An Update on Integrated Behavioral Health Projects in California Counties

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 of the types of integrated behavioral health projects that have been implemented in the past few years by California counties. An emerging body of information suggests that integrated care programs contribute to a reduction of stigma and discrimination experienced by persons with mental health and substance use problems. The Mental Health Services Act provided funding to counties that has resulted in multiple programs and projects that support integrated primary care and behavioral health services, as well as stigma reduction. Examples of those programs are described for each of the MHSA components:

- **Community Supports and Services.** Under the CSS program, many counties designed programs integrating behavioral health and primary care, and created partnerships with primary care organizations such as federally qualified health centers and other community clinics.
- **Prevention and Early Intervention**. An analysis of 485 program descriptions contained in 59 approved PEI plans showed that 86% of counties addressed co-occurring mental health and substance abuse issues as an element of at least one of their PEI programs. In addition, 81% of counties committed to providing PEI services in primary care settings.
- **Workforce Education and Training**. Of the 448 WET programs counties proposed across the state, 24% involved the integration of mental health and physical health, and 44% involved enhancing the workforce with consumers or peers.
- **Innovation**. Nearly one-quarter (24%) of the 91 Innovation plans included a component integrating mental health and physical health services.

While integration initiatives are primarily county-based and often bring together partnerships of counties and community-based organizations, some statewide initiatives are advancing program models in multiple counties. The **California Institute for Mental Health**, **SAMHSA Primary and Behavioral Health Care Integration Program, California Mental Health Management Program** (CalMEND) and the **County Medical Services Program** have all established collaborative integration projects in support of county efforts.

Counties have taken important steps in building the infrastructure for integrated primary care, mental health and substance abuse services, but integrated services are still early in their evolution. Strategies need to continue to be developed, tested, and implemented to better support the coordination and integration of services at the county level, to address the training needs of a changing and growing integrated workforce, and to reduce stigma and discrimination.

INTRODUCTION

The purpose of this issue brief is to provide an update of the types of integrated behavioral health projects that have been implemented in the past few years by California counties. As will be described in more detail, health care reform has provided the framework for advancing patient-centered health homes in which the patient's physical and behavioral health needs are met by a coordinated care team. The Mental Health Services Act (MHSA) provided funding to counties that has resulted in multiple programs and projects that support integrated primary care and behavioral health services. Some of these projects are working to reduce stigma and discrimination experienced by people seeking or receiving mental health or substance abuse services. While integration initiatives are primarily county-based and often bring together partnerships of counties and community-based organizations, some statewide initiatives are advancing program models in multiple counties. This paper describes some of these programs and projects, and identifies strengths and challenges encountered along the way that can inform future activities.

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 is 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**). 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, and 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 treatment services, and other non-profit agencies.

There is wide variation in how county mental health and substance abuse programs are organized,[12] as well as in the services provided and methods of service delivery.[13,14] Thirty-seven of the 58 counties in the state have integrated behavioral health departments responsible for mental health and substance use services.[15] However according to a 2011 report by the Insure the Uninsured Project, county mental health and substance use care often are uncoordinated and separated from primary care services.[16]

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.[17] 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*.[18]

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.

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 serious mental illness, 582,770 will have serious psychological distress and 648,588 will have substance abuse disorder (see **Table 1** above).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.

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.[19]

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.[20] Under this program, counties cover physical as well as certain mental health services for individuals whose conditions meet a medical threshold.[21] 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.

MHSA INTEGRATION PROGRAMS AND PROJECTS

The **Mental Health Services Act** funded programs and services to support improved behavioral health in California through the following MHSA components, which are described in more detail below:

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

The MHSA includes funding for reducing stigma and discrimination experienced by people with mental illness, and it has created a framework for stigma reduction, in part by establishing the 16-member Mental Health Oversight and Accountability Commission (MHOAC) in July 2005. The commission approved an annual allocation of $20 million per year over the first four years to reduce stigma and discrimination. In June 2007 the commission produced a report entitled, *"Eliminating Stigma and Discrimination Against Persons with Mental Health Disabilities: A Project of the California Mental Health Services Act,"* that recommended developing a 10-year strategic plan to guide MHSA activities that reduce stigma. In 2008, the MHOAC requested the California Department of Mental Health (DMH) to develop the strategic plan.[22] In 2009, DMH developed the *"California Strategic Plan on Reducing Mental Health Stigma and Discrimination."* [23] Stakeholders developed over 25 projects based on this plan, such as social marketing to increase public knowledge about stigma, training communities about the importance of including consumers in mental health services, and many other activities **to reduce stigma and to create permanent change in the public perception of mental illness**.[24]

COMMUNITY SERVICES AND SUPPORTS

Under the CSS program, some counties created full-service partnerships in which subcontractors provide a full spectrum of services to the client.[25] Many counties designed programs integrating behavioral health and primary care, and created partnerships (including full-service partnerships) with primary care organizations such as federally qualified health centers (FQHCs) and other community clinics. Examples of CSS programs supporting integration are as follows:

Contra Costa County: Older Adult Systems Development

Two older adult mental health programs funded by CSS that focus on integrated services are IMPACT (Improving Mood – Providing Access to Collaborative Treatment) and Intensive Care Management Teams. **IMPACT** delivers services, in collaboration with primary care clinics, to older adults who are experiencing symptoms of depression. One LCSW staff member located in each region of the county provides services to older adults using problem-solving therapy. The **Intensive Care Management** program is comprised of three multi-disciplinary teams consisting of a psychiatrist, nurse, mental health clinical specialist, and mental health community support worker. Services are provided in the home or community and may include individual therapy, family support, mental health assessments, consultation services, medication monitoring and support, transportation services, and linkages to other necessary resources. During Fiscal Year (FY) 2010-2011, the Intensive Care Management Teams provided services to approximately 160 seniors throughout the county.[26]

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.[27]

Sacramento County: Sierra Elder Wellness Full Service Partnership

The Sierra Elder Wellness Program administered by El Hogar Community Services, Inc., provides specialized geriatric services including psychiatric support, multidisciplinary mental health assessments, treatment, and intensive case management services to persons ages 55 and over with co-occurring mental health, physical health, and/or substance abuse and social service needs. The goals of the program are to improve psychiatric and functional status, increase social supports, decrease isolation, reduce trips to the emergency room and/or hospital, reduce homelessness, and improve overall quality of life. The program serves approximately 150 individuals annually.[28]

Stanislaus County: High Risk Health and Senior Access

The High Risk Health and Senior Access program offers outreach and other services focused on engaging diverse ethnic populations, including those who have mental illness and are 1) homeless or at risk of homelessness; 2) at risk of institutionalization, hospitalization or nursing home care; or 3) frequent users of emergency rooms. The

program serves adults ages 18 and over who have chronic health conditions co-occurring with serious mental illness. Participants have 24/7 access to a service provider, and are able to participate in recovery groups for individuals with co-occurring health and mental health disorders, among other services.[29]

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 must provide outreach to primary health care providers to help patients recognize the early signs of potentially severe mental illnesses. Programs provide linkages to medically necessary care as early as possible, and support an "integrated client experience."[30] A MHOAC analysis of 485 program descriptions contained in 59 approved PEI plans found that 86% of counties addressed co-occurring mental health and substance abuse issues as an element of at least one of their PEI programs. In addition, 81% of counties committed to providing PEI services in primary care settings. Programs in Kern, Santa Barbara and Marin counties are good examples of PEI programs that support integrated services.

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.[31]

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 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.[32]

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.[33]

WORKFORCE EDUCATION AND TRAINING

An overall investment of $210 million in the MHSA Workforce Education and Training (WET) program is being distributed to county mental health departments over a 10-year period between 2008 and 2018. According to the California Social Work Education Center (CalSWEC), the public mental health workforce in the state has been historically underfunded and has lacked the cultural background and linguistic skills to serve an increasingly diverse population.[34] There continue to be unmet needs throughout county mental health programs for providers with cultural and linguistic competencies[35] and/or lived mental health and substance use experience to serve a diverse clientele.[36]

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,"* [37] by increasing employment opportunities in the county mental health system for practitioners from diverse backgrounds, and creating a workforce that includes consumers of behavioral health services and their family members (also known as "persons with lived experience") as paraprofessional service providers.[38,39] This is accomplished through stipends, loan assumption and training programs, as well as direct workforce education and training services provided by counties.

To gain a greater understanding of the degree to which MHSA plans included integrated services, the IBHP team closely reviewed the county WET plans for FYs 2008-09 and 2009-10.[40] They found that of the 448 WET programs counties proposed across the state, 24% (106) involved the **integration of mental health and physical health** and 44% (195) involved **consumers or peers**.[41] A good example of a WET program that supports integration is one that was developed by Sacramento County for psychiatric residents and fellows:

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Sacramento County: Psychiatric Residents and Fellowships
This program was implemented in FY 2011-12 and is being administered by the UC Davis Department of Psychiatry. Interested psychiatric residents and fellows are placed at public/community mental health settings with dedicated supervision to ensure a positive community mental health experience. Additionally, residents, fellows, and other team members receive in-service trainings on wellness and recovery principles, the consumer movement and client culture, and integrated service delivery systems. Targeted activities to promote holistic services while coordinating services with the

primary care needs of consumers are part of this integrated service delivery experience.[42]

The MHSA "*Five-Year Workforce Education and Training Development Plan"* emphasizes stigma reduction through workforce development strategies.[43] This plan is needed in part because some consumers perceive that they are stigmatized as they try to enter the mental health workforce, which may be the result of mental health providers having concerns about the quality of consumers' work.[44] This perception was evidenced in some of the WET plan needs assessments, as consumers reported in focus groups that they felt they needed "credibility" in order to feel like valued participants in the workforce (see **sidebar**).

County WET program strategies that address stigma and discrimination in the workforce faced by people with lived mental illness and substance use experience include:

- Developing a culturally competent workforce
- Developing an ethnically and linguistically diverse workforce that mirrors the clients served
- Developing a workforce that values consumers as service providers
- Providing education, outreach, and awareness of mental illness to reduce stigma within the community and among mental health clients

Consumers' Perspective

"In focus groups and key expert interviews with consumers and family members, participants repeatedly focused on the need to transform the culture of the mental health service system in order to… include consumers and family members as employees of the system.

There was a shared frustration that ***'the stigma of mental health illness permeates all provider/ consumer interactions.'*** Consumers described providers as patronizing, having low expectations of consumers' abilities, exerting minimal effort, and reinforcing learned helplessness and dependency within an unresponsive uncaring system."

Excerpt from County WET Plan

To counter the stigma faced by consumers entering the workforce, counties have instituted a variety of measures in their WET plans, such as:

- Providing system-wide training on the value of consumers in the workforce
- Training mental health partners on consumer perspectives
- Giving consumers the opportunity to provide input as trainings are developed
- Affording leadership opportunities for consumers
- Ensuring consumer representation on committees and workgroups
- Providing opportunities for consumers to make presentations to staff
- Developing career pathways for consumers

In addition to efforts to reduce the stigma related to consumers in the workforce, MHSA plans focused on providing culturally competent services and hiring culturally and linguistically diverse staff within counties.

INNOVATION

Five percent of the total MHSA dollars for each county is allocated for INN work plans,[45] which are defined as *"novel, creative and/or ingenious mental health practices/approaches that contribute to learning."*[46] INN programs may support other MHSA program areas such as PEI and WET. As of March 2011, counties requested approximately $57 million of INN funding, of which $27 million (47%) was dedicated to projects with an integration component.[47] More than 50,000 consumers were targeted for the first year of implementation.[48]

Nearly one-quarter (24%) of the 91 INN plans included a component integrating mental health and physical health services. Of these, more than three-quarters (76.2%) provided for physical health integration with mental health, while about one-quarter (23.8%) blended physical health care with both mental health and alcohol and other drug services. The principal goals of INN work plans with an **integration component** were to:

- Improve the quality of services, including better outcomes (67%)
- Promote interagency collaboration (33%)
- Increase access to services (14%)
- Increase access for underserved groups (9.5%)

Counties indicated they would take various approaches to accomplishing these goals. Half of the work plans indicated the organization would **co-locate** services. Just over one-third (36%) would use **peers, consumers,** or **family members** (paid or volunteer) to deliver support or services. Smaller percentages would establish intervention teams to provide services (23%), implement a new program or treatment modality (14%), or establish a mobile team (e.g., response team, intervention team) (14%).

Further analysis of INN projects indicated counties would use different types of integration models. The highest percentage (27%) planned to use a **bi-directional integration model** in which each partnering entity accepts referrals and provides care. Slightly fewer plans (23%) planned to **co-locate services** in the same office or clinic location. Others described integration occurring within community-based or freestanding agencies with co-location of two or more disciplines (18%). Still other plans described their intention to integrate services by improving care coordination, for example by creating multi-disciplinary teams with regular meetings to coordinate care (18%).

A large percentage of INN work plans with an integration component (41%) included using **consumers** to provide services. More than half (52%) of the work plans emphasized educating consumers for the purpose of professional or personal development, and many of these endorsed peer coaching and mentoring. All INN work plans with an integration component included supportive services (e.g., consumer education, peer coaching/mentoring, linkages to resources, and support groups) to augment the integrative component. Examples of INN work plans supporting integration are as follows:

Los Angeles County: Integrated Clinic Model

Los Angeles County has implemented multiple integration programs with INN funding. One of those programs, the Integrated Clinic Model (ICM), is designed to improve access to services for individuals with physical health, mental health, and co-occurring substance use diagnoses by integrating care within both mental health and primary care provider sites. ICM programs are staffed with multidisciplinary professional teams, specially trained peer counselors, and paraprofessionals. Services provided by ICM programs include recovery-oriented assessments, mental health treatment services, co-occurring substance abuse services, peer counseling and self-help, primary care services, homeless/housing services, care management, wellness activities and outreach.[49]

Madera County: Linkage to Physical Health and Reverse Integration from Mental Health to Physical Health

In this program, a contracted pharmacist and psychiatrist are available to consult with emergency room staff and primary care providers as a way to link mental health and physical health. The program tests whether a pharmacist in the role of care manager can increase integration, and specifically if a pharmacist can transition people with serious mental illness to a health care home in a primary care setting. Program planners anticipated serving 50 individuals in FY 2012/13.[50,51]

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.[52]

Sonoma County: Three-Pronged Integrated Community Health Model
This program adds peers with lived experience of mental health issues to an integrated, multi-disciplinary team with primary care physicians, psychiatrists, nurses, behavioral health clinicians and care managers. Peers help design the program; collaborate with clients to create individual care plans; and develop and deliver a community health education curriculum. The program will test whether consumers with serious mental illness will have improved outcomes as a result of peers being including in the design and delivery of integrated services.[53,54]

OTHER COUNTY INTEGRATION PROGRAMS AND PROJECTS

A 2012 survey conducted by the California Institute for Mental Health (CiMH) indicated that virtually all mental health departments in the 23 responding counties were involved in working on an integration initiative within the organization (96%), as well as in partnership with one or more outside organizations (92%).[55] The degree of integration varied from minimal collaboration (8.3%) to close collaboration in a fully integrated system (12.5%). One-third of respondents indicated they had basic collaboration at a distance, meaning primary care and mental health providers were at separate sites but had periodic communication about shared clients (see **Figure 1**).

More than half of responding counties (54%) reported that their mental health department was utilizing evidence-based approaches for integrated care. **IMPACT** and **SBIRT** (Screening, Brief Intervention, and Referral to Treatment) were the top evidence-based practices used. The vast majority of responding counties (84%) offer **care management** to coordinate clients' care among health care providers. The majority (60%) also reported that their department planned to use **health navigators/*promotores*** to assist clients and family members with accessing health care. One of the challenges in collaborating with other organizations was the inability to share client information. Nearly three-quarters of counties (72.0%) reported that their department did not have a system for sharing client **electronic health information** with integrated care partners.

Figure 1: Integration Partnership Structure, California Counties, 2012

8.3%	**Minimal Collaboration**	Mental health and primary care providers work in separate facilities, have separate systems, and communicate sporadically.
33.3%	**Basic collaboration at a distance**	Primary care and mental health providers have separate systems at separate sites, but engage in periodic communication about shared clients.
16.7%	**Basic collaboration on-site**	Mental health and primary care professionals have separate systems but share the same facility. Proximity allows for more communication, but each provider remains in his or her own professional culture.
16.7%	**Close collaboration in a partly integrated system**	Mental health professionals and primary care providers share the same facility and have some systems in common, such as scheduling appointments or medical records. Physical proximity allows for regular face-to-face communication and there is a sense of being part of a larger team treating shared clients.
12.5%	**Close collaboration in a fully integrated system**	The mental health and primary care providers are part of the same team. Mental health or substance use services are provided in a primary care setting, or primary care services are provided in a mental health or substance use clinic.
12.5%	**(None of the above)**	

Source: California Institute for Mental Health Survey of Counties, 2012 (n = 23 counties)

Examples of county primary care and mental health integration initiatives are shown below. More program descriptions are provided in **Attachment 2,** with a complete summary available on the CiMH website as part of their mapping project.[56]

Los Angeles County: Center for Community Health, Downtown
Center for Community Health (CCH) supports the systematic integration of primary care, dental, mental health, addiction, and chronic disease management programs with a multi-disciplinary approach and emphasis on the needs of the homeless who are multi-diagnosed and are residents of Skid Row.

Humboldt County: Department of Mental Health Branch
The Humboldt County Department of Health and Human Services holds regular meetings with the county's network of FQHCs and rural health centers to discuss opportunities for collaboration. The Mental Health Branch developed processes for communicating with patients' primary care physicians.

San Francisco Department of Public Health: Community Behavioral Health Services
Behavioral health clinical staff have been integrated into all of the San Francisco Department of Public Health primary care clinics. They work as part of the primary care health home team to screen and provide brief interventions for mental health and substance abuse issues, making referrals to the specialty behavioral health system as needed.

MULTI-COUNTY INTEGRATION INITIATIVES

CIMH LEARNING COLLABORATIVES

The California Institute for Mental Health was established in 1993 to support and enhance mental health services through training, technical assistance, research and policy development. Over the last several years, CiMH has supported MHSA implementation by serving as a clearinghouse for MHSA plans and updates, and providing training and technical assistance to counties. In addition, CiMH has implemented multiple statewide programs to further integration in the public mental health system.[57] With funding from the Department of Health Care Services, they currently sponsor three **learning collaboratives** for promising practices in health integration in partnership with county mental health agencies and other organizations:[58]

- The **Care Integration Collaborative** brings together representatives from the local Medi-Cal health plan, primary care, specialty mental health, and substance use disorder treatment in six counties: Los Angeles, Merced, Napa, Nevada, Orange, and Riverside. The county teams are testing changes that will improve the health status for their shared clients, including those living with co-occurring serious mental illness and/or substance use disorders, as well as chronic disease. The one-year program began in January 2012.[59]

- The **Small County Care Integration** collaborative concentrates on increasing the capacity of mental health providers to identify and monitor physical health and to connect clients with primary care. Eleven teams consisting of mental health care staff and clients from small counties worked to achieve improved health for individuals with serious mental illness. Mental health agencies now work more closely with primary care after changing and improving systems of communication, collaboration, and coordination. The pilot took place from January 2012 to February 2013.[60]

- **Strategies for Integrating Health, Prevention, and Community** works with community health centers serving low-income ethnically and racially diverse populations in Sacramento County that have or are at risk for co-occurring mental and physical health problems. The collaborative supports participants in developing effective partnerships

with community organizations that offer wellness promotion, prevention, and self-management services. This collaborative started in approximately January 2012.

SAMHSA Primary and Behavioral Health Care Integration Program

In FY 2009, SAMHSA launched the Primary and Behavioral Health Care Integration (PBHCI) program to reduce morbidity and mortality among adults with serious mental illness. 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 county or county-contracted grantees, including 10 in California (see **Figure 2**).[61] Descriptions of sample programs are as follows:

San Diego County: Mental Health Systems, Inc.
The San Diego PBHCI project is administered by Mental Health Systems, Inc. (fiduciary agent) and the Council of Community Clinics (project management). Mental Health Systems, Inc. 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.[62]

San Mateo County: Behavioral Health and Recovery Services
This program offers embedded care coordination and wellness services with FQHC staff co-located in behavioral health clinics. Clients receive a total wellness assessment from nurses or health educators. As part of the program they receive care coordination, individual coaching on various health topics, wellness action plans, and the option to participate in a variety of groups focusing on topics such as smoking cessation, weight management, nutrition, and diabetes. Staff monitor clients through weekly team meetings and informal huddles.[63]

Figure 2: 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

CalMEND Integration of Mental Health and Primary Care Learning Collaborative

The California Mental Health Care Management Program (CalMEND),[64] funded by MHSA,[*] was established as a quality improvement project to promote wellness and recovery for individuals with mental illness. CalMEND administered the *Integration of Mental Health and Primary Care Learning Collaborative*, the goal of which was *"to improve the health outcomes of those with serious mental illness and co-occurring chronic medical disorders through effective partnerships between mental health and primary care providers."*[65] The learning collaborative implemented an 18-month pilot in which partnerships were developed between mental health and primary care organizations in six counties (see **sidebar**) to improve the health of the population with serious mental illness through regular screening and treatment of health risks and conditions, care management, care coordination, and self-management support. County teams then measured the impact of their practice innovations, and shared experiences across teams in order to improve care delivery overall. Among the key findings:

- Engaged and sustained leadership at the highest level is essential whether integration is taking place within one organization or it bridges two organizations with very different operations and cultures.

- It was extremely difficult to identify shared clients between organizations, though this was essential for coordinating and integrating care. In addition, teams faced significant barriers to sharing the client's clinical information, including lab results and medication lists. Solving the problem of health information exchange while complying with confidentiality requirements will be essential to integrating services between partnering organizations.

CalMEND's Integration of Mental Health and Primary Care Learning Collaborative 2010

Pilot Counties

Contra Costa County in partnership with the Contra Costa Health Plan

Orange County in partnership with CalOPTIMA and Asian Health Center, a private FQHC look-alike clinic

Placer County within the county between Mental Health and the Placer County Community Clinic located in Auburn

Sacramento County within the county between its primary care and mental health divisions

San Mateo County between the Health Services Department's Behavioral Health and Recovery Services and the San Mateo Medical Center-Family Health Clinics in partnership with the Health Plan of San Mateo

Shasta County in partnership with Hill Country Community Clinic, an FQHC serving persons in Central and Eastern Shasta County

[*] The project was funded with the state's administrative allocation of MHSA funds.

- Strong teamwork between the client, mental health provider, and primary care provider is essential and may require a shared care plan, workflow redesign (i.e. warm handoffs), and strong care management.

CMSP Behavioral Health Pilot Project

Over the past few years, 15 of the 35 **County Medical Services Program (**CMSP) counties participated in the **Behavioral Health Pilot Project**, an innovative integration model in small, primarily rural counties across California.[66] After finding that the lack of coverage for behavioral health treatment might negatively impact the health of CMSP members, the CMSP Governing Board initiated the behavioral health pilot project to assess the impact of providing integrated mental health and primary care services on health, utilization and cost.[67] The program reimbursed pilot sites for providing an additional set of behavioral health services and allowed for reimbursement on the same day as a primary care visit. The program took place between March 2008 and February 2011 at 14 primary care provider sites, primarily community clinics (see **Figure 3).** Evaluators concluded that the project improved coordination between primary care and behavioral health, increased the use of appropriate services, and decreased hospitalizations and emergency room use.[68]

Figure 3: Funded CMSP Behavioral Health Pilot Sites by Region

Region	Lead Agency (Grantee)	Other Sites
Coastal North	Open Door Community Health Centers	Del Norte Community Health Center Eureka Community Health Center Humboldt Open Door Clinic North Country Clinic
	Redwoods Rural Health Center	
Bay Area	Community Health Clinic Ole	
	Petaluma Health Center	Southwest Community Health Center West County Health Centers, Inc.
	Sonoma Valley Community Health Center	
Central Valley North	Del Norte Clinics, Inc.	Chico Family Health Center Del Norte Family Health Center Lindhurst Family Health Center Oroville Family Health Center Richland Family Center
	Shasta Consortium of Community Health Centers	Hill Country Community Clinic Shasta Community Health Center Shingletown Medical Center
	Tehama County Health Services Agency	Corning Medical Associates, Inc.
Mountain North	McCloud Healthcare Clinic, LLC	
	Chapa-De Indian Health Program, Inc.	
	Sierra Family Medical Clinic, Inc.	Western Sierra Medical Clinic, Inc. Miners Community Clinic, Inc.
Mountain South	El Dorado County Community Health Center	
	Southern Mono Healthcare District	Mammoth Hospital
	Sonora Regional Medical Center	

Source: Lewin Group. (2011, February 17). Evaluation of the CMSP Behavioral Health Pilot Project.

CONCLUSION

California counties are well positioned to build upon their early integrated primary care and behavioral health programs and expand their reach as health care reform is implemented. The ACA will result in increased access to physical and behavioral health services for individuals who were previously uninsured and therefore could not afford services. The California Bridge to Reform 1115 Medicaid waiver accelerated integrated care tenets in its transition of SPDs from fee-for-service to mandatory Medicaid managed care, and in the Low Income Health Program, which covers primary care and mental health services.

Counties have used MHSA dollars to develop and implement integrated behavioral health projects, often times in partnership with community-based organizations such as community clinics. In many cases, this was the first time counties had the resources to reach out to FQHCs and community clinics. The resulting partnerships have been beneficial to clients and have created the foundation for deeper relationships between counties and primary care providers. The variety of MHSA integration activities points to the many ways in which integration can be accomplished, and will ultimately create a statewide body of knowledge regarding models, approaches, and lessons learned.

Additional county **strengths** and **opportunities** related to integrated primary care and behavioral health services are as follows:

- As has been demonstrated in this report, many counties have embarked upon integrated service programs. The CiMH study showed that 30% of responding counties had close collaboration in a partly integrated system, meaning they had the same facility and had some systems in common, or had close collaboration in a fully integrated system, meaning mental health and primary care providers were part of the same team.

- To effectively deliver integrated, culturally appropriate, linguistically diverse, and stigma-free services, there are opportunities for employing a workforce with lived experience and from diverse backgrounds. Integrated care and the use of peer providers promote more efficient and effective use of the limited mental health workforce.[69]

- Since the CiMH survey found that virtually all responding counties had at least one integration initiative, counties have the capacity to build upon these early efforts by expanding their reach. Counties could take the lead in partnering with community organizations to discuss options for future collaborations in which coordinated physical and behavioral health services are offered.

- As health care reform is implemented, partnerships developed between counties, community clinics, and other community-based providers will create the opportunity to coordinate care as more people become insured. SAMHSA's Primary Care and Behavioral Health Care Integration program, CalMEND's Integration of Mental Health and Primary Care Learning Collaborative, and the CMSP Behavioral Health Pilot Project, have all laid the groundwork for expanded partnerships and increased services to individuals living in their counties.

Although California has begun to address the need to integrate mental health and primary care, many challenges and obstacles must be overcome before successful integration can occur. As shown during implementation of the Bridge to Reform 1115 Medicaid Waiver, operationalizing integrated services and care coordination can be challenging since new administrative systems need to be put into place, staff need to be trained, and health plan members need to be educated about how to access their new benefits. These challenges will be compounded as 5.4 million previously uninsured Californians gain health coverage and begin to access their primary care, mental health and substance use benefits. Additional **challenges** are as follows:

- **Although county collaborations on integrated care are taking place, it is mostly at the lower levels of collaboration.** The CiMH study reported that 70% of responding counties were in the lower end of the collaboration scale, meaning they had minimal collaboration, basic collaboration at a distance, basic collaboration on-site, or no collaboration at all. County integrated care programs need to advance in their level of integration so closer collaboration takes place in partly or fully integrated systems.

- **Considerable structural, functional, financial, and information/data sharing barriers impede effective integration in California counties.**[70] Enhanced connections are needed between county mental health and substance use services, and for stronger partnerships between behavioral health and primary care, including with FQHCs. These connections will depend on the ability to share health information.[71] Currently, sharing information about the same patient within a county system -- for example between mental health and substance abuse services -- can be challenging. This challenge is even greater when two different systems such as a county behavioral health department and a community clinic attempt to share information about a patient, for example when a county provides behavioral health services and the community clinic provides primary care. Confidentiality requirements create actual or perceived barriers to sharing information.

- **Counties and community-based organizations need to learn how to communicate, collaborate, and build trust in order to apply limited resources to treating the communities they jointly serve**. Sometimes the gap between county and private

provider service cultures creates a barrier to more effective partnerships. Individuals using services in one of these systems are usually not familiar with the type of care offered in the other system and therefore tend not to cross over, even if there would be value in doing so.

- **Stigma and discrimination manifest themselves in many ways, and these barriers will need to be eliminated or significantly reduced in order for clients to gain access to comprehensive care**. Stigma needs to be eliminated not only toward patients and clients with mental health or substance abuse service needs, but also across professional groups, such as between primary care providers and behavioral health providers.

- **The workforce needs to be developed to increase the capacity for providing integrated services.** Currently, there are notable knowledge and skills gaps for providers and staff working in integrated care. More training is needed at all workforce levels. In addition, the pipeline of new workers needs to be trained so they are better prepared to work in integrated care settings. Workforce competencies need to be developed and put into place so that as integration activities advance across the state, a standardized approach will promote consistencies in service delivery based on lessons learned from various pilots, projects and initiatives. Furthermore, although California is trending towards the meaningful inclusion of consumers in the workplace (e.g., as providers or trainers), the need remains to recruit, train, and employ mental health providers with lived experience from diverse backgrounds.

- **WET allocations may not be adequate for all counties**. In many cases, such as in small counties that will receive only $450,000 for 10 years, funding may not be sufficient to make significant impact on the workforce. Since WET funding is scheduled to end in 2018, programs need to share strategies and to evaluate emerging and evidence-based practices.[72] Additionally, counties need to develop alternate funding streams to sustain their efforts once WET funding concludes.

Stigma and discrimination manifest themselves in many ways, and these barriers will need to be eliminated or significantly reduced in order for clients to gain access to comprehensive care. Stigma needs to be eliminated not only toward patients and clients with mental health or substance abuse service needs, but also across professional groups, such as between primary care providers and behavioral health providers.

In summary, counties have taken important steps in building the infrastructure for integrated primary care, mental health and substance abuse services, but integrated services are still early in their evolution. Health care reform and MHSA have spurred integrated behavioral health activities and have created needed funding streams. Many county-community partnerships have been developed as a result of state and federal funding initiatives. Unfortunately, counties tend to be on the lower levels of integration partnerships, in part due to the lack of information systems and other infrastructure needed to support true collaboration. Major differences in the county and community organizational cultures create barriers to integrated services. Stigma and discrimination permeate public and private sectors not only toward clients but also between providers. **The workforce, including the pipeline of new workers, needs extensive training, not only to reduce stigma and discrimination, but also to operationalize close collaboration in fully integrated systems**.

Counties that have started down the path of integrated services should share lessons learned with those who are just beginning. Full integration will take time, but some counties have embarked upon the journey and are developing stronger partnerships both internally and with community-based organizations. Strategies need to continue to be developed, tested, and implemented to better support the coordination and integration of mental health, alcohol and drug programs, and primary care services at the county level, to address the training needs of a changing and growing integrated workforce, and to reduce stigma and discrimination.

ATTACHMENT 1: KEY INFORMANTS

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County/State Departments		
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ATTACHMENT 2: ADDITIONAL EXAMPLES OF COUNTY INTEGRATION INITIATIVES

Calaveras County: Behavioral Health Services
Calaveras County Behavioral Health Services (CCBHS) is in the beginning stages of health care integration. Initial efforts include psychiatric nurse coordination between CCBHS and primary care clinics, embedded CCBHS interns in a local non-profit clinic, and consultation services provided by CCBHS's psychiatrist. (Information updated on CiMH website,12/2011)

Napa County: Health and Human Services Agency
Community Health Clinic Ole, the only local FQHC, has embedded a health care clinic on the site of the Napa County Health and Human Services Agency HHSA to primarily serve clients with mental health needs or substance use disorder. The county is working to share clinical information, create shared client plans, and reconcile medications. (6/2012)

Placer County: Adult System of Care
The Placer County Adult System of Care provides integrated behavioral health and social services, and it coordinates closely with the Placer Community Clinic to transition clients from specialty mental health and substance use disorder treatment to primary care. Placer Community Clinic has a psychiatrist and behavioral health unit that is focused on whole health treatment for all clients. The Children's System of Care provides integrated behavioral health, social services, education, and probation services governed through an interdepartmental MOU.

San Benito County: Behavioral Health
San Benito County Behavioral Health (SBCBH) co-locates staff who serve as liaisons between the San Benito Health Foundation (an FQHC) and the county operated behavioral health programs. The partnership with the health center has resulted in improved access to behavioral health services, especially for the monolingual Spanish speaking Latino population. (4/2012)

San Joaquin County: Behavioral Health Services
San Joaquin County BHS is involved in bi-directional integration efforts with partner agencies, FQHCs and the Health Plan of San Joaquin. They provide behavioral health services in a primary care setting, including psychiatric consultation. They recently embedded a physician assistance in Older Adult Services to provide targeted medical care for behavior health clients who have diabetes. (4/2012)

Source: California Institute for Mental Health website, California Primary Care and Mental Health Integration Initiatives located at http://www.cimh.org/Initiatives/Primary-Care-BH-Integration.aspx. Follow the link to the mapping project: https://sites.google.com/site/cacountyintegrationinitiatives/

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