An Update on Integrated Primary Care and Behavioral Health Services in California Community Clinics and Health Centers

INTEGRATED CARE ISSUE BRIEF

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KEY CONSIDERATIONS FROM THIS ISSUE BRIEF

The purpose of this issue brief is to provide an update on integrated primary care, mental health and substance abuse services in community clinics and health centers (CCHCs). There is increasing recognition that mental illness and substance use impact overall health and wellness, and can be appropriately addressed and managed in primary care settings. Integrated care approaches that treat the full spectrum of health, mental health and substance use needs are not only person-centered, but also reduce stigma for many individuals who would not seek specialized treatment outside of the primary care setting.

California CCHCs served 5.1 million patients in 15.8 million encounters in 2011. Some clinics have offered both physical and behavioral health services since the 1960s and 1970s. Early on, health centers began providing supportive services such as transitional housing, or referrals to community agencies for services not provided at the clinic. Today, health center primary care physicians, nurses and staff are often the first point of contact for patients when it comes to physical and behavioral health. The CCHC history as a social justice movement serving the disenfranchised, and recent policy developments in the past few years, all support continued and enhanced behavioral health services in community-based settings.

Although some health centers have provided behavioral health services since their inception in the early- to mid-twentieth century, passage of the **Mental Health Services Act** in 2004 was a turning point in furthering the clinic conversation around integrated services. Not only did the MHSA provide more funding for behavioral health services via the counties, but it opened the door for counties and CCHCs to collaborate to a greater degree. The **person-centered health home** movement further supports integrated services, and recognition agencies are affirming the value of including behavioral health standards.

Despite the progress that has been made, CCHCs face certain challenges that impede further development of integrated behavioral health services and the corresponding reduction of stigma. These include lack of knowledge about diagnoses and treatment approaches, lack of treatment resources, inadequate staffing, poor reimbursement and disparate reimbursement systems, and lack of data and integrated information technology systems. Policy changes are needed, such as Med-Cal reimbursement for same-day medical and behavioral health visits, and for licensed marriage and family therapist services. **With continued dedication, funding, and policy changes, as well as enhanced county/clinic relationships, CCHCs will continue to make progress on the path to enhanced integrated primary care and behavioral health services as well as stigma reduction, in order to meet the needs of the communities they serve.**

INTRODUCTION

The purpose of this issue brief is to provide an update on integrated primary care, mental health and substance abuse services in community clinics and health centers (CCHCs). There is increasing recognition that mental illness and substance use impact overall health and wellness, and can be appropriately addressed and managed in primary care settings. Integrated care approaches that treat the full spectrum of health, mental health and substance use needs are not only person-centered, but also reduce stigma for many individuals who would not seek specialized treatment outside of the primary care setting. The interrelationship between physical health, mental health and substance underscores the need for comprehensive care to be coordinated. The CCHC history as a social justice movement serving the disenfranchised, and recent policy developments in the past few years, all support continued and enhanced behavioral health services in community-based settings. To understand if integrated services are making the desired impact on persons using health centers, data need to be collected, reviewed and analyzed - a process that is still in development. This issue brief provides the policy framework for integrated services and describes the current state of the field.

BACKGROUND

The Integrated Behavioral Health Project (IBHP) team conducted a **statewide needs assessment** of the status of integrated behavioral health trainings and activities in California. The IBHP project was administered by the California Mental Health Services Authority (CalMHSA) with funding from the Mental Health Services Act's Prevention and Early Intervention component. The purpose of the needs assessment was to develop a strategic plan for training and technical assistance that would build capacity across the health, mental health and substance use provider sectors to provide integrated care for safety net populations, to reduce stigma and discrimination, and to increase access to care. Over 150 individuals were interviewed across the state in 2012 as part of the needs assessment process (see **Attachment 1**), including health centers that received grants from IBHP, community health center staff from across the state, the California Primary Care Association (CPCA), and the CPCA Behavioral Health Network. In addition, consultants reviewed California clinic consortia websites, as well as Area Health Education Center (AHEC) and training websites. The interviewees' information and insights, as well as additional research conducted by the IBHP team, resulted in a series of issue briefs that summarize key findings pertaining to counties, primary care, peer model services, substance abuse services, and workforce.

Integrated care is defined as services in which providers consider all of an individual's health conditions in the course of treatment, including physical illness, mental disorders, or substance abuse, in which these providers coordinate care for the patient or client.[1] An example of an

integrated care setting is one in which mental health or addiction treatment services are provided in primary care clinics. Another approach is one in which a community behavioral health organization contracts with a primary care provider to conduct screenings, referrals, and health education onsite.

Integrated care allows for treatment of chronic diseases such as diabetes, cancer, and heart disease, which are often found undetected or untreated in people with mental illness.[2] Individuals with substance use disorder are more likely to have lung disease, hepatitis, HIV/AIDS, cardiovascular disease, and cancer, as well as mental disorders such as depression, anxiety, bipolar disorder and schizophrenia.[3] Many people with mental disorders, or who abuse alcohol, prescription drugs, nicotine or other substances, can be identified by primary care providers and either treated onsite or referred offsite to appropriate treatment services.[4] In fact, integrated care for people with mental or substance use disorders can be more effective than traditional treatment in terms of health outcomes and cost.[5,6]

There is an emerging body of information suggesting that integrated care programs contribute to a reduction of stigma and discrimination experienced by persons with mental health and substance use problems. In the case of mental illness, stigma refers to *"negative beliefs (e.g., people with mental health problems are dangerous), prejudicial attitudes (e.g., desire to avoid interaction), and discrimination (e.g., failure to hire or rent property to such people.)"*[7] A core value within all MHSA initiatives is the reduction of stigma and discrimination in the workforce and for those seeking the diagnosis and treatment of mental illness.[8] Research has confirmed that the provision of mental health services in primary care settings has positive impacts, including the improvement of patient and provider satisfaction; overall efficiencies in health care costs, including primary and specialty costs for physical health care; improved clinical and functional patient outcomes; and adherence to regimens and treatment of mental health disorders. Offering behavioral health services in nontraditional settings encourages participation by people wanting to avoid the stigma surrounding mental health treatment.[9]

Integrating mental health care with primary care services is a strategy for improving access and reducing stigma. Offering behavioral health services in nontraditional settings encourages participation by people wanting to avoid the stigma surrounding mental health treatment.

In California, counties have statutory responsibility for mental health and substance use treatment services, as well as primary care services for low-income and uninsured populations.[10] Realignment, which occurred in 1991 and 2011, transferred the majority of mental health and substance abuse treatment administration and funding from the state to the county level.[11] Counties work to varying degrees with other community-based organizations in the delivery of behavioral health services, such as federally qualified health centers (FQHCs), rural

health centers, community clinics, dedicated substance abuse and mental health treatment services, and other non-profit agencies.

HEALTH CARE REFORM

Integration is taking place within the context of a rapidly changing health care environment in which more people will gain coverage for behavioral and primary care services. The national **Patient Protection and Affordable Care Act** (ACA) will increase the number of people with coverage for physical and behavioral health services, not only because more people will be insured, but because the ACA requires health plans to offer mental health and substance abuse services in addition to a full range of medical inpatient and outpatient services. The **Mental Health Parity and Addiction Equity Act of 2008** requires group health insurance plans that offer coverage for mental illness and substance use to provide those benefits at the same levels as medical and surgical benefits.[12] ACA and parity are policies that address systemic stigma and discrimination.

As the number of individuals with health coverage increases, so will the demand for services. The Substance Abuse and Mental Health Services Administration (SAMHSA) estimated the number of newly covered California adults ages 18-64 that will have serious mental illness (SMI), psychological distress (mental health problems such as anxiety or stress in the past year), or substance use disorder, based on data from an annual survey they sponsor called the *National Survey on Drug Use and Health*.[13] SAMHSA projected that out of over 5.4 million newly covered Californians through the Medicaid Expansion or the Health Insurance Exchange, 233,082 will have SMI, 582,770 will have serious psychological distress and 648,588 will have substance abuse disorder (see **Table 1**). The resulting increased demand for services will push an already strapped county system to respond, and will most likely accelerate partnerships with community-based organizations.

Table 1: Prevalence of Serious Mental Illness, Serious Psychological Distress, and Substance Use Disorder by Eligibility for Medicaid Expansion and the Health Insurance Exchange in California

Organization	Medicaid Expansion	Health Insurance Exchange	Total
Serious Mental Illness	108,393 (4.4%)	124,689 (4.2%)	233,082
Serious Psychological Distress	256,202 (10.4%)	326,568 (11%)	582,770
Substance Use Disorder	253,738 (10.3%)	394,850 (13.3%)	648,588
Total eligible population	2,463,476 (100%)	2,968,796 (100%)	5,432,272

Source: SAMHSA (undated) Enrollment under the Medicaid Expansion and Health Insurance Exchanges: A focus on those with behavioral health conditions in California. Data sources included the 2008-2010 National Survey on Drug Use and Health (Revised March 2012) and the 2010 American Community Survey for population estimates.

Under California's 1115 Medicaid Waiver, called the "**Bridge to Reform**," new programs are increasing access to integrated physical and behavioral health services for low income populations. Between June 2011 and May 2012, the Medi-Cal program transitioned **Seniors and Persons with Disabilities** (SPDs) from fee-for-service to mandatory Medicaid managed care, with beneficiaries required to choose or be assigned to a health plan by the first day of their birth month. This affected almost 240,000 beneficiaries, or approximately 40% of the total SPD population in California, of which more than three-quarters are younger people with disabilities. The SPD transition was intended to improve access to care, increase plan and provider accountability, and reduce costs. Another goal was to improve care coordination for SPD beneficiaries, including those needing both physical and behavioral health services. The transition did not go smoothly, as providers reported that captitation rates did not cover actual costs, and that the SPD population had more complex care coordination needs than they were prepared to provide. Improved care coordination continues to be a work in progress.[14]

Over 550,000 previously uninsured adults under 133% of the federal poverty level (FPL) have enrolled in California's **Low Income Health Program** (LIHP) as of January 2013.[15] Under this program, counties cover physical as well as certain mental health services for individuals whose conditions meet a medical threshold.[16] In addition, counties ensure that contracting providers link enrollees with a medical home with adequate care coordination. These Bridge to Reform programs have provided an important framework for integrated services and have opened more conversations between counties, health plans, community clinics, and other providers, on how to better coordinate care for individuals needing physical and behavioral health services. By doing so, these organizations are also addressing systemic and institutionalized stigma and discrimination.

HISTORY OF COMMUNITY CLINICS AND HEALTH CENTERS

The first federally funded community health centers were established in the 1960s as part of the War on Poverty, and they continue with the same mission today: to provide health care services to low income culturally diverse patient populations regardless of their ability to pay. The Office of Economic Opportunity approved funding to place health centers in medically underserved inner city and rural areas of the country, with the first two health centers being approved in 1965 in Boston and in Mound Bayou, Mississippi. The model that emerged combined both federal funding and local resources to serve communities in need. In addition, communities formed their own community clinics as a response to the high number of uninsured people needing health care services. Many of these health centers, though not all, sought and received federal designation.

Today in the federal program, over 1,200 health centers in over 7,000 communities serve as the health care home for over 18 million people nationwide. In addition to providing primary care services, some offer dental, mental health, and substance abuse services to low income and uninsured individuals. Health centers are governed by a board in which the majority of members are health center patients or consumers.[17] Some clinics have offered both physical and behavioral health services since the 1960s and 1970s. Early on, health centers began providing supportive services such as transitional housing, or referrals to community agencies for services not provided at the clinic. The health center mission of meeting the health needs of the community it serves continues today – almost five decades after the first neighborhood health centers were funded.

In 1971, California defined **"community clinic"** as a clinic operated by a nonprofit corporation that was supported at least in part by donations, grants, or fees, and that provided services based on the patient's ability to pay. In 1976, state statute defined a **"free clinic"** as a clinic operated by a nonprofit clinic in which patients did not have to pay for services. In 1978, the state's licensing laws underwent substantial revisions, and the California Health and Safety Code, Section 1204(a), required community clinics and free clinics to become licensed as **"primary care clinics."** Other types of clinics do not require state licensure, such as private clinics, clinics operated by governmental entities (i.e., county primary care clinics), clinics operated by tribal organizations, clinics operated as outpatient departments of hospitals, and intermittent clinics. In today's definition of a community clinic, which was written into California law in 1985, only primary care clinics operated by nonprofit organizations (community and free clinics) are required to be licensed by the California Department of Public Health Licensing and Certification Division.[18] Some in the clinic environment feel that primary care clinics should be

treated like any other type of clinic and not be required to meet additional licensing laws since health centers have become much more mainstream since the early days.

The broader category of **"safety net clinics"** includes not only primary care clinics but also public community-based clinics such as those sponsored by cities, counties and health care districts. Safety net clinics can also be federally designated as federally qualified health centers (FQHCs), FQHC Lookalikes (FQHCLAs) or rural health centers (RHCs). Other types of safety-net clinics include Indian Health Services clinics, family planning clinics, school-based health centers and others. These are defined in more detail in **Figure 1**.

This paper will use the term **"community clinics and health centers"** to refer broadly to nonprofit, tax-exempt clinics that are licensed as community or free clinics as defined by the California Health and Safety Code (Section 1204), and that provide services to patients on a sliding fee scale basis or, in the case of free clinics, at no charge. The term includes federally designated community health centers, migrant health centers, rural health centers, and frontier health centers.[19] The FQHC is increasingly the most common model because of their access to enhanced payment and grant opportunities. Despite this common model that requires a set of care services and operational standards, individual CCHCs seek to meet their communities' needs and therefore they provide a myriad of additional social and enabling services. Thus, even the FQHC designation does not mean that all FQHCs are exactly alike. More information about the federal models can be found in **Attachment 2**.

Regional associations of clinics, also known as "consortia," represent and support their member clinics at the local level as well as statewide. While some of the regional associations statewide represent only the health centers in their county, other consortia serve CCHCs across several counties (see **Figure 2**). The Central Valley Health Network, for example, represents 17 counties. Some regional consortia include county representation as members and participants in their initiatives but most do not. Regional associations provide a range of support services for their members, such as advocacy, information technology support, serving as the fiscal agent for grants involving multiple member clinics, contracting support, countywide planning efforts, training, peer networks, and other services.[20] Some regional associations are supporting integrated behavioral health projects either for their own member clinics or in partnership with county specialty mental health providers.

The **California Primary Care Association,** the statewide clinic association, represents the interests of more than 900 not-for-profit CCHCs statewide. Their mission is to *"lead and position community clinics, health centers, and networks through advocacy, education and services as key players in the health care delivery system to improve the health status of their communities."*

Figure 1: Characteristics of Safety Net Clinics

Federally Qualified Health Centers are non-profit private or public entities that are determined by HRSA to meet the requirements necessary for receiving a federal Section 330 grant (see below). In 2011, California had 121 FQHCs operating at 1,032 service delivery sites.[21] Health centers serving a large population of migrant and seasonal farmworkers, the homeless, or residents of public housing, may apply to receive funding under the corresponding primary care program, and could receive additional funding. Health centers are required to:[22,23]

- Be located in or serve a high-need community (designated Medically Underserved Area or Population).
- Be governed by a community board in which the majority of members (51% or more) are health center patients who represent the population served.
- Provide comprehensive primary health care services as well as enabling services (i.e., translation, transportation, education, and care coordination) that promote access to health care.
- Provide services on a sliding-fee scale based on a patient's ability to pay.
- Meet other performance and accountability requirements regarding administrative, clinical, and financial operations, and report on these annually on the HRSA Uniform Data System report.

FQHC lookalikes also provide access to health care for low income and vulnerable populations by increasing access to quality, comprehensive, and culturally competent primary care services. They meet the same requirements as FQHCs but they do not receive federal funding. They do, however, enjoy other FQHC benefits such as enhanced reimbursement, and access to drug discount programs.

Rural health centers (RHCs) increase access to primary care in rural communities where there may be a shortage of Medicaid and Medicare providers. RHCs make more use of non-physician providers such as nurse practitioners and physician assistants. The health centers may be run by a for-profit or not-for-profit entity, and are not required to maintain an "open-door policy." They are not required to provide the same set of preventive and primary care services as an FQHC.[24]

Community and free clinics *lack federal recognition and funding but they provide free or low-cost services to low income and uninsured populations.*

Sources: Health Center Program Requirements, October 2012, Retrieved from http://bphc.hrsa.gov/about/requirements/hcpreqs.pdf; and Rural Health Clinic Fact Sheet, Centers for Medicare and Medicaid Services, retrieved from http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralHlthClinfctsht.pdf

CPCA hosts a number of peer networks in which clinic staff convene around a focus area and share best practices and lessons learned. The **Behavioral Health Network** is one of about a dozen peer networks and is comprised of clinic behavioral health directors and other staff who meet on a quarterly basis to address clinic operational, billing, workforce and access issues, as well as best practices.[25]

Figure 2: Regional Associations of California, 2013

Regional Association	Counties Served
Alameda Health Consortium	Alameda
Alliance for Rural Community Health	Mendocino, Lake
California Consortium for Urban Indian Health	All
California Family Health Council	All
Capitol Community Health Network	Sacramento
Central Coast Health Network	Monterey, San Luis Obispo, San Benito, Santa Clara, Santa Cruz, Ventura, Santa Barbara
Central Valley Health Network	Kern, Colusa, San Joaquin, Madera, Calaveras, Solano, Butte, Tulare, Stanislaus, Merced, Kings, Yuba, Fresno, Tulare, San Bernardino, Madera
Coalition of Orange County Community Clinics	Orange
Community Clinic Association of Los Angeles County	Los Angeles, Orange
Community Clinic Association of San Bernardino County	San Bernardino
Community Clinic Consortium of Contra Costa and Solano Counties	Contra Costa, Solano
Community Health Partnership	Santa Clara, San Benito, San Mateo
Council of Community Clinics	Imperial, Riverside, San Diego
North Coast Clinics Network	Humboldt, Del Norte, Trinity
Planned Parenthood Affiliates of California	All
Redwood Community Health Coalition	Sonoma, Napa, Marin, Yolo
San Francisco Community Clinic Consortium	San Francisco
The Health Alliance of Northern California (The HANC)	Nevada, Shasta, Trinity, Siskiyou, Lassen, Modoc, Plumas, Tehama, Sierra

POLICY INITIATIVES DRIVING INTEGRATED SERVICES AND COUNTY PARTNERSHIPS

The majority of individuals needing behavioral health care seek it from general medical providers, who have collectively become the "de facto" mental health system in the United States.[26] New integration models bring mental health and/or substance abuse providers into the primary care setting so that behavioral health services become a routine part of a health care visit. Integrated care reduces both institutionalized as well as self-stigma, increases an individual's engagement, and results in the client or patient continuing with needed services. Several policy initiatives and statewide projects in the past 10 years -- in addition to the Bridge to Reform initiatives described earlier -- have promoted increased integration and collaboration between counties and community clinics.

Although some health centers have provided behavioral health services since their inception in the early- to mid-twentieth century, passage of the **Mental Health Services Act** in 2004 was a turning point in furthering the clinic conversation around integrated services. Not only did it provide more funding for behavioral health services via the counties, but it opened the door for counties and CCHCs to collaborate to a greater degree. Counties that were previously strapped for funding viewed this new funding as an opportunity to work with community providers to offset the population's behavioral health prevention and treatment needs. The **Health Care Coverage Initiative** again gave counties and community clinics the opportunity to work together to provide primary care services to previously uninsured populations. The **Integrated Behavioral Health Project** was the first targeted statewide effort to promote and advance integrated physical and behavioral health care in primary care settings. Each of these programs served as building blocks to the current system of integrated services, both within organizations and through county/clinic partnerships. **Figure 3** describes these milestones in more detail.

Figure 3: Policy Initiatives Driving Integrated Services and County Partnerships

November 2004 - Mental Health Services Act

- MHSA provides funding to counties for prevention, early intervention, and services, as well as for infrastructure, training and technology. While very few counties allocated funding to community clinics initially, this has changed in recent years. Today, many MHSA-funded projects reflect partnerships between counties and community clinics to better support integrated services.

August 2005 - Health Care Coverage Initiative

- Senate Bill 1448 provided the statutory framework for the development and implementation of the Health Care Coverage Initiative to provide health care coverage to uninsured individuals who were not eligible for Medi-Cal, Healthy Families, or the Access for Infants and Mothers (AIM) program. The Coverage Initiative was intended to build upon the local health care safety net system, including county and community clinics. It encouraged the establishment of medical homes, preventive and primary care services, care management services for patients with chronic care conditions or mental illness, and quality monitoring. In some cases this funding created the first impetus for counties and clinics to establish relationships and work together to serve uninsured populations.

March 2006 - Integrated Behavioral Health Project

- The Integrated Behavioral Health Project, launched by The California Endowment and the Tides Foundation in 2006, was the first intentional statewide effort to support community clinics and consortia in developing or enhancing integrated physical and behavioral health services. Funding was rolled out in three phases until December 2010. Grant recipients in Phase I, the demonstration phase, became known "**vanguards**" due to their position at the forefront of integrated services, a relatively new development at the time. IBHP today continues to dedicate their work to advancing integrated services.

STIGMA REDUCTION IN CCHCS

The majority of people with mental health issues and substance use disorders in the United States remain either untreated or poorly treated, in part due to the perceived stigma in seeking services.[27] To avoid this negative labeling of oneself, or to conceal one's challenges, as many as two-thirds of individuals with mental illness will not seek treatment. This is especially true for culturally diverse and low income communities. Some of the reasons people do not seek help are lack of knowledge of services, fear of disclosure, rejection by friends, and fear of discrimination. Treatment environments that are incompatible with cultural traditions may also deter people from seeking treatment, or will reduce the length of treatment or follow-up care.[28]

What is stigma?

Stigma refers to *"**negative beliefs** (e.g., people with mental health problems are dangerous), **prejudicial attitudes** (e.g., desire to avoid interaction), and **discrimination** (e.g., failure to hire or rent property to such people.)"*

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The experience of mental illness and any associated stigma varies widely across cultures, since mental illness and what it means to be mentally and physically "healthy" are greatly influenced by a multitude of cultural, ethnic, religious and regional contextual factors.[29] Many of the ethnic and racial populations that CCHCs serve are ashamed to seek services labeled as "mental health." Some consumers, particularly individuals of color, attribute their mental health symptoms to physical illness and seek treatment in primary care settings or the emergency room. Research has shown that racial and ethnic minorities are less likely to access mental health care in dedicated county or community mental health settings, even when referred by a medical provider.[30] Concern about stigma appears to higher in rural areas than in larger towns or cities, and stigma also disproportionately affects certain age groups, such as children and older people. Individuals with co-occurring mental health and substance use disorders are particularly vulnerable to issues of stigma, as the criminalization of substance use and addiction in this society continues to affect community and provider attitudes.

Integrating mental health care with primary care services is a strategy for improving access and reducing stigma.[31] Research has confirmed that the provision of mental health services in primary care settings has positive impacts, including the improvement of patient and provider satisfaction; overall efficiencies in health care costs, including primary and specialty costs for physical health care; improved clinical and functional patient outcomes; and adherence to regimens and treatment of mental health disorders. Receipt of mental health services in primary care settings also reduces stigma for some consumers.[32] An Institute of Medicine

report in 2005 concluded that the only way to achieve true quality (and equality) in the health care system is to integrate primary care with mental health care and substance abuse services.[33]

Integrating substance use disorder services in primary care is another strategy for reducing stigma. The vast majority of people with substance use disorders – almost 95% who meet the diagnostic criteria for substance abuse or dependence -- do not receive treatment because they do not think they need it. Individuals recognizing they need services may not seek it due to the perceived stigma of being labeled as an alcoholic or addict. However individuals with SUD do present in primary care settings for treatment of physical or mental concerns that are interconnected with their substance use behaviors. Primary care providers can identify patients abusing substances through validated screening tools such as CAGE or CAGE-AID, or through comprehensive programs such as SBIRT (screening, brief intervention, and referral to treatment).[34]

> *"Most Americans rely on family doctors and pediatricians for early detection of mental illness and in many cases treatment. Family dependence on primary care for mental health needs is especially great in smaller communities and rural regions. Primary care professionals need to be prepared to meet the challenge."*
>
> Michael Fitzpatrick, Executive Director
> National Alliance on Mental Illness

CCHCs are ideally positioned to identify and treat patients with mental health and substance abuse concerns. Primary care physicians, nurses and staff are often the first point of contact for patients when it comes to physical and behavioral health. Thus **CCHCs are uniquely positioned as primary care providers to screen for and identify mental health conditions and substance use disorder, and to address these concerns through education, referral, brief treatment, and/or care coordination.**[35]

Staff and providers within CCHCs and other settings need to be trained on how to be sensitive to the needs of individuals seeking behavioral health services, and how to create an environment free from discrimination and stigma. IBHP key informants reported that some CCHC staff had concerns about serving individuals with substance use disorders and co-occurring disorders (COD), as well as persons with SMI. In a recent needs assessment of California's mental health and substance use service systems, researchers found that stigma associated with SMI was the reason that some in the substance use workforce are reluctant to work with persons needing treatment for mental illness. Similarly, people in the mental health field are sometimes hesitant to work with individuals abusing substances.[36] (Note: More information is available in the *Integrated Care Workforce Issue Brief #1: Stigma and Attitudes Toward Working in Integrated Care*.)

According to a recent article in the New York Times,[37] multiple studies have shown that people with serious mental illness receive worse medical care than those without it. This is due to "diagnostic overshadowing," in which physicians hesitate to prescribe additional medication due to an inaccurate fear of drug interactions, or belief that symptoms may be psychosomatic even when they are not. People with bipolar disorder, major depression, schizophrenia or schizoaffective disorder are more likely to end up with wrong diagnoses or undertreated. Two studies showed that patients with both a mental illness and a cardiovascular condition who had a heart attack received half the number of interventions such as bypass surgery or cardiac catheterization than those without mental illness. When people with mental illness needed medication to reduce or eliminate pain, they were more likely to be denied that medication due to perceived drug seeking behavior, even when that was not the case. The sidebar shows additional examples of how stigma affects patient/client health.

As more and more CCHCs move to team-based care models, all team members will need to understand the various roles different professionals play, including mental health and substance abuse treatment staff. Team members will need to recognize the importance of having expertise across physical and behavioral health arenas when working with patients with complex health, mental health and substance abuse treatment needs. **There is a long way to go for professionals from various backgrounds and specialties to work together effectively**.

Why Stigma Should Matter to Medical Care Providers

Medication Adherence: The more the perceived stigma, the less the medication adherence among outpatients with major depression.

Drop-Outs: Perceived stigma is a predictor of treatment discontinuation among older outpatients with depression.

No Shows: Latinos who report high levels of perceived stigma are more likely to miss scheduled appointments.

Access: Stigma is a strong barrier to people accessing needed mental health care.

Physical Health: People seen as having a mental disorder are less likely than others to get the physical care they need even when they seek it out. Those with schizophrenia are less likely than the general population to receive basic health checks like cholesterol and blood pressure measurements and substantially less likely to undergo cardiovascular procedures. Those with co-occurring mental disorders and diabetes are less likely to be admitted to the hospital for diabetic complications than those without mental disorders.

Source: IBHP Partners in Health, Mental Health, Primary Care and Substance Use Interagency Collaboration Tool Kit, 2013

IBHP integration vanguards are identifying stigma and discrimination issues within their practices and are implementing professional development opportunities to address them (see **sidebar**). Some of these vanguards report that front desk staff and medical assistants would benefit most from training on how to reduce stigma and discrimination. Key informants commented that training on the topic of stigma and discrimination was unlikely to have uptake in participation; however incorporating the topic in a training that advances the primary care medical home and helps a health center work toward achieving the Institute for Healthcare Improvement's *Triple Aim*[*] is of great interest to primary care clinics. **The Triple Aim's focus on the patient experience provides a framework for addressing stigma and discrimination as a way of increasing patient satisfaction**.

Professional Development as a Strategy for Reducing Stigma

*"Provide **professional development opportunities** for staff regarding diversity, mental health issues, and fostering an inclusive work environment.*

"Include mental illness in discussions about acceptance of diversity, just as you would discuss cultural diversity, religious beliefs, physical disability, and sexual orientation."

NAMI Multicultural Action Center
The Facts about Stigma and Mental Illness in Diverse Communities

[*] The Institute for Healthcare Improvement's Triple Aim describes an approach to optimizing health system performance by improving the health of populations; improving the patient experience of care (including quality and satisfaction); and reducing the per capita cost of health care.

CCHC INTEGRATED SERVICES ENVIRONMENT

California CCHCs served 5.1 million patients in 15.8 million encounters in 2011.[38] Mental health services were provided at 351 clinic sites and substance abuse screening or treatment services at 249 sites in over 560,000 encounters or contacts.[39] Approximately 48 sites employ substance abuse counselors, though substance use disorder services are also offered by other types of providers. California's federally-funded community health centers (FQHCs and rural health centers) provided 2.9 million patients with 8.9 million medical visits, 502,000 mental health (MH) visits, and 220,500 substance use disorder (SUD) visits in 2010. Other non-profit community clinics provided additional visits that are not captured in the federal numbers.

Any health center receiving a Section 330 grant is required to provide *referrals* to substance abuse and mental health providers. Most health centers exceed this requirement and instead provide behavioral health services onsite.[40] Health centers that are part of the "Health Care for the Homeless" federal health center program are required to provide substance abuse services.[41]

A national survey of federally qualified health centers conducted by the National Association of Community Health Centers found that almost **65%** of respondents (420 out of 1080 FQHCs) had the key components of integrated care, meaning services were co-located, there was good communication and coordination among behavioral health and primary care providers, they shared behavioral health treatment plans, and they made joint treatment decisions. The survey found that mental health services were provided at over 70% of FQHCs, but substance abuse services were only provided at 55% of the responding FQHCs. Forty percent of FQHCs provided mental health services at all of their sites, and 32% provide substance abuse services at all of their sites. [42]

California Statistics

Clinic Types

- 934 CCHC sites
- 121 FQHCs
- 516 FQHC sites
- 38 FQHC Look-alike sites
- 20 Rural Health Center sites

Community Clinics and Health Centers

- 5.1 million patients
- 15.8 million encounters
- 351 clinic sites providing mental health services
- 249 sites providing substance abuse screening or treatment services

Federally-Funded Health Centers

- 2.9 million patients
- 8.9 million medical visits
- 502,000 mental health visits
- 220,500 substance use disorder visits

Source: CPCA 2012 Profile of Community Clinics and Health Centers, www.cpca.org

Note: Due to varying reporting requirements, data are provided for one-year periods between 2010 and 2011.

CPCA Behavioral Health Integration Survey Results

A 2012 survey conducted by CPCA's Behavioral Health Network on ***Integrated Primary Care and Behavioral Health Services at Community Clinics and Health Centers*** (n=40)[*] found that responding CCHCs had a high degree of integration between physical and mental health services, but less so with substance abuse services. Some of the key findings are as follows:

- Almost two-thirds of CCHCs (60%) reported that **primary care services were co-located** with mental health services in the same practice area, but only 23% offered substance abuse services in the same practice area.

- Almost all responding CCHCs (86%) had high or very high levels of **behavioral health expertise** in the primary care setting. The behavioral health workforce was comprised primarily of LCSWs, but also included psychologists, psychiatrists, substance abuse counselors, and MFTs.

- Almost all respondents (94%) used a warm handoff/same-day **visit model** in which a primary care provider linked the patient with a behavioral health provider during or after their medical visit. Almost three-quarters (72%) offered traditional therapy and treatment, such as 30-, 45- or 50-minute counseling sessions. Almost half (42%) offered 15-minute behavioral health coaching sessions in the primary care service area or pod by a licensed clinician or a health educator, depending on the need.

- More than three-quarters of respondents (79%) had **treatment team meetings** or trainings that included primary care providers and behavioral health providers, whether quarterly, monthly, or weekly.

- Among respondents that had implemented **E.H.R.**, primary care and behavioral health providers were able to easily view each other's notes and treatment plans. At the time of the survey, 87% of CCHCs had either implemented E.H.R. or had purchased their system.

In addition to enhancing integration within their own health centers, **some CCHCs were reaching out to counties** to develop referral mechanisms in which patients needing more intensive services could be referred to county specialty mental health providers. Conversely, some counties are seeking to link stabilized behavioral health clients with a medical home at a CCHC where a primary care provider can monitor their medication and provide primary care

[*] Forty individuals, mostly behavioral health directors, completed the survey. One survey was completed per health center even if the clinic had multiple sites. Eighty-eight percent of respondents were federally qualified health centers (FQHCs), and 10% were FQHC-lookalikes. Fact sheets created from survey results can be found at www.cpca.org.

services. While some clinics and counties have had success in developing such referral relationships, others have found it more challenging, since in many regions, CCHCs have not been able to establish relationships with county behavioral health services. The disconnect may be due to siloed or inadequate funding, differences in organizational cultures, and lack of understanding of the services provided by each agency.

SUBSTANCE ABUSE SERVICES

The number of individuals eligible for covered substance abuse services will expand dramatically as a result of the ACA, the American Recovery and Reinvestment Act of 2009, and the Mental Health and Addiction Equity Act of 2008.[43] Research has demonstrated that integrated primary care and substance use disorder services are more effective for patients than non-integrated services. Despite this, **little is known about how substance use disorder services should be integrated with primary care and mental health services.[44] A few key studies and reports referenced below are helping to shed light on this topic, but more information is needed**.

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS – SURVEY RESULTS

As was mentioned previously, substance abuse services are not provided at as many CCHCs as mental health services. A nationwide survey conducted by the National Association of Community Health Centers in 2010 described the use of mental health and substance abuse services in FQHCs, and queried respondents about their degree of integration.[45] A total of 420 FQHCs responded -- almost a 40% response rate -- of which 348 FQHCs reported that they provided mental health or substance abuse services onsite (85.6%) or through formal linkages with community-based specialty mental health or substance abuse providers (14.4%). Researchers said the responding health centers were representative of health centers nationwide. The national survey found the following:

- Almost 65% of the responding FQHCs met all of the criteria for **integrated care** (i.e. co-location, good communication and coordination between behavioral health and primary care providers, shared treatment plans and medication lists, and joint decisions by providers on patient treatment.)
- 55% of respondents provided **substance abuse services** at one or more sites, and over 70% provided mental health services.
- **Medically-assisted treatment** (Buprenorphine) for opiate abuse was provided at 15% of responding CCHCs.

- Out of the FQHCs that provided substance abuse services, 54.7% (n=105) offered **structured substance abuse treatment programs onsite**, meaning patients were seen in individual and/or group sessions on a regularly scheduled basis. The remaining 45.3% (n=87)) offered unstructured programs, meaning they allowed patients to obtain services as needed or in conjunction with their medical visits, but not at regularly scheduled times.
- **Substance abuse screening** took place on a regular basis in 62.6% (n=218) of responding FQHCs. The **CAGE questionnaire** (see **sidebar**) was by far the most common screening tool. CAGE is an acronym referring to the four questions that comprise the tool. Depression screening took place at almost 90% of responding FQHCs, most often with the PHQ-2 or PHQ-9.
- 22% of grantees (n=77) reported that medical **staff met regularly** with substance abuse staff to discuss substance abuse cases, whereas 75% (n= 261) did not meet regularly or only did so on an as-needed basis.

The most commonly used substance abuse screening tool: CAGE Questionnaire

The questionnaire asks the following questions:

1. Have you ever felt you needed to **C**ut down on your drinking?
2. Have people **A**nnoyed you by criticizing your drinking?
3. Have you ever felt **G**uilty about drinking?
4. Have you ever felt you needed a drink first thing in the morning (**E**ye-opener) to steady your nerves or to get rid of a hangover?

Two "yes" responses indicate that the possibility of alcoholism should be investigated further.

(Source: Wikipedia)

California Health Center Substance Use Disorder Services

CPCA's 2012 behavioral health integration survey found that most responding clinics providing substance abuse services offered screenings in which a client was asked during their visit about their level of alcohol or other substance use. Some clinics used the Screening, Brief Intervention and Referral to Treatment program to identify patients with substance use disorder (SUD) and referred them to needed services at the clinic or in the community. A small number of clinics had substance abuse counselors onsite, and even fewer offered more intensive treatment such as medication-assisted substance use services or residential services. Some rural CCHCs integrated mental health and substance use disorder services into their systems by adding staff and setting up their own training programs.[46]

A subset of CCHCs have been licensed or certified by the State Department of Health Care Services to provide substance abuse services, such as:[47]

- Axis Community Health Center, Pleasanton, CA
- Native American Health Center, Oakland and San Francisco, CA
- Northern Valley Indian Health, Inc., Chico and Willows, CA
- Wellspace Health (formerly "The Effort") (3 locations), Sacramento
- CommuniCare Health Centers, Yolo County
- San Diego American Indian Health Center, San Diego County

The mental health and substance abuse services are carved out of the state Medi-Cal program and are the responsibility of counties. Both carve-outs create service fragmentation resulting in barriers to services. While some counties have contracted with CCHCs to provide behavioral health services, other counties have kept the function within their own domain. Limited budgets make it difficult for counties to meet the mental health and substance abuse needs of their residents. In some cases, health centers have stepped forward to fill the service gaps by seeking grant funding to pay for substance abuse services and to hire staff with certification in alcohol and other drug treatment.

Two researchers with the **UCLA Integrated Substance Abuse Programs** conducted a study to better understand how well SUD services are integrated with primary care and mental health services in FQHCs. Researchers invited 18 diverse FQHCs representing a full range of integration to participate in the study in order to learn more about their SUD practices, the extent of integration between their SUD services and primary care and mental health, and how services are funded, among other things. Fourteen out of 18 invited FQHCs completed the initial online survey. Researchers followed up with interviews and focus groups.

The study found that only half of the participating FQHCs reported collaboration between SUD and primary care. Again, SUD services were not as well integrated with primary care as mental health services. Only one of the 14 responding clinics had SUD services located in the same building as primary care. No FQHCs provided SUD services on the

A UCLA study of 14 California community clinics found:

- Only half of the participating FQHCs reported collaboration between SUD and primary care.
- SUD services were not as well integrated with primary care as mental health services.
- Only one clinic had SUD services located in the same building as primary care.
- No FQHCs provided SUD services on the same day as a primary care referral, and in most cases it took more than a week for a person to be connected with SUD services.

Source: Urada D & Teruya C. (2012, August). Findings: Integration of substance use disorder treatment with primary care in preparation for Health Care Reform. California Program on Access to Care.

same day as a primary care referral, and in most cases it took more than a week for a person to be connected with SUD services. SUD services were rated as less effective than mental health services, but the difference in effectiveness seemed to be related more to provider training rather than attitudes toward patients with SUD. Reimbursement for SUD services also varied. Eight of the 14 FQHCs included SUD services in their FQHC prospective payment system rate. Other revenue sources were county health sources and federal grants, in addition to self-payment. [48,49]

To better serve the newly insured under the ACA who will access substance abuse services, more information is needed about the scope of SUD services provided at California community clinics beyond the 14 that participated in the UCLA study. Further understanding will be required about staffing structure, reimbursement, community linkages, county relationships, and other characteristics to better inform the field as a whole on best practices. Last but not least, FQHCs will need stable sources of funding that support integrated SUD, primary care and mental health services.

PERSON-CENTERED HEALTH HOME

The movement toward more fully integrated primary care and behavioral health services complements the recent developments in the **person-centered health home** (PCHH) model. This model evolved from the **Joint Principles of the Patient-Centered Medical Home** issued by the American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, and American Osteopathic Association in 2007**.** The key principles of the medical home model continue today. According to the National Committee for Quality Assurance (NCQA), the patient-centered medical home is ***"a model of care that strengthens the clinician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship."***[50] The primary care provider leads a team that takes collective responsibility for the patient's care, providing services at the clinic location or coordinating with specialists and other providers outside the medical home. Part of the purpose of the health home is to coordinate care with other clinicians, such as those specializing in mental health and substance use.

The term *"person-centered health home"* evolved from the term used initially, which was *"patient-centered medical home."* The latter supports a medical model – referencing the term "patient" and "medical" in the definition. The phrase "person-centered health home" is now generally preferred by consumer groups, community clinics, and other organizations recognizing that services are targeted to "persons" not "patients," and that services are provided in a "health home," rather than a "medical home." "Health home" is viewed more broadly to include not only physical health but also to oral and behavioral health. This updated term will be used throughout

the remainder of this paper, though "medical home" continues to be used by recognition agencies such as NCQA.

The Health Resources and Services Administration (HRSA) provided seed money to clinics to develop health home activities. Under the **Patient-Centered Medical/Health Home Initiative,** HRSA released $32 million in ACA funds to 904 clinics nationwide, including 101 in California. Each grantee received $35,000 in FY 2012 for a one-year period to support their efforts to become PCHHs. Funding covered care planning, support for team-based models of service delivery, and system upgrades. Each health center had one year to apply for PCHH recognition through one of three recognition programs (NCQA, Accreditation Association for Ambulatory Health Care, or The Joint Commission) and to pass at least the first level of standards.[51]

NCQA Patient Centered Medical Home Standards Related to Behaviors Affecting Health, Mental Health and Substance Abuse

PCMH 1: Enhance Access and Continuity

- Comprehensive assessment includes depression screening for adolescents and adults

PCMH 3: Plan and Manage Care

- One of three clinically important conditions identified by the practice must be a condition related to unhealthy behaviors (e.g., obesity) or a mental health or substance use condition.

PCMH 5: Track and Coordinate Care

- Track referrals and coordinate care with mental health and substance abuse services.

Source: Standards and Guidelines for NCQA's Patient-Centered Medical Home, 2011 (Rev. 7/29/13), Appendix 2

PCHH recognition agencies have established numerous standards, of which a subset are related to integrated behavioral health. For example, in its 2011 standards (the most recent), NCQA included a requirement for depression screening for all adults and adolescents in the standard on comprehensive health assessments. Standards require applicants to demonstrate that they can *arrange or provide treatment for mental health and substance use disorders*, and that they will provide *referral tracking and follow-up* (see **sidebar**).[52] NCQA has indicated that there will be a greater focus on integrated behavioral health in their next revision, which is anticipated in 2014.[53]

CPCA supports their membership in several ways around PCHH and integrated behavioral health services. For example, CPCA co-developed a **PCHH initiative** with a technical consultant to support health centers in their efforts to achieve PCHH status. Program resources include a web portal, mock survey process, coaching, and other training and technical assistance.

The association has also dedicated resources to researching and making recommendations on how to **reform payment systems** to cover the cost of the added PCHH responsibilities. For

example, some clinic “enabling services,” such as translation, transportation, and health education services, are included in the grants of federally-funded health centers (a subset of California community clinics), but federal grants do not cover the depth of services offered under the health home model, such as case management and care coordination. Additional PCHH expenses incurred by CCHCs include managing each provider's panel of patients, generating quality reports to assure patients receive standard screenings and preventive care measures, and reviewing population health measures, such as which patients have not filled prescriptions for chronic illness. Lack of payment in CCHCs for a primary care and behavioral health visit in the same day also impedes the PCHH model. Inadequate compensation for certain components of the health home model has raised questions about how the model can be sustained in CCHCs in the long term.

The CPCA Behavioral Health Network is working to **facilitate relationships between health centers and counties** in order to better meet population behavioral health needs, and to provide care to individuals in the most appropriate setting. For example, counties provide the bulk of specialty mental health services for the SMI population. CCHCs in general provide more services to those with mild to moderate needs, though many also see individuals with SMI. Some counties would also like to refer persons with SMI whose mental health status is stabilized to CCHCs so the person is linked with a health home. Improvements in clinic/county relationships statewide are needed to facilitate referrals and coordinate care.
The PCHH model will not be successful unless it addresses patients' mental health or substance use issues in addition to their primary care needs.[54] Mental health issues are 2-3 times more likely in patients with chronic medical diseases such as diabetes, arthritis, chronic pain and heart disease. A person's health and well-being will depend upon identifying and addressing all conditions. Numerous studies show that primary care providers can effectively treat depressive disorders in the primary care setting, and more and more studies are showing the same for anxiety and substance use disorders.[55]

Both PCHH and integrated behavioral health services require common elements: provider and staff training; redefinition of staff roles and responsibilities; and the development of collaborations between primary care and behavioral health providers. Integrated behavioral health programs that include core PCHH elements, such as being patient-centered, comprehensive and coordinated, tend to result in the best mental health outcomes. The PCHH model assumes care is delivered in a partnership between providers, patients and their families, an approach that is central to mental health treatment as well. The model emphasizes treating the whole person, and coordinating care with other providers as needed.[56] Integrated behavioral health services are highly compatible with PCHH, and therefore can be expected to continue to develop in this model.

PEER MODELS

Although peer models are used in primary care as well as mental health and substance abuse services, the way in which they are used is very different between the groups. A growing number of CCHCs train and hire consumers to support care delivery through ***promotora*** models in which trusted community members educate individuals and groups about different aspects of primary care or behavioral health. *Promotoras* and community health workers have been used broadly for decades to address a variety of medical conditions and to outreach to populations reluctant to seek services. In addition, consumers play an important role in federally funded health centers, because federal guidelines require 50% plus one of their board of directors to be health center patients. This governance model provides greater opportunity to involve consumers on health center boards and committees in order to convey their perspectives about behavioral health services.

The mental health and substance abuse treatment fields have a unique provider role for **consumers** or **peers** in delivering effective services to client populations. Peer advocates have been a part of the 12-step alcohol and substance use recovery movement for years. Peer specialists are those considered to have *"lived experience,"* and can be individuals diagnosed with mental illness or substance abuse, or their family members. They may also be individuals with similar economic, cultural or social backgrounds that match or establish trust with a population of focus.[57] Unlike *promotoras*, consumers have expertise in a particular condition. **The difference in the use of peers in the medical world compared to the behavioral health world may create confusion, and therefore could be barriers between the two fields until adequate education is provided**. (See the *Peer Models Issue Brief* for more information.)

INTEGRATION INITIATIVES

INTEGRATED BEHAVIORAL HEALTH PROJECT

IBHP is now a team of consultants working for the Tides Center for Care Initiatives (CCI) and the California Mental Health Services Authority (CalMHSA) as part of its Statewide Stigma and Discrimination Reduction Initiative. It is an outgrowth of a project funded by The California Endowment to the Tides Center, called the Integrated Behavioral Health Project, an initiative that funded community clinics and consortia working on developing or enhancing integrated services. The project took place in three phases between 2006 and 2010:

- In **Phase I**, IBHP funded nine demonstration projects -- seven based in primary care clinics and two in regional consortia -- to see what components of integrated care correlate with successful results.
- In **Phase II**, IBHP awarded 16 grants to primary care clinics and clinic consortia to foster innovative projects that not only furthered their own integrated care programs, but offered the possibility of becoming a best practice to be replicated by others. IBHP also awarded 11 "learner grants" to enable the participation of key primary care personnel in the training and information exchange generated in the project learning community and mentoring program.
- In **Phase III**, IBHP funded specialized projects proposed by six clinics and one clinic consortia to study aspects of integrated care that would advance the field.

The IBHP team now serves in a broader statewide role to support integrated services and the reduction of stigma and discrimination. Not only did they conduct the extensive **needs assessment** that forms the basis of this issue brief and others in the series, but IBHP also:

- Maintains a clearinghouse on their website of strategies, tools, research, policy issues and other relevant information to advance the integrated behavioral health field.
- Developed *Partners in Health: Primary Care / Mental Health Collaboration Tool Kit* synthesizing advice, models, forms and other practical material to advance interface between the primary care and mental health systems, which was updated in 2013.
- Collaborates with CiMH and CPCA to build and expand capacity for integrated behavioral health through learning collaboratives, payment reform research and developing recommendations for improving clinical information systems to support integrated care.
- Conducts web-based training in behavioral health integration in collaboration with the Agency for Health Care Research and Quality.

- Facilitates county and regional summits to strengthen relationships and develop networks across health and behavioral health stakeholders committed to advancing integration.
- Profiles CCHCs in California with experience implementing substance use services to share lessons learned with other primary care clinics

Participants in each phase of the initial Integrated Behavioral Health Project are shown in **Figure 4,** and findings from each phase, as well as additional resources, are available on the IBHP website.[58]

Figure 4: Integrated Behavioral Health Project Grantees, Phases I – III, 2006 - 2010

Phase I

Early adopters of integrated behavioral care were selected for Phase I. These "vanguard" primary care clinics and consortia were thought to be more advanced than many others across the state and therefore in a better position to serve as mentors and role models.

Family Health Centers of San Diego
Family Healthcare Network, Visalia
Golden Valley Health Center, Merced
Mendocino Community Health Clinic, Inc., Ukiah
Open Door Community Health Centers, Arcata
Sierra Family Medical Clinic, Nevada City
Social Action Community Health System, San Bernardino
Council of Community Clinics, San Diego
Northern Sierra Rural Health Network, Nevada City

Phase II

The 27 California clinics and clinic consortia receiving Phase II grants from IBHP, including both "Learner Site" and "Development Site" funds, were:

All for Health, Health for All, Glendale
Asian Health Services, Oakland
Asian Pacific Health Care Venture, Los Angeles
Avenal Community Health Center, Avenal
Central City Community Health Center, Los Angeles
Chapa-De Indian Health, Grass Valley
CommuniCare Health Centers, Davis
Community Health Clinic Olé, Napa
Council of Community Clinics, San Diego
Eisner Pediatric & Family Medical Clinic, Los Angeles
Family Health Centers of San Diego, San Diego
Glide, San Francisco
Golden Valley Health Centers, Merced
La Clinica De La Raza, Oakland LifeLong Medical Care, Berkeley
Long Valley Health Center, Laytonville
Mendocino Community Health, Ukiah
North Coast Clinic Networks, Eureka
Open Door Community Health Centers, Arcata
Petaluma Health Center, Petaluma
Ravenswood Family Health Center, East Palo Alto Area
St. John's Well Child and Family Center, Los Angeles
San Francisco Clinic Consortia, San Francisco
Share Our Selves, Costa Mesa
Sierra Family Health Center, Nevada City
South Bay Family Healthcare, Torrance
URDC/Bill Moore Community Health, Pasadena

Phase III

A more select group of clinics/consortia was chosen for Phase III, based on the organization's ability to implement components basic to a person-centered health care home. The Phase III recipients were:

Council of Community Clinics, San Diego
Golden Valley Health Centers, Merced
Hill Country Community Clinic, Shasta
Lifelong Medical Care, Berkeley
Open Door Community Health Centers, Arcata
St. John's Well Child and Family Center, Los Angeles County
Sierra Family Health Center, Nevada City

MENTAL HEALTH SERVICES ACT

The **Mental Health Services Act** provided funding for programs and services to support improved behavioral health in California through the following MHSA components:

- Community Services and Supports (CSS)
- Prevention and Early Intervention (PEI)
- Workforce Education and Training (WET)
- Innovation (INN)

Health centers have been involved in all MHSA components, though less so with WET since much of the emphasis is on academic training programs. Although clinics have received MHSA dollars to operate full service partnerships or particular program areas, there have been inconsistencies across counties regarding their involvement with health centers. CCHCs are most involved in prevention and early intervention services, and many of them seek an expanded role in delivery of those services as they identify young people and families in need of intervention.

Community Services and Supports

Under the CSS program, counties designed programs integrating behavioral health and primary care, and created partnerships (including full-service partnerships) with primary care organizations such as FQHCs and other community clinics. An example of a program involving FQHCs is as follows:

> **Shasta County: Rural Health Initiative**
> The focus of the Rural Health Initiative is to serve severely and persistently mentally ill individuals of all ages that have previously not been able to access mental health services in rural areas. The county contracts with **four FQHCs** in Shasta County to provide integrated primary care and mental health services, such as telepsychiatry, intensive case management, medication management, crisis services and support, and integration with primary care physicians. From July 2011 through March 2012, the FQHCs provided 9,400 services through their contracts with the County Health and Human Services Agency.[59]

Prevention and Early Intervention

MHSA requires 20% of its funds to be dedicated to prevention and early intervention programs that prevent mental illnesses from becoming disabling. Among other things, PEI programs are required to provide outreach to primary health care providers to help patients recognize the

early signs of potentially severe mental illnesses. Programs must provide linkages to medically necessary care as early as possible, and support an "integrated client experience."[60] Examples of programs involving CCHCs are as follows:

Kern County: Project Care

Project Care integrates behavioral health care services in **six FQHCs** and one Kern Medical Center outpatient clinic by providing certain mental health and substance abuse screening and on-site therapeutic services in primary care settings. Each clinic employs psychiatrists, mental health therapists and substance abuse counselors to work as a team led by the primary care provider. A total of 8,352 individuals were screened in FY 2010-11, the first year of Project Care implementation.[61]

Santa Barbara County: Integrating Primary and Mental Health Care in Community Clinics

In this program, medical care, health education, early intervention, nutritional instruction and mental health services are provided in **seven community health centers** (both county-operated and private not-for-profits) in Santa Maria, Lompoc and Santa Barbara. Services include trauma screening, consultation, psychiatric evaluation, counseling, and prescriptions for underserved clinic patients referred by their primary care providers. Some clinics are also implementing the IMPACT program which screens older adults for depression and provides follow-up as needed. A total of 2,765 individuals were served in FY 2010-11.[62]

Marin County: Integrated Behavioral Health in Primary Care

Marin Community Clinics and Coastal Health Alliance have received MHSA funds since July 2009 to provide mental health services in primary care settings, such as routine screening for depression and other behavioral health concerns; a warm hand-off to behavioral health staff when needed; brief interventions for behavioral health concerns; referrals to additional services; collaboration between primary care and behavioral health providers; and consultation for behavioral health staff and primary care providers with a psychiatrist to inform client care. In FY 2012-13, 1,710 clients were screened for behavioral health concerns and 425 received brief interventions.[63]

WORKFORCE EDUCATION AND TRAINING

The goal of the WET component of the MHSA is to *"remedy the shortage of qualified individuals to provide services to address serious mental illness."* [64] This is accomplished through training, stipends, loan assumption and training programs, as well as direct workforce education and training services provided by counties. An example of a training program involving a clinic regional association is provided below.

San Diego County: Integration Institute

The San Diego Integration Institute provides a series of webinars and an annual conference to educate providers on the many different aspects of effective integrated behavioral health services. Funding is provided by MHSA and the County of San Diego through a contract granted to the **Community Clinics Health Network**, a subsidiary of the Council of Community Clinics. The institute conducts an annual integration summit sponsored by the County of San Diego in which over 300 local and regional primary care, mental health and alcohol and other drug service providers convene to discuss best practices and current integration topics. The Integration Institute also conducts one-hour training webcasts targeted to physicians and behavioral health providers. Webcasts are available on-demand on their website.[65]

INNOVATION

Five percent of the total MHSA dollars for each county is allocated for INN work plans,[66] which are defined as *"novel, creative and/or ingenious mental health practices/approaches that contribute to learning."* [67] An example of an INN work plan involving CCHCs is as follows:

Orange County: Integrated Community Services

The Integrated Community Services (ICS) pilot project provides outreach to the medical community to fully integrate primary care and behavioral health services. There are two components to the project: ICS Community Home and ICS County Home. In the ICS Community Home project, a mental health team is brought into **two community health clinics**. The ICS County Home pilot project provides primary medical care services to transition-aged youth, adults, and older adults who have a chronic health problem and are currently receiving behavioral health services at a county clinic. The ICS project began providing services in November 2011, serving 283 individuals in FY 11/12. The projected number to be served in FY 12/13 is 588, and in FY 13/14 is 800.[68]

SAMHSA-HRSA Center for Integrated Health Solutions

The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) promotes the development of integrated primary and behavioral health services in specialty mental health and primary care provider settings such as CCHCs for individuals with mental health and substance use conditions. CIHS is funded jointly by SAMHSA and HRSA. The center provides training, web-based seminars, and technical assistance to community behavioral health organizations, community health centers and other primary care and behavioral health organizations.[69]

In FY 2009, SAMHSA launched the **Primary and Behavioral Health Care Integration** (PBHCI) program to reduce morbidity and mortality among adults with SMI. The PBHCI program established projects to co-locate primary and specialty care medical services in community-based behavioral health settings, thereby improving the physical health of individuals with SMI or co-occurring SMI and substance abuse. Programs track health outcomes for participating clients, and report the data to SAMHSA. To date, the program has rolled out five cohorts comprised of 64 county or county-contracted grantees nationally, of which 63% partnered with an FQHC. **Figure 5** shows the 11 California partnerships.[70] One of those partnerships is described in the **sidebar**.

San Diego County: Mental Health Systems, Inc. and the Council of Community Clinics

The San Diego Primary and Behavioral Health Care Integration Project is administered by Mental Health Systems, Inc. (fiduciary agent) and the Council of Community Clinics (project management). MHS is a county-contracted specialty mental health provider, and the Council of Community Clinics provides support services to FQHCs and other community clinic members. This project consists of two community mental health and FQHC pairings: A south pairing (Community Research Foundation and Imperial Beach Health Center) and a north pairing (Mental Health Systems and Neighborhood Healthcare). For both projects, FQHC staff (RN, NP, and others) are out-stationed at the community mental health center to perform health screening and education, and clients are referred to the FQHC for more extensive medical home services. The program funding period is October 2009 to September 2013. As of September 2012, the program had 900 unduplicated program participants.*

Figure 5: SAMHSA Primary and Behavioral Health Care Integration Project – California Grantees

Grantee	Primary Care Partners	Region
Cohort 1: (Awarded September 2009)		
Mental Health Systems, Inc.	Neighborhood Healthcare, Imperial Beach Health Center	San Diego, CA
Cohort 2: (Awarded September 2010)		
Alameda County Behavioral Health Care Services	Lifelong Medical Care, Tri-City Health Center	Oakland, CA
Cohort 3: (Awarded September 2010)		
Asian Community Mental Health Services	Asian Health Services	Oakland, CA
Glenn County Health Services Agency	Ampla Health, Glenn Medical Center	Orland, CA
San Mateo County Health System	San Mateo Medical Center	San Mateo, CA
Tarzana Treatment Centers, Inc.	N/A	Tarzana, CA
Cohort 4: (Awarded September 2011)		
Catholic Charities of Santa Clara County	San Jose State University Nursing Program, Kaiser Permanente Resident Medical Program	San Jose, CA
San Francisco Department of Public Health	Tom Waddell Health Center	San Francisco, CA
Cohort 5: (Awarded October 2012)		
Didi Hirsch Community Mental Health Center	N/A	California
Monterey County Health Department	N/A	California
Native American Health Center, Inc.	N/A	California

Source: SAMHSA-HRSA Center for Integrated Health Solutions, PBHCI Learning Community, Western Region; retrieved from http://www.integration.samhsa.gov/pbhci-learning-community/Western%20Region

CALIFORNIA INSTITUTE FOR MENTAL HEALTH

California is taking steps to bring the systems of care together to enhance care coordination for safety net populations. The California Institute for Mental Health's (CiMH's) **Care Integration Collaborative** supported stigma and discrimination reduction by bringing stakeholders from six counties together to focus on coordination of care across mental health, substance abuse treatment, and primary care.[71] Another CiMH collaborative, **Strategies for Integrating Health, Prevention, and Community,** works with community health centers to enhance partnerships with community organizations that offer wellness promotion, prevention, and self-management services in order to better support individuals with behavioral health needs.

DATA COLLECTION

As the ACA is implemented, collecting valid and reliable medical and behavioral health data is essential in order to assess each component of the triple aim (outcomes, patient experience and decreased costs). The federal government and private foundations have invested in the CCHC information technology (IT) infrastructure, but accurate and timely data collection and reporting continues to be a work in progress. CCHCs are most experienced in collecting and reporting data that describe their patient population, such as its demographics, primary diagnosis, and payer source; they are still developing ways to measure patient health outcomes, the patient experience, and cost.

Annual CCHC Data Reporting. All California community clinics, whether or not they receive federal funding, report information about their staffing, patient services, expenses and revenues to the **Office of Statewide Health Planning and Development** (OSHPD) in an Annual Utilization Report. FQHCs and FQHC lookalikes also submit the Uniform Data System (UDS) report annually to the **HRSA Bureau of Primary Health Care**. The UDS report requires similar information as the OSHPD report, but it also requires reporting on measures related to quality of care and health outcomes/disparities.[72] In addition, every health center must select one mental health or substance abuse measure to report on annually. A subset of reported data for both agencies are related to the number of visits and patients diagnosed with or receiving mental health and substance abuse services (see **Figure 6**). This descriptive information about the patient population is tracked largely through E.H.R.s, and prior to that, practice management systems.

Figure 6: Mental Health and Substance Abuse Data Reported Annually by California Community Clinics and Health Centers

OSHPD Annual Utilization Report of Primary Care Clinics 2011 (Reported by all California CCHCs)

- FTEs and encounters by primary care provider (psychiatrists, psychologists, LCSWs)
- FTEs and contacts by clinical support staff (MFTs, substance abuse counselors)
- Encounters by principle diagnosis: mental disorders

Bureau of Primary Health Care - Uniform Data System (Reported by Federally Designated Health Centers Only)

- Personnel FTEs, clinic visits and number of patients by provider type (psychiatrists, psychologists, social workers, other licensed mental health providers, other mental health staff, substance abuse providers, and others)
- Number of visits and number of patients with primary diagnosis:
    - Alcohol related disorders
    - Other substance related disorders (excluding tobacco use disorders)
    - Depression and other mood disorders
    - Anxiety disorders including PTSD
    - Attention deficit and disruptive behavior disorders
    - Other mental disorders excluding drug or alcohol dependence
- Number of visits and number of patients for the following service categories:
    - Screening, brief intervention, and referral to treatment (SBIRT)
    - Smoke and tobacco use cessation counseling
- Quality of Care Indicators:
    - Patients queried about tobacco use one or more times in the measurement year or prior year.
    - Tobacco users aged 18 or older who have received cessation advice or medication.
- Financial Costs
    - Mental health services
    - Substance abuse services
- Clinical Performance Measures
    - In addition to reporting on a number of clinical measures, each health center must select one mental health or substance abuse measure.

Quality of care measures. Health centers regularly track and review quality of care measures, either for their UDS reporting, for quality improvement initiatives, or for contracted and grant-funded programs. Some health centers track whether or not patients completed certain screenings, such as the percentage of patients that completed a depression screen on an annual basis. In response to multiple programs requiring tracking and reporting of population health measures or clinical outcomes, CCHCs have employed the use of registries, such as i2iTracks, or have developed home-grown databases and spreadsheets that tend to be project specific. Use of these tools is sporadic and labor intensive; consequently, when project funding ends, health centers are unlikely to be able to finance the staff needed to continue data collection and reporting.

Electronic health records. Within the last couple of years, significant federal funding has enabled most CCHCs to implement E.H.R., which has dramatically improved health centers' abilities to document patient health information, to assure screening and preventive services have been completed, and to easily refer to consult reports. Unfortunately, no single software system can perform individual record tracking, practice management/billing functions, and population management. None of the E.H.R. systems have devised a meaningful and comprehensive way to integrate health and behavioral health information and data. This means that health centers still have to augment E.H.R. with home grown registries or other data collection tools to manage population health.[73]

Mental health data collection. Depression is the most common condition for which health centers collect data. Several simple screening tools are available, such as the PHQ-2, PHQ-9, Duke, SF-12 and MINI, and it is easy for the tool to be administered either through self-administration, i.e. while completing paperwork in the waiting room, or by the primary care provider or the medical assistant before or during the visit in the exam room. Providers are more confident in diagnosing and managing depression than they are other conditions, and research shows a clear tie between reducing depression and improving health outcomes related to chronic diseases such as diabetes and cardiovascular disease. Other behavioral health service delivery data that are collected by some clinics include no-show rates, referrals to community-based and specialty services, provider productivity, treatment plan goals, pain contracts, and patient/provider satisfaction.[74]

Meaningful use. To encourage medical providers (not only clinic providers) to maximize the capability of E.H.R. systems, Medicare and Medicaid have created incentives for physicians to make **"meaningful use"** of their certified E.H.R. with the goal of improving patient care. Medical providers do this by meeting certain objectives. The requirements are staged in three steps with increasingly stringent requirements. Currently, providers need to meet core (required) objectives and menu objectives in which they are able to choose their preferred objectives.

Physicians, psychiatrists and other eligible professionals that show meaningful use can receive up to $44,000 from Medicare or $63,750 from Medicaid.

Although the 2013 standards did not include objectives related to mental health and substance abuse, this will change in 2014 at which time **adults AND children ages 12 and older will need to be screened for clinical depression.** In 2014, the process will change to require eligible providers to report on 9 of 64 approved clinical quality measures. CMS is recommending 9 core measures for practices serving adults and 9 for pediatric practices, but they will allow providers to choose their own (out of a menu of 55) if the recommended measures are not relevant to their organization. Examples of meaningful use requirements are shown in **Figure 7,** with additional detail provided in **Attachment 3**.

Challenges. Advancing integrated behavioral health data systems and measurement is challenging on many levels. Most health centers appreciate the value of collecting behavioral health data, but there is little agreement on the data elements that are most critical to collect, nor the instruments or collection methods that should be used. E.H.R. systems need to be updated to easily incorporate behavioral health data. This would result in fewer health centers needing to create their own registries or databases to track outcomes. If registries continue to be used, then crosswalks will need to be created to easily transfer data from registries to the E.H.R. -- a less desirable scenario.

Adequate funding is needed for system planning and implementation, as well as ongoing technical assistance and modifications. Staff are needed to develop reporting templates, ensure data integrity, and print regular and custom reports. Also needed is buy-in among staff to develop new skills and change clinical and operational practices to collect and report data. Behavioral health staff have not generally played a large role, if any, in E.H.R. and data collection planning processes, so their perspectives about how to improve systems needs to be incorporated into future planning. A lack of consensus on standardized data elements and the role of data collection and reporting in integrated behavioral health is a major barrier to moving the field forward.

Opportunities. Despite the challenges, E.H.R. implementation and recent experiences with the integrated behavior health programs offered through LIHP and the SPD program provide a foundation for future discussions. In addition, health centers implementing PCHH should capitalize on data collection required for their recognition program as well as for their meaningful use activities. Health plans that routinely collect HEDIS and other data may be in a position to take a stronger role in sharing integrated behavioral health data so that providers can benefit from their data collection and computing power. Stronger leadership and strategic thinking on the topic will be needed to continue to advance the field.[75]

Figure 7: 2014 Meaningful Use Clinical Quality Measures Related to Mental Health and Substance Abuse

RECOMMENDED CORE CLINICAL QUALITY MEASURES

9 CQMs for the adult population, including the following:

- Percentage of patients aged 12 years and older screened for **clinical depression** on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.

9 CQMs for the pediatric population, including:

- Percentage of children 6-12 years of age and newly dispensed a medication for **attention-deficit/hyperactivity disorder** (ADHD) who had appropriate follow-up care. Two rates are reported:
  a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase.
  b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.
- Percentage of patients aged 12 years and older screened for **clinical depression** on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.

EXAMPLES OF ALTERNATIVE CLINICAL QUALITY MEASURES (see **Attachment 2)**:

- Percentage of patients 13 years of age and older with a new episode of **alcohol and other drug (AOD) dependence** who received treatment.
- Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of **major depression or dysthymia** who had a suicide risk assessment completed at each visit during the measurement period.
- Percentage of patients 18 years of age and older who were diagnosed with **major depression** and treated with antidepressant medication, and who remained on antidepressant medication treatment.
- Percentage of patients with **depression or bipolar disorder** with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.
- The percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during child's first 6 months, and who had a **maternal depression screening** for the mother at least once between 0 and 6 months of life.

CONCLUSION

CHALLENGES

Challenges impeding the further development of integrated behavioral health services and the corresponding reduction of stigma include lack of knowledge about diagnoses and treatment approaches, lack of treatment resources, inadequate staffing, poor reimbursement and disparate reimbursement systems, lack of data and integrated information technology systems, and policy challenges. Despite the extensive integration training available to the field through webinars and on-demand training libraries, many CCHCs are only beginning to consider how to integrate mental health and perhaps SUD services. Those without federal grants lack access to organized training and funding to support practice transformation. More work is needed related to data collection and reporting, such as agreeing upon data to be collected, putting the necessary information technology support into place, and developing processes to use the data to make practice changes. More cross-system collaboration is needed between health centers, counties, and community-based providers. Developing the workforce to include more care coordinators and consumers to help individuals link with community resources would serve to further reduce stigma and would be beneficial in many other ways. Additional challenges are as follows:

- **Some primary care providers do not feel confident** in addressing mental health and substance abuse issues. They need timely access to psychiatric consults and a strong care team in which different members of the team -- such as LCSWs, MFTs and substance abuse counselors -- lend their expertise and provide services.

- Managing increasingly complex care in fast-paced primary care settings will require new **payment models** to be successful.

- **Some non-federally funded health centers remain outside of federal primary care and integration initiatives** and therefore lack access to funding for infrastructure (such as E.H.R.) and training.

- Critical **shortages within the mental health workforce** also contribute to the need for expanded capacity in primary care to adequately address mental health and substance use disorders. In California there is a shortage of psychiatrists, in particular child and adolescent psychiatrists.

- **Stigma continues to be a barrier**. Health centers need to make use of more peers, consider cultural attitudes toward identifying and seeking behavioral health services, and create seamless systems of care in which persons needing services can easily access

them. CCHCs continue to be a major access point for mental health services because they are culturally competent, so health centers should build upon this strength.

POLICY BARRIERS

Although many CCHCs have been working toward clinical integration of physical, mental health, and substance abuse services, certain federal, state and local policies do not support the model. In California, for example, community clinics cannot bill Medi-Cal for **same day visits** for both primary care and mental health encounters, though they can bill for both a medical and dental visit. Medicaid currently pays for a mental health visit on the same day as a medical visit in FQHCs in 32 states, including Washington, Oregon, Nevada and Arizona.[76] California should follow suit in order to further support integration and improved person-centered services.

In addition, Medi-Cal does not reimburse for **licensed marriage and family therapist** (LMFT) services. Medicaid does reimburse for LMFT services in other states, such as North Carolina, South Carolina, Oklahoma, Tennessee and Washington.[77] Out of over 500 California Medical Service Study Areas (MSSAs),[†] 118 are designated as geographic mental health HPSAs (health professional shortage areas) and 19 as population shortage areas.[78] If LMFTs were reimbursed by Medi-Cal, they could help to alleviate workforce shortages for mental health services.

OPPORTUNITIES

Today there is more support for integrated behavioral health services than ever before. The ACA as well as California's Bridge to Reform activities, such as the LIHP program and services for the SPD population, have all created building blocks upon which to enhance services. One of the greatest benefits of these programs has been to encourage stronger relationships between counties and CCHCs. **MHSA has provided a broad framework for services, and much of its funding has been dedicated to integrated services in clinics.** The **person-centered health home** movement further supports integrated services, and recognition agencies are affirming the value of including behavioral health standards. **E.H.R. implementation** has been essential to the success of PCHH activities. **Meaningful use requirements**, in particular those slated for 2014, require depression screens and offer several alternative measures focusing on mental health and to some degree substance abuse screening and services.

Finally, **the health centers themselves have innate strengths in furthering integration**. The health center movement has valued treating the whole person -- even those who cannot afford

[†] MSSAs are composed of one or more census tracts but do not cross county lines. MSSAs are recognized by HRSA as "rational service areas" for purposes of designating HPSAs, medically underserved areas, and medically underserved populations (MUA/MUPs).

to pay -- since they were established in the early to mid-twentieth century. They are **community-based** and are run by a board with a **consumer majority**. Health centers need to leverage this consumer focus by taking concrete steps to reduce stigma and discrimination, whether personal or institutional, where they may occur. **Regional associations** provide further health center support in some counties and regions, and **CPCA** is engaged in numerous policy and operational activities to support health centers in many arenas, including behavioral health, PCHH, quality initiatives, payment reform, policy/advocacy, and many more. Federal, state and private funders have devoted dollars to different aspects of integrated services. **Training** on mental health and substance use services is available locally, statewide and nationally, and additional training is needed on stigma reduction. **With continued dedication, funding, and policy changes, as well as enhanced county/clinic relationships, CCHCs will make progress on the path to enhanced integrated primary care and behavioral health services as well as stigma reduction, in order to meet the needs of the communities they serve**.

ATTACHMENT 1: KEY INFORMANTS

Key Informant	Position	Organizational Affiliation
County/State Departments		
Rus Billimoria, MD, MPH	Senior Director Medical Management	Los Angeles Care Health Plan
Libby Boyce, LCSW	Homeless Coordinator, Office of the CEO	Los Angeles County Systems Integration Branch
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Key Informant	Position	Organizational Affiliation
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Kathleen Reynolds, MSW	Vice President, Health Integration and Wellness Promotion	National Council for Community Behavioral Health
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Neelam Gupta	Director	Los Angeles Health Action
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Lucien Wulsin, JD	Executive Director	Insure the Uninsured Project
Bobbie Wunsch, MBA	Management Consultant	Pacific Health Consulting Group

ATTACHMENT 2: COMMUNITY CLINIC AND HEALTH CENTER MODELS AND CHARACTERISTICS

CALIFORNIA SAFETY NET CLINICS

- Are defined by their mission to provide health care to individuals regardless of their ability to pay.
- May be operated by for-profit corporations, public agencies, or private, nonprofit organizations.
- Include not only private primary care clinics but also public community-based clinics such as those sponsored by cities, counties and health care districts.
- Focus mainly on providing preventive and primary care, but may also provide specialty and urgent care services depending on community need, funding and licensing limitations.
- Can also be federally designated as federally qualified health centers (FQHCs), FQHC Lookalikes (FQHCLAs) or rural health centers (RHCs) (see below).
- Are required to be licensed by the California Department of Public Health Licensing and Certification division if they are operated by nonprofit organizations, such as federally-funded clinics, free-standing nonprofit rural health clinics, family planning clinics, community clinics and free clinics.

FEDERALLY-DESIGNATED HEALTH CENTERS

HRSA's health center program includes four key primary care programs: the Community Health Center program, the Migrant Health Center program, the Health Care for the Homeless Program, and the Public Housing Primary Care Program. The Health Center Program is guided by Section 330 of the Public Health Service Act (42 U.S.C. §254b).

FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS)

- Receive a HRSA designation based on a national competition and on meeting model requirements.
- Serve Medically Underserved Areas (MUAs) or Medically Underserved Populations (MUPs).
- Are tax exempt public (i.e. county-operated) or private organizations.

- Provide all required primary, preventive and enabling health services and additional health services, such as behavioral health, either directly or through established written arrangements and referrals.
- Offer sliding fee discounts based on a patient's ability to pay.
- Operate under the direction of a governing board with a majority of board members who use the health center and represent the diversity of the individuals being served.
- Meet all performance and accountability requirements for administrative, clinical and financial operations.
- Receive the following benefits:
    - Health Center Program Section 330 grant funding
    - Eligibility to apply for Medicaid FQHC payment methodologies (prospective payment system)
    - Eligibility to apply for Medicare FQHC Payment methodologies
    - Access to 340B drug pricing
    - Eligibility for Federal Tort Claims Act medical malpractice insurance
    - Automatic Health Professional Shortage Area designation.

County-based FQHCs have access to additional grant funding and enhanced reimbursement by Medicare and Medi-Cal. The biggest challenges counties face in obtaining FQHC status are avoiding service area overlap with existing Section 330 grantees, and meeting the strict health center governance requirements.

FQHC LOOKALIKES

- Must meet the same Health Center Program requirements as FQHCs (many of which are mentioned above), but the application process is not competitive and application deadlines are rolling.
- Do not receive the Section 330 funding.
- Enjoy several of the same benefits as FQHCs, including access to enhanced Medicaid and Medicare payment, 340b drug pricing, and an automatic Health Professional Shortage Area designation.

RURAL HEALTH CENTERS

The Rural Health Clinic Services Act of 1977 was enacted to address the lack of supply of physicians in rural areas to serve Medicare and Medicaid patients. The model seeks to provide access to primary care and emergency services in rural communities, and to utilize both physicians and non-physician providers such as nurse practitioners and physician assistants. Like FQHCs, RHCs receive enhanced reimbursement from Medicaid and Medicare based on the cost of providing services. To qualify as an RHC, a clinic must:

- Be located in a non-urban area and in a Health Professional Shortage Area or MUA/MUP.
- Employ or contract with a nurse practitioner, physician assistant, or certified nurse midwife who works at the clinic at least 50% of the time the RHC operates.
- Have arrangements with one or more hospitals to provide services that are not provided at the clinics.
- Not be an FQHC.

RHCs differ from FQHCs in several ways. An RHC:

- Is not required to provide the comprehensive scope of primary care and preventive services.
- May be run by a for-profit or not-for-profit entity.
- Does not receive federal grant funds to support the cost of care for individuals that cannot afford to pay.
- Is not required to offer sliding fee discounts.

INDIAN HEALTH SERVICE CLINICS

- Are public entities such as tribes, and private non-profit organizations, such as tribal corporations, that have an MUA/MUP within their service area.
- Are governed by a community board or operated by an Indian tribe or tribal or Indian organization.
- Provide comprehensive primary care services as well as enabling/supportive services.
- Provide services to all with fees adjusted based upon ability to pay.
- Meet other performance and accountability requirements.
- Can receive FQHC designation and access to enhanced Medicaid and Medicare payment.
- Can receive a HRSA Section 330 operating grant.
- Have access to other HRSA-supported programs, such as the National Health Service Corps and 340b drug pricing.

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ATTACHMENT 3: 2014 MEANINGFUL USE CLINICAL QUALITY MEASURES RELATED TO MENTAL HEALTH OR SUBSTANCE ABUSE

RECOMMENDED CORE CLINICAL QUALITY MEASURES

9 CQMs for the adult population, including the following:

- Percentage of patients aged 18 years and older who were screened for **tobacco use** one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.
- Percentage of patients aged 12 years and older screened for **clinical depression** on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.

9 CQMs for the pediatric population, including:

- Percentage of children 6-12 years of age and newly dispensed a medication for **attention-deficit/hyperactivity disorder** (ADHD) who had appropriate follow-up care. Two rates are reported:
  a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase.
  b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.
- Percentage of patients aged 12 years and older screened for **clinical depression** on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.

ALTERNATIVE CLINICAL QUALITY MEASURES:

- Percentage of patients 13 years of age and older with a new episode of **alcohol and other drug (AOD) dependence** who received the following. Two rates are reported.

  a. Percentage of patients who initiated treatment within 14 days of the diagnosis.

  b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.

- Percentage of patients aged 18 years and older who were screened for **tobacco use** one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

- Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of **major depression or dysthymia** who had a suicide risk assessment completed at each visit during the measurement period.

- Percentage of patients 18 years of age and older who were diagnosed with **major depression** and treated with antidepressant medication, and who remained on antidepressant medication treatment. Two rates are reported.

    a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks).

    b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).

- Percentage of children 6-12 years of age and newly dispensed a medication for **attention-deficit/ hyperactivity disorder (ADHD)** who had appropriate follow-up care. Two rates are reported.

    a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase.

    b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

- Percentage of patients with **depression or bipolar disorder** with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.

- Percentage of patients aged 12 years and older screened for **clinical depression** on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow up plan is documented on the date of the positive screen.

- Adult patients age 18 and older with **major depression or dysthymia** and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.

- Adult patients age 18 and older with the diagnosis of **major depression or dysthymia** who have a PHQ-9 tool administered at least once during a 4 month period in which there was a qualifying visit.
- Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of **major depressive disorder** with an assessment for suicide risk.
- The percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during child's first 6 months, and who had a **maternal depression screening** for the mother at least once between 0 and 6 months of life.
- Percentage of patients, regardless of age, with a diagnosis of **dementia** for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period.

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