Provision” will create more options for CMHCs to bring medical services to the people they serve by fostering collaboration among other local health care providers.

Some other states (Georgia, West Virginia, and Ohio) that are working to integrate primary and behavioral health care services do not share Kentucky’s constraints in primary care licensure regulations. The ICAT does not seek to do away with licensure, but to assure it is flexible enough to meet the needs of the patient population and improve their health status. The Cabinet for Health and Family Services has considerable latitude in regulating licensure of health services in KRS 216(b), permitting it to deal with changes in health care practices over time and address the needs of residents of the Commonwealth.

Across the nation, licensing has been a barrier to integrating services on a number of levels. Community Mental Health Centers are often licensed and overseen by a district mental health department within state government; these entities are typically highly regulated. Primary care practitioners, in contrast, are accustomed to being credentialed by a variety of payers, including Medicaid and other public funders, and focus on individual professional licensure status and scope of practice rules. Integrating these two distinct systems of care can therefore be challenging.

States can take multiple routes to avoid these barriers;

- Review and amend licensing rules: States can take a variety of approaches in shaping licensing rules to support physical health care integration. States may amend licensing rules to specifically permit the provision of health care services as a part of Community Mental Health Center licensing scope. States can interpret existing language to encourage better coordination or co-location with physical health care providers.
- Use deemed equivalence of status across state agencies to encourage integrating care: The state of Pennsylvania, for instance, “deemed” mental health providers and substance abuse providers across separate licensing spheres to encourage the treatment of these co-occurring disorders.
- Encourage leasing of staff, as Missouri has done, or memoranda of agreement across provider settings, and other co-location strategies which may not require licensing changes

Recommendation:

- **That Medicaid payment (907 KAR 1:054) and OIG licensure (902 KAR 20:058) regulations or revision of KRS 216(B), if deemed necessary, be instituted to permit provision for physical health services at community mental health centers by partnering with licensed primary care centers in a fashion similar to what is currently allowed in school health services.**

3. MEDICAID REIMBURSEMENT FOR MENTAL HEALTH CONSULTATION IN PRIMARY CARE

Currently in Kentucky, Mental Health Center staff may provide a consultative assessment in a medical setting. However, they are reimbursed only if they find a psychiatric condition requiring further treatment. As one ICAT member has noted, this is like telling an orthopedist, assessing whether a patient has a broken bone, that he or she will only be compensated if the patient leaves in a cast.

Many states are struggling with variations on this theme. The following represent a selection of integrated care tools that states are using to better support behavioral health in the primary care setting:

Screening: The first step in identifying the need for additional intervention is the use of an evidence-based tool for screening in the primary care setting. For example, Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based tool that can be implemented in the primary care setting to detect alcohol and substance abuse problems. The tool is designed for use in a variety of settings, and need not be administered by a behavioral health professional. SBIRT is a resource that states are using to effectively integrate important components of behavioral health screening and treatment into physical health care settings. Wisconsin's Medicaid program, for instance, allows primary care providers to bill for providing SBIRT to pregnant women in the Medicaid program, and plans to expand the service to all its Medicaid beneficiaries in January of 2010¹.

States are also employing standardized, validated screening tools to identify depression in primary care, with a wide range of billing procedures available to pay for this service. Some states allow for specific billing for screening, such as Illinois, which permits providers to bill for perinatal depression screening. Other state Medicaid programs encourage screening for the broader population using evaluation and management codes for primary care. Materials from New York state, while they do not mandate a specific ICD-9 code to support such billing, indicate that code 311.00 (Depressive Disorder, not otherwise specified) is the most commonly used code for depression screening in primary care, and that most claims using this diagnostic code are paid routinely.² Other states encourage physicians to use patient self-administered tools, such as the Patient Health Questionnaire (PHQ-9). These involve little physician time and can be incorporated as part of a routine office visit. Self-screens that indicate additional behavioral health concerns can then be referred for additional services either inside or outside the practice.

States can choose to pay for behavioral services beyond the initial screening in a variety of ways. Many states, such as Maine and Missouri, allow licensed clinical social workers employed by primary care

¹ http://www.wiphl.com/uploads/media/WIPHL_SBIRT_fact_sheet.pdf; retrieved December 1, 2009

² <http://www.nyc.gov/html/doh/downloads/pdf/dmh/dmh-depression-reimbursement.pdf>; retrived on December 1, 2009

practices to bill for services that are within the scope of their practice. While the physician might perform or review the initial screening, patients with positive screening results can then be referred to the in-house LCSW.

Other patients may have behavioral health issues caused by underlying physical health care diagnoses. Some major payers, including Medicare, have adopted Health Behavior Assessment and Intervention codes that allow certain practitioners, such as psychologists, to provide behavioral interventions for problems associated with a primary physical diagnosis. These codes allow the primary care practice to work with patients on issues related to many chronic conditions, such as medication adherence, symptom management, risk-taking behaviors, or other behavioral components of a physical health condition. No psychiatric diagnosis is required.

Even with available billing codes in place, other issues can impede or support the provision of integrated health care. 22 states, for instance, permit same-day billing for both primary care and psychiatric services. Kentucky is one of a minority of states that specifically prohibit this kind of practice³.

Recommendation:

- **Applicable codes and appropriate Medicaid reimbursement levels be determined to support mental health screening and consultation in a medical setting, even in circumstances when the clinical assessment rules out a psychiatric diagnosis.**

4. MEDICAID REIMBURSEMENT FOR TELEMEDICINE COLLABORATION

Telemedicine services have been documented as effective in providing mental health services. Texas pioneered the use of telepsychiatry in its prison system in the mid- 1990s, showing both cost and quality improvements in service and outcomes. With the documented shortage of psychiatrists and other mental health professionals many states have moved aggressively to expand telemedicine services, especially in more rural areas of the nation. In Kansas, for example, multiple primary sites receive services over a telehealth system from ARNP-PSY supervised by psychiatrists. Kentucky has one of the most wide-spread telemedicine systems in the nation. However, reimbursement, particularly from Medicaid, lags behind other states and even reimbursement from commercial payers. Under Kentucky Medicaid reimbursement practices, a patient seen by a health care provider in one site, with telemedicine services from a remote-stationed psychiatrist or ARNP-PSY, the site where the patient is physically located can charge a “facility fee,” and the site rendering the service is paid for the actual encounter.

³ http://www.thenationalcouncil.org/galleries/resources-services%20files/BHCoverage_onSameDay_byState_9_14.BMP

Currently, the Kentucky Medicaid Program has strong regulation for reimbursement of mental health services provided via telemedicine. However, it has not been fully implemented and there are multiple restrictions on reimbursement. Most therapies provided by professionals other than a psychiatrist or ARNP are not reimbursed. The Medicaid program has a major revision of regulation to permit primary care physicians to bill for telemedicine encounters and it retains the provisions for mental health.

In other states, telemedicine is effectively supported at both the “hub” and “spoke” sites. In North Dakota, for instance, with its large rural areas, Medicaid pays for physician services where the patient is located, and for services provided by the offsite consulting provider⁴. In addition, a flat user fee that is currently set at \$20.00 is also permitted. Minnesota also permits both providers involved to bill for services rendered.⁵

Currently, the Commonwealth is undertaking a major revision of regulations, to permit primary care physicians to bill for telemedicine encounters.

Recommendation:

- **That the expanded use of telemedicine reimbursement be addressed by moving forward with this new regulation, its filing as a state plan amendment and provisions for payments for mental health and primary care services delivered via telemedicine, with implementation as soon as is practical. This would assure that Medicaid reimburses both for the provider of service where the patient is located and for services provided via telemedicine by the offsite consulting provider.**

5. MEDICAID REIMBURSEMENT FOR PEER SUPPORT SPECIALIST

There is a growing movement in the United States to incorporate peer support specialists as part of the mental health care team. There is a national organization, the National Association of Peer Specialists, Inc. – www.naops.org – dedicated to peer support in mental health systems. Studies have shown that people with serious mental illness who receive Peer Support Services can have better outcomes, including reduced hospital use.⁶ The New Freedom Commission identified Peer Supports as a beneficial

⁴ <http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/cpt/telemedicine.pdf>

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http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008926#P477_33438

⁶ Min et al., 2007

service⁷, and CMS offered its explicit support for the practice in a “Dear State Medicaid Director” letter in 2007.⁸

In Kentucky, the state had sought a Medicaid State Plan Amendment, to permit reimbursement for the work of peer support specialists on a pilot basis, but subsequently withdrew this plan amendment request. Under the plan amendment, which was to have been effective January 1, 2009, a peer support specialist was defined as a worker who is a former or current consumer of mental health or dual diagnosis services and well-grounded in their recovery, with at least one year between diagnosis and application for peer support specialist training, a high school diploma or GED, reading, writing, and advocacy skills, and who has completed a state-sponsored peer support training program and attained competency in seven specified areas.

Other states, such as Georgia, Iowa, Wisconsin, South Carolina, and Arizona currently offer Peer Supports as Medicaid-reimbursable services. These states access Medicaid reimbursement in a variety of ways. Georgia, one of the first states to include Peer Supports as a Medicaid benefit for people with serious mental illness, includes Peer Supports under its Medicaid Rehabilitation package of services⁹. Iowa, which carves out its behavioral health services under a 1915(b)(3) waiver, uses that waiver to fund its peer supports program.

States that provide reimbursement under Medicaid for peer support services generally have a licensing or certification procedure that requires completion of a specified Peer Support training program. In Georgia, for instance, the Certified Peer Support training program is a ten-day course offered three times per year. The training is designed to prepare these individuals to “promote hope, personal responsibility, empowerment, education, and self-determination in the communities in which they serve.”¹⁰

Recommendation:

- **The Commonwealth complete a state plan amendment, to permit training and licensing of peer support specialists throughout Kentucky.**

⁷ President’s New Freedom Commission on Mental Health, 2003, p. 37

⁸ U.S. Centers for Medicare & Medicaid Services, 2007; See appendix

⁹ http://www.gacps.org/files/Peer_Support_FY_10.pdf

¹⁰ <http://www.gacps.org/Home.html>

CONCLUSION: WHY NOW?

Uncoordinated care is inefficient and costly, both in lives and in resources, to the taxpayers of Kentucky. Now, when we face daunting shortfalls in revenue at the state and federal levels, it is more important than ever to “work smart” with the prudent use of limited health care resources, and Medicaid funds.

Most of the changes sought can be attained at the administrative level in Kentucky, although one requires a state plan amendment and another may require a change in legislation. Even the proposal that appears to increase cost exposure – peer specialist funding – has been shown, where these workers are used, to result in better clinical outcomes and reduced systems costs.

On behalf of the members of the Integrated Care Action Team (ICAT) that assisted bringing these obstacles and recommendations to the forefront and the Foundation for a Healthy Kentucky, we hope this document will bring more attention to the kinds of policy change needed to improve access to more integrated care in Kentucky.

ABOUT THE FOUNDATION

The Foundation for a Healthy Kentucky is a non-profit, philanthropic organization working to **address the unmet health care needs of Kentuckians**. Our approach centers on developing and influencing health policy, to promote lasting change in the systems by which health care is provided and good health sustained, to: Improve access to care, reduce health risks and disparities and promote health equity.

The Foundation makes grants, supports research, holds educational forums and convenes communities to engage and develop the capacity of the Commonwealth *to improve the health and quality of life of all Kentuckians*. For more information about the Foundation, please visit www.healthy-ky.org

For information on the Foundation’s initiative on Integrating Mental Health and Medical Services, please contact:

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