



Environmental Scan: Integrated Physical and Behavioral Health Programs in San Diego County

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1. Environmental Scan Interviewees
2. County of San Diego, Health and Human Services Agency, Behavioral and Physical Health Integration: The San Diego Vision, July 1, 2011
3. Physical and Behavioral Health Coordination of Care Guidelines, Healthy San Diego
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5. County Integration Support Documents
 - a. County Mental Health and Primary Care Pairings by Region
 - b. Pairing of Primary Care and Mental Health Clinic Guidelines
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INTRODUCTION

On the landscape of integrated physical and behavioral health care in San Diego County, the number and variety of programs for low income and uninsured populations are greater than they have ever been. Funding from public and private sources has spurred collaboration in new ways. Today it seems that virtually all physical and behavioral health care providers recognize the importance of integrated care. The conversation has now shifted to how best to achieve it, or progress toward it. Not only does the approach require adequate funding and reimbursement, but it mandates a change in the way both physical and behavioral health providers have done their work over the course of decades.

What is integrated care? The definition varies considerably, depending on who is describing it. The American Psychological Association offers a comprehensive definition (see text box), but so do many other organizations and experts. One of the most detailed descriptions of the continuum of integration describes three levels of care: coordinated, co-located, and integrated (Collins et al., 2010). With coordinated care, the primary care physician (PCP) screens for behavioral health problems and develops a referral relationship between primary care and behavioral health, which may be located on- or off-site. With co-located care, medical and behavioral health services are located in the same facility and enhanced communication takes place between the providers. In integrated care there is one treatment plan for the individual that includes both medical and behavioral components. Care teams are organized around meeting the physical and behavioral health needs of the person (Collins et al., 2010).¹

¹ Collins, C., Hewson, D. L., Munger, R., & Wade, T. (2010). *Evolving Models of Behavioral Health Integration in Primary Care*. New York: Millbank Memorial Fund.

WHAT IS INTEGRATION?

"Integration is characterized by a high degree of collaboration among the various health professionals serving patients in terms of assessment, treatment planning, treatment implementation, and outcome evaluation."

~ The American Psychological Association's
Presidential Task Force on Integrated Health Care

The County of San Diego's Behavioral Health Services Division within the Health and Human Services Agency has been instrumental in promoting integrated services. Their leadership has shown a commitment to integrated care in numerous ways. Partial funding from the Mental Health Services Act passed in 2004 has been directed to programs that promote integration. Recent planning documents at the Agency and Division levels emphasize the importance of integrated services for patients. They have convened regional collaboratives to bring stakeholder organizations together to improve communication and coordination. County-contracted specialty mental health providers such as Mental Health Services, Inc., and Community Research Foundation continue to work toward better integration. CRF, for example, has a history of contracting with mobile health units to provide physical care for clients with serious mental illness (see text box on next page.)

Community clinic and health center leadership, with the support of the Council of Community Clinics (CCC) and its subsidiary, the Community Clinics Health Network (CCHN), have also taken significant steps to support integrated care. Community clinics and health centers (CCHCs) are implementing new models of care, and they are joining conversations at the state and national level to learn more about best practices and lessons learned. They are advocating for policy changes to support integrated care, such as Medicaid reimbursement for same day visits. They are providing numerous training opportunities to increase provider willingness and capacity to provide integrated care.

ONGOING C.R.F. PROGRAMS TO IMPROVE THE PHYSICAL HEALTH OF ITS CLIENTS WITH SERIOUS MENTAL ILLNESS, INCLUDING YEAR STARTED:

- Family Health Centers of San Diego Mobile Medical Unit at CRF Downtown Impact (2006)
- Imperial Beach Health Center dedicated appointments (2008)
- St. Vincent's Mobile Medical Unit at New Vistas Crisis Center (2009)
- Family Health Centers of San Diego Mobile Medical Unit at South Region locations (2009)

- Pilot programs have been developed to improve the physical health of individuals with serious mental illness who are seen in County-contracted specialty mental health programs.
- Programs are in development to make psychiatry consults available on demand to CCHC providers through telephone or electronic consults.

The purpose of this environmental scan is to describe a sampling of efforts throughout San Diego County that increase the level of physical and behavioral health integration. This report is by no means definitive of all programs, but rather provides examples of programs in a number of arenas. It will describe 1) the County's vision and activities; 2) CCHC activities; 3) CCC/CCHN initiatives; and 4) detailed model programs and success stories from County-contracted specialty mental health providers and CCHCs. Several leaders and program directors generously shared their time and expertise as they described key aspects of their programs as well as lessons learned along the way (see Attachment 1, Interviewees).

In San Diego County, some models of care that support the continuum of integration are as follows:

- CCHCs are working on providing more integrated care through the use of behavioral health specialists to support primary care providers while they are seeing patients, or the IMPACT program for patients with depression.
- CCHCs are contracting with other organizations to provide services at their sites such as traditional mental health services, integrated behavioral health services using a behavioral health specialist, or psychiatry services via telemedicine.
- Referral relationships have been formalized between CCHCs and County-contracted specialty mental health programs so that services are matched to the individual's needs and stable clients can be stepped down to primary care settings for continued maintenance of care.

COUNTY OF SAN DIEGO

VISION

The County of San Diego's Health and Human Services Agency documented the county's vision for healthy communities in their summary entitled, "Health Strategy Agenda: Building Better Health," dated July 13, 2010. They created a 10-year Health Strategy Agenda to encourage and support healthy communities. The first two activities under the first objective of the first goal are below. The timeframe for these activities are FY 13-14 through FY 15-16.

- Integrate physical health, behavioral health, and social services into a patient-centered medical home, so that quality of care is enhanced and provided more efficiently for high-need, high-cost people.
- Reduce stigma associated with seeking and obtaining mental health counseling and substance abuse treatment so people can obtain needed care.

While the Health Strategy Agenda provides the overall framework for achieving the county vision over the next 10 years, the County Behavioral Health Services (BHS) division within HHS created a document entitled, "Behavioral and Physical Health Integration: The San Diego Vision," (Attachment 2) which details their approach to integration. Their goal is:

- To reduce the 25-year mortality disparity for individuals with SMI and improve the health of the community at large by creating virtual person-centered medical homes via behavioral and physical health integration.

Their approach promotes community partnerships where individuals can be served in the setting that is most appropriate for their needs, and where BHS and primary care providers have shared ownership of the safety net population and its behavioral health care needs. Individuals needing behavioral health services would move seamlessly between specialty mental health providers and primary care providers as their condition becomes more stable and as primary care providers become more comfortable meeting patients' ongoing needs.

THE BEHAVIORAL HEALTH SERVICES DIVISION SERVES:

Approximately 61,000 clients per year for mental health

- 18,000 children/transition-age youth (30% uninsured)
- 43,000 adults and older adults (50% uninsured)

12,000 clients per year in Alcohol and Drug Services

The vast majority of services are provided through contracted organizational providers.

MENTAL HEALTH SERVICES ACT

The Mental Health Services Act (MHSA) was passed by California voters in 2004 to tax Californians earning more than \$1 million per year to use toward expanding mental health services. In partnership with the community, County BHS has funded numerous programs through these funds in five main areas:

- Community Supports and Services (CSS)
- Prevention and Early Intervention (PEI)
- Innovations
- Workforce Education and Training
- Capital Facilities and Technology

Among the many programs funded by MHSA, the county allocated funding to community clinics and health centers to provide mental health services to patients with serious mental illness (SMI) or severe emotional disturbance (SED). The funding was also used to implement the IMPACT program at community health centers, and to utilize senior promotor programs to reach out to seniors in the community needing mental health services. Numerous other programs were funded and they are described in some detail in the document entitled, "San Diego County Behavioral Health Services MHSA Report: Update on Five Years of MHSA Transformation," which is available on the county website.

HEALTH COVERAGE ENVIRONMENT

MCE/LIHP IMPLEMENTATION

The Low Income Health Program (LIHP) supports integrated primary care and behavioral health care services to some degree. Implemented in July 2011, LIHP serves medically indigent individuals at or below 133 percent of the federal poverty level, and provides them with a patient-centered medical home. As required by the state, the program covers primary care as well as limited mental health services, including 12 outpatient encounters per year (with prior authorization), medication, and psychiatry visits for those with serious mental illness. LIHP also requires the patient's medical home to have a care coordinator to coordinate care between all providers, including mental health providers. Participating community clinics, which are those that had previous CMS contracts with the County, cover the cost of the care coordinator outside of the program reimbursement rate. Unlike some counties, San Diego County maintained mental health services as part of the network of care for this program rather than carving it out, which will further encourage coordination and communication. Just over 20,000 patients will be served per year under the Medicaid Expansion (MCE) portion of this program through 2014, and some existing Health Care Coverage Initiative patients receiving care for diabetes and hypertension will also be included under the LIHP umbrella.

HEALTHY SAN DIEGO - MEDI-CAL MANAGED CARE

In July of 1998 the State Department of Health Care Services contractually carved out specialty mental health from Medi-Cal managed care resulting in no care coordination at the health plan level. Despite a movement over the years to encourage coordination between physical and mental health providers, coordination is minimal at best. The Healthy San Diego Behavioral Health Work Team developed a coordinated care form and conveying basic information to behavioral health providers to help address the problem (see Attachments 3-4 for guidelines and form), though it is not widely used. The lack of coordination and communication was magnified as approximately 35,000 seniors and persons with disabilities receiving Medi-Cal only were required to begin enrolling in a Medi-Cal managed care plan effective June 2011. It is assumed that approximately 40% of seniors and persons with disabilities have a serious mental illness. Coordination of care will be essential to meet the needs of this population.

COUNTY COLLABORATIVES

Four collaboratives sponsored by the County BHS are taking place throughout the county to bring together County-contracted specialty mental health programs, primary care providers, hospitals, drug and alcohol service providers, crisis residential facilities, clubhouses, and others who are interested in better integrating services for mutual consumers. The four collaboratives along with the date they began are as follows:

- North County Collaborative (February 2010)
- East County Collaborative (April 2010)
- South County Collaborative (May 2010)
- Central/North Central Collaborative (October 2010)

The purpose of the bimonthly meetings is to provide a forum for networking and learning about each other's programs. In doing so, participants hope that referrals between agencies will be improved so that the consumer experiences more seamless care. These collaboratives provide a forum to encourage communication, talk about concerns, and increase the level of trust between individuals and agencies.

In addition, the collaboratives are forming "pairings" with a focus on developing processes for referring clients in specialty mental health settings to primary care clinics (see Attachment 5a for a list of pairings). Guidelines on steps to take to create the pairing, such as identifying referral protocols as well as establishing a contact person at both sites, are detailed in Attachment 5b. Clients who are stable (see Attachment 5c for definition), i.e. they have had a stable psychotropic medication regimen for at least six months, among other criteria, would be referred to the primary care clinic for continued care. The North County Collaborative took the guidelines a step further and developed a North County Referral Decision Tree to aid in making the decision of whether or not to refer a client (see Attachment 5d). A referral form was developed to aid in the transition of clients countywide (see Attachment 5e).

COMMUNITY CLINICS AND HEALTH CENTERS

OVERVIEW OF BEHAVIORAL HEALTH SERVICES

Community clinics and health centers (CCHCs) address mental health services in a variety of ways. A primary care physician may prescribe medication for mild to moderate depression, or some other mental health issue that they are comfortable addressing. Some clinics, such as Neighborhood Healthcare and San Diego Family Care, have developed integrated behavioral health programs in which a behavioral health specialist such as a psychologist or LCSW support one or more primary care physicians by joining them to see the patient in the exam room for an assessment, and following up with short 15-30 minute interventions. In other cases, a physician will refer a patient to an in-house counseling department where traditional therapy is offered by licensed mental health providers or interns who are in graduate social work or psychology programs at local universities. At least one clinic contracts with a community mental health agency to provide services to their patients. Some clinics, especially those in outlying areas, are using telepsychiatry to link patients with psychiatry services, or to provide consults to primary care physicians. Patients needing higher level services, such as those with serious mental illness, are referred to County-contracted specialty mental health programs. CCHCs are also working with County-contracted specialty mental health programs on how to accept stable patients with serious mental illness who could be cared for in a primary care setting.

CCHCs have made progress in addressing multiple mental health issues (depression, anxiety, bipolar disorder) that are presented by patients, whether through primary care or through dedicated mental health services. In addition, clinics help patients who have depression associated with chronic diseases such as diabetes and asthma; women with post-partum depression; clients with depression and other disorders associated with HIV and AIDS; and immigrant clients with post-traumatic stress disorder. CCC member clinics strive to meet the diverse needs of the populations they serve. Providers are specially trained in the behaviors, attitudes and policies that recognize, respect and value the uniqueness of individuals of various ethnic and racial groups. A list of community clinics and the mental health services they provide can be found in Attachment 6.

EXAMPLES OF CCHC PROGRAMS

NEIGHBORHOOD HEALTHCARE

Neighborhood Healthcare (NHCare) offers counseling services, integrated behavioral care services, and a variety of other services to help patients address behavioral health concerns. Services for patients with serious mental illness are offered at two locations in Escondido, and the IMPACT model (described in more detail below) is being implemented in Escondido. Integrated behavioral health is offered at three locations in Escondido and one in El Cajon in which a behavioral health specialist is located in the primary care setting, allowing for immediate behavioral health assessment and intervention for patients during their primary care visit. The medical director of behavioral health services is double-boarded in family medicine and psychiatry and has led efforts in integrated behavioral health. He provides both physical and behavioral health services to his patients, and has just begun providing telepsychiatry services to the El Cajon site. Telepsychiatry is also offered at the Temecula clinic. Additional staff include licensed mental health professionals and graduate student interns. NHCare's goal is to implement integrated behavioral health care services at all sites. NHCare provides physical health care for patients with serious mental illness at Mental Health Services, Inc., North Inland Mental Health Center, as well as at their Grand Avenue location. (This pilot will be described in more detail later in the report.)

LESSONS LEARNED: An organization has to commit to the concept of providing behavioral health services, even if the program doesn't support itself financially for a few years. The behavioralist's primary customer is the PCP and their role is to relieve the workload of the physician. The behavioralist must be available for a warm handoff. He or she needs to be willing to be interrupted and easily accessible to PCPs. Using interns is a cost effective way of filling the role of behavioral health specialist, but the "right fit" of the provider and intern is key. It is important for behavioral health consultants to have colleagues (other licensed staff) to support them and to use for consults as needed. Since NHCare implemented integrated behavioral health, physician productivity and satisfaction have both increased.

SAN DIEGO FAMILY CARE

LINDA VISTA HEALTH CARE CENTER (LVHCC) AND MID-CITY COMMUNITY CLINIC (MCCC)

San Diego Family Care offers traditional counseling services to its clients, as well as behavioral health consulting services which are provided in partnership with PCPs. Psychologists spend time in medical departments to collaborate with physicians and meet with patients in pediatrics, ob-gyn, and primary care departments.

One doctoral level psychologist/behavioral health specialist spends about half of his time seeing children and their parents in the pediatric department at MCCC. He screens patients in the exam room before, during and/or after the visit. Physicians are glad to have his assistance, and at times both he and the physician will assess a patient together. A physician will make a warm handoff when needed. About 70% of his time is unscheduled so he is available as needed, and the other 30% of his time is scheduled for follow-up visits. Most of his time is spent on short-term interventions and involve teaching concerned mothers or fathers about new parenting skills or advising them how to manage a child with behavioral challenges. Patients needing further counseling are scheduled for a "psy-med" visit in their counseling department. Progress notes are added to the electronic health record by the behavioral health specialist, so physicians have easy access to the notes as well. The psychologist sees 10-15 parents or children per day, and has recently expanded services to the LVHCC location. He offers occasional trainings to primary care physicians on integrated behavioral health.

A second psychologist was recently hired to provide behavioral health support to physicians in prenatal and adult service areas. In the prenatal area, all pregnant women receive a behavioral health screening, and those needing services are sent to the psychologist for a brief visit in the ob-gyn department. If longer-term behavioral health services are needed, the patient is referred to the counseling department. Relationships between the physicians and psychologist are strong.

Integrated behavioral health services are still in the early stages in adult medicine. Most referrals are urgent, such as patients who are in domestic violence situations, are hurting themselves, or are suicidal. About 80% of the patients the psychologist sees are in crisis. She links them with community resources or refers them to the counseling department. Because this role is new in the adult medicine department, the psychologist is still building trust with the physicians. She sees patients needing mental health services as well as hypertension, pain management, chronic headaches, GI disorders, smoking cessation, substance abuse, and numerous other conditions. Additional referrals are anticipated.

LESSONS LEARNED: A physician champion is essential to success. Not all clinicians are open to working with a psychologist/behavioral health consultant in the clinic. This is a very different model than what they are used to. The clinic is a fast-paced environment with patients and family members going in and out relatively quickly. Behavioral health consultants need to be experienced and preferably bilingual in Spanish. The types of conditions they see are usually complicated and they need to make decisions very quickly.

MENTAL HEALTH AND PRIMARY CARE INTEGRATION PROJECT

Nine of the CCC member clinic organizations are participating in the Mental Health and Primary Care Integration Project, funded with MHSA dollars through the County of San Diego, and managed by CCHN, a subsidiary of the CCC (see Attachment 7). The three components to this program are specialty pool services for patients with SMI or SED, IMPACT depression care services, and senior peer promotora services. Implementation began in early 2007 and continues to the present.

SERVICES TO PATIENTS WITH SMI OR SED

All participating clinics provide therapy and medication management services for up to one year to clients with SMI or SED who are unfunded for mental health services and have a social security number.

A psychiatrist does an assessment and provides medication management. Therapy is provided by a psychologist, MFT, LCSW, or interns. A maximum of 24 visits are allowed for children and youth, including family therapy when needed. Additional medication visits are also allowed. Adults and older adults are allowed a maximum of 12 visits, including medication visits. The cost of medications are covered for up to 90 days from issuance of first prescription, and then the patient is referred to pharmacy assistance program (PAPs) for longer term medication needs. After one year of services, those needing additional treatment/services are transitioned to traditional County-contracted specialty mental health providers.

"The [SPS and IMPACT] programs achieved the goal of reaching patients with mental health needs in primary care settings who may not otherwise seek out or receive care in the specialty mental health system." ~ UCSD School of Medicine report, p. iii

IMPACT

IMPACT (Improving Mood - Promoting Access Collaborative Care Treatment) is currently being implemented at seven health centers. It is an evidence-based practice for the treatment of depression which has been well researched. Findings suggest that IMPACT is twice as effective as usual care for treatment of depression in primary care. Patients meeting a certain score threshold on the nine questions of the Patient Health Questionnaire (PHQ-9) are eligible for services. A depression care manager (DCM) treats the patient using behavioral activation, problem-solving therapy, and pleasant activity scheduling, combined with medication management by a PCP. The PHQ-9 is completed at every visit to measure changes in the depression score. Clients are eligible for up to 16 visits with the DCM and up to 4 visits with a PCP to prescribe and monitor medication. A consulting psychiatrist works with each DCM to monitor treatment response and make treatment suggestions when indicated. Treatment and medication for each enrolled patient is available for up to one year.

DEPRESSION CARE MANAGER RESPONSIBILITIES:

- Educate the patient about depression
- Support antidepressant therapy and behavioral changes prescribed by the patient's primary care provider
- Coach patients in behavioral activation and pleasant events scheduling
- Provide problem solving therapy
- Offer brief counseling sessions
- Monitor depression symptoms for treatment response
- Complete a relapse prevention plan with each patient who has improved

SENIOR PEER PROMOTORA PROGRAM COMPONENT

The senior peer promotora program component provides outreach, education and engagement activities to assist older adults and their families to access mental health and primary care services and stay in treatment. The promotora component is specifically designed for older adults who are:

- Less likely to seek services on their own
- Less likely to identify their symptoms as depression
- More likely to isolate
- More likely to commit suicide

Senior peer promotoras also provide peer counseling and support, social service referrals, advocacy, and transportation referrals or resources for isolated and hard to reach older adults. Services include client and family/caregiver information, education and advocacy on how to navigate the mental health system, and peer support to help them through difficult times.

PROMOTORA RESPONSIBILITIES:

- Provide outreach and engagement to older adults and link them with mental health services and other resources.
- Provide culturally and age-sensitive outreach, engagement, education, peer counseling and support, social service referrals and other services for older adults.
- Arrange transportation for seniors and family/caregivers through vouchers, taxi services, contracted van services or other means.
- Refer older adults to nearby clinics for SMI or IMPACT program services.

LESSONS LEARNED

A number of lessons learned were identified in focus groups conducted by David Sommerfeld and colleagues at the UCSD School of Medicine and reported in the document entitled, "San Diego County Mental Health in Primary Care Integration Evaluation - Final Report," dated October 13, 2010. For example:

- For the SPS and IMPACT programs to operate smoothly, the numerous persons involved in direct services and administrative support need to be trained so they know how to appropriately schedule, provide, record, track, and/or bill for the treatment services.
- Depression care managers and promotoras worked with patients with complex needs. They had to help patients obtain food, employment, shelter and safety. These needs had to be addressed before starting depression care.
- There is a challenge to provide care for patients who have completed the SPS and IMPACT programs but still have ongoing needs for mental health services or medication.

Program staff observed the following about using the IMPACT model with the low-income, culturally diverse community clinic population:

- Before talking about treating depression, DCMs often need to educate clients about what it is they are suffering from. Some in the Latino culture manifest symptoms differently and may assume all issues are physical.
- Sometimes it is necessary to explain the meaning of some of the questions on the PHQ 9 screening tool.
- Typically the DCM will encourage the client to develop his or her own solutions. However, because the cultural norm is to defer to the "expert," the DCM may need to provide suggestions.
- The problem solving worksheet is sometimes a challenge with this population as it is hard for client to pick one problem to focus on.
- Often it is necessary to provide education about parenting due to role confusion and culture clashes.
- The notion of having fun can be foreign to some clients as they don't realize they are entitled to have fun, so the notion of pleasant activities can be foreign.

COUNCIL OF COMMUNITY CLINICS/ COMMUNITY CLINICS HEALTH NETWORK

INTEGRATED BEHAVIORAL HEALTH PROJECT (IBHP)

The CCC participated in the Integrated Behavioral Health Project, which was developed by the Tides Center with funding from The California Endowment. IBHP took place from 2006 - 2010. The purpose of the project was to promote integration of behavioral health services into primary care settings. Its goals were to:

- Increase access to behavioral health services;
- Reduce stigma associated with seeking treatment;
- Improve treatment outcomes; and
- Strengthen linkages between mental health and primary care.

Phase I of IBHP involved the selection of seven primary care clinics and two clinic consortia, including the CCC, to receive grants as demonstration sites. Subsequent years focused on providing technical assistance to clinics to increase intra-clinic integration. Funding was used to study each organization's operations and to track services and outcomes. Participating in this project was especially valuable because it gave participants access to subject matter experts in the field of integrated behavioral health. It sparked conversation among CEOs and medical directors about how to create more integrated services within their own clinics.

INTEGRATION INSTITUTE

CCHN has a contract with County BHS to implement the Integration Institute over a 26-month period of time, which began on May 1, 2011. The overall purpose is to develop, implement, and evaluate an Integration Institute to promote the vision of shared population management of behavioral health and physical health illness through working relationships of paired behavioral health (BH) and primary care (PC) organizations. The goal of the Institute is to support BH and PC providers to enhance intra-organization integration and in achieving integration between PC and BH service organizations, including alcohol and other drugs services. The Integration Institute encourages organizations and providers to lead change at the provider, program, and system levels in order to

reduce barriers and increase integration. Over the 2 year project, it is anticipated that three learning communities will be established with 2-3 BH/PC pairings established per learning community. CCC will also develop an integration toolkit including protocols and standards for pairings, education resources, and peer recovery practices. Materials and lessons learned will be disseminated statewide as part of this project.

DATA SHARING PROJECT

In recognition of the importance of sharing health information data in order to be truly integrated, the CCHN supported County BHS' application to the State Department of Mental Health related to information technology. The submission proposed to utilize up to \$1,000,000 in MHSA funding to link behavioral health data with primary care health information to build an integrated community health record for clients seen at community health centers and county contracted behavioral health programs. If approved, the project will be piloted between the County MIS system and 2-3 community health centers. County BHS is currently engaging in its own IT strategic planning process. Once they complete their planning they will be in a better position to decide how best to expend any funds for data sharing.

TRAINING

A robust training schedule was developed for members of the CCHN on various topics in support of integrated behavioral health based upon input from the clinics. Experts from the local area as well as from around the state and nation have conducted webinars over the past two years. These webinars can be accessed on-demand by CCHN members. Webinars were funded by the County of San Diego.

(For a listing of webinars, please see next page.)

COMMUNITY CLINICS HEALTH NETWORK/CCC
ON-DEMAND WEBCASTS FOR MEMBERS

2011

[Eating Disorders Webinar](#)

PRESENTED BY: WALTER KAYE, MD (AUGUST 10, 2011)

[Assessment and Treatment of Perinatal Depression](#)

PRESENTED BY: KATIE HIRST, MD (MAY 11, 2011)

[Bipolar Disorder; Detection, Management and Referral](#)

PRESENTED BY: RYAN SHACKELFORD, MD (MAY 3, 2011)

[Treating Personality Disorders in Primary Care](#)

PRESENTED BY: GABRIEL RODARTE, MD (APRIL 27, 2011)

[Cultural Competency: Pan-Asian Communities](#)

PRESENTED BY: DIXIE GALAPON, PHD (APRIL 20, 2011)

[Complex Medication Management in Primary Care](#)

PRESENTED BY: GABRIEL RODARTE, MD (MARCH 23, 2011)

[Treating Adolescent Depression in Primary Care](#)

PRESENTED BY: BRETT JOHNSON, MD (MARCH 17, 2011)

[Treating ADHD in Primary Care](#)

PRESENTED BY: BRETT JOHNSON, MD (JANUARY 26, 2011)

2010

[Treating Anxiety in Primary Care](#)

PRESENTED BY: NICOLE LANOUILLE, MD (DECEMBER 16, 2010)

[Treating Depression in Primary Care](#)

PRESENTED BY: RYAN SHACKELFORD, MD (NOVEMBER 18, 2010)

[Risk Management for Narcotic Prescribing](#)

PRESENTED BY: MARK WALLACE, MD (NOVEMBER 4, 2010)

[An Introduction and Overview of Mental Illnesses and Symptoms](#)

PRESENTED BY: RYAN SHACKELFORD, MD (OCTOBER 13, 2010)

[Part II: Latino Cultural Competence](#)

PRESENTED BY: JAMES "DIEGO" ROGERS, PSYD (JUNE 2, 2010)

[Use of Psychotropic Medications with Children](#)

PRESENTED BY: BRETT JOHNSON, MD (APRIL 28, 2010)

[Part I: Overview Cultural Competence](#)

PRESENTED BY: JAMES "DIEGO" ROGERS, PSYD (APRIL 28, 2010)

<http://www.cchealthnetwork.com/about/cchn-events-calendar/on-demand-webcasts.aspx>

MODEL PROGRAMS

INTEGRATED CARE RESOURCES (ICARE)

PARTNERS:

- Community Research Foundation (CRF)-Areta Crowell Site
- Family Health Centers of San Diego (FHCS D)
 - Logan Heights Family Health Center
 - North Park Family Health Center
 - City Heights Family Health Center

DESCRIPTION: The purpose of this program is to improve access to primary care for CRF clients with serious mental illness, and to step down stable patients with SMI to a health center where a primary care physician continues their care.

ICARE is an integration demonstration pilot that began in January 2011. When fully staffed, an RN care coordinator will be implanted in the specialty mental health team at CRF to provide health assessments to CRF clients and link them with more comprehensive health care at FHCS D. Stable patients are referred to FHCS D where a primary care provider continues to manage their physical and mental health care.

FUNDING: January 2011 - June 2013. The program is funded by the County of San Diego's MHS A Innovations funding. FHCS D receives a per member per month payment from the County for patients transitioned to FHCS D care.

TARGET POPULATION: Adults ages 18 and over with serious mental illness; at least 50% must be uninsured. The goal is for 300 stable SMI patients to be treated entirely by primary care physicians; and 300 clients remaining at CRF to have coordinated care with a PCP.

PARTNERSHIP DEVELOPMENT: This program builds upon the success these two organizations have had working together since February 2010 when they established a relationship to support transfer of stable patients to FHCS D for continued mental health services in a primary care setting. Over 50 clients had been successfully referred to FHCS D prior to the start of the ICARE program. The two organizations already had weekly communication meetings in place. To strengthen the relationships between providers, CRF provided training to

physician champions about how best to support their transitioning clients. CRF leadership staff are also part of project steering committee meetings. Program directors received site tours.

START-UP: The organizations signed an MOU on the referral and treatment process based on their earlier project. Tenant improvements were made at CRF to incorporate a private exam room for the nurse to use to see patients. FHCS D created office space at their Gateway administrative site for the project manager, and a work area for peer support staff to use when they were not in clinics.

KEY STAFF: In addition to the 1.0 FTE RN care coordinator, staff include a .75 FTE manager, 1.0 FTE drug and alcohol specialist shared by both organizations, 1.5 FTE peer support positions, 1.0 FTE eligibility specialist and 1.0 FTE data entry clerk. The budget includes release time so physician champions can meet quarterly.

REFERRAL PROCESS: The CRF discharge planner works with the client to determine which of the three primary care sites is the best match, and works with that site coordinator to transfer care. FHCS D staff make a notation in the schedule and give priority to these clients.

MEDICAL RECORD: The CRF client signs a release of information and CRF sends a copy of the medical record to FHCS D. FHCS D has a shared medical record for both physical and mental health. E.H.R. will be fully implemented by early 2013 which will further facilitate communication.

TRAINING: Key FHCS D staff, including the manager, completed the University of Massachusetts Certificate Program in Primary Care Behavioral Health. Peer support staff completed the Recovery Innovations of California (RICA) training, a peer-run non-profit based in San Diego. All therapists and the manager completed at least a few modules of the RICA training.

STRENGTHS: The organizations trust and respect each other based on their history of working together. Both organizations are large, have a long history in the community, and have a strong infrastructure.

CHALLENGES: There have been challenges historically within the behavioral health system and some CRF staff to resist transitioning stable clients, in this case to FHCSO, since in some cases these are long term relationships that are very positive. Some clients have resisted the change because they are satisfied with the current arrangement. Some receiving primary care providers have been reticent because their practices are already busy and they do not feel as well-versed in psychotropic medications as they would like to be.

LESSONS LEARNED: Strong leadership is essential to supporting change. Physician champions at each of the three FHCSO sites have been critical to supporting PCPs during the transition.

SUCCESS STORY: BECOMING MORE HOPEFUL

Kevin had a fulfilling and successful career. Unfortunately, after experiencing family- and work-related stressors, he began feeling depressed. Having lost his job, his symptoms were exacerbated, which made it even more difficult for him to deal with physical and mental health issues. For example, it had been 4-5 yrs since his last physical exam. Now, under the ICARE project, Kevin attended his first doctor's appointment and has scheduled a follow-up appointment. He has been linked to the ICARE peer support specialist and she is assisting him with resources. During his last visit, Kevin said he is preparing himself for the workforce. He seems more hopeful.

SAN DIEGO PRIMARY AND BEHAVIORAL HEALTHCARE INTEGRATION PROJECT (SD-PBHCI)

The Substance Abuse and Mental Health Services Administration (SAMHSA) initially awarded \$25.9 million over four years for primary and behavioral health care integration programs to address the needs of people with serious mental illnesses. San Diego Mental Health Systems, Inc. (MHS) and the CCC were one of 13 nationwide recipients to be awarded the \$500,000 annual grant in Phase 1. Since then, additional awards have been made throughout the U.S.

PARTNERS:

North Pairing:

- Mental Health Systems, Inc. - North Inland Mental Health Center (NIMHC)
- Neighborhood Healthcare (NHCare)

South Pairing:

- Community Research Foundation - Maria Sardiñas Wellness & Recovery Center (CRF)
- Imperial Beach Health Center (IBHC)

DESCRIPTION: The purpose of this project is to improve the health of persons with SMI in mental health settings by linking participating County-contracted specialty mental health program clients to a medical home in a federally qualified health center (FQHC). A nurse care manager (RN) provided by the FQHC is placed in the specialty mental health setting. To assess basic health, the nurse care manager provides a standard screening four times per year and draws blood for lab tests annually. In the North Pairing the nurse practitioner provides some treatment services on-site at NIMHC, and some at NHCare. In the South Pairing all treatment is provided at IBHC. Primary care goals are incorporated into mental health treatment plans. For both pairings, some clients at the MH agency have one-on-one wellness visits resulting in individualized wellness plans, and group wellness programming is offered to all.

Additional program objectives include 1) designing and implementing wellness programs and client engagement strategies to help persons with SMI to improve their health status; 2) developing and implementing strategies to connect mental health and primary care information to improve health status and provider decision-making; and 3) developing long-term data sharing strategies for electronically sharing data between mental health agencies and FQHCs which will enable providers to access more comprehensive, reliable, and accurate information on individuals with SMI.

FUNDING: The funding period is October 2009 to September 2013.

TARGET POPULATION: The goal is to serve 1,050 unduplicated individuals over the 4-year project. As of June 2011, 612 individuals have been enrolled and screened by the SD-PBHCI project.

PARTNERSHIP DEVELOPMENT: MHS is the fiduciary agent and the CCC is responsible for project management. MHS holds MOUs with all partners, and NIMHC and NHCare have their own more detailed MOU. Both pairings have had a history of working together, and in the case of the South Pairing the relationship goes back to 2004 when CRF outstationed mental health staff to IBHC to provide screening, assessment, and linkage to services. Since being funded, the CCC convenes meetings with each pairing on monthly basis and with both pairings combined quarterly. In the North Pairing the NIMHC Program Manager has attended one of NHCare's monthly PCP lunch meetings. MHS and CRF have done presentations for clinic providers.

START-UP: Pairings worked closely together to operationalize the program. Staff were hired and trained. NIMHC created an exam room out of a large storage room. CRF has an exam room next to the psychiatrist's office.

SUCCESS STORY: EXERCISE, DIET AND WEIGHT LOSS!

S.A. is a 50-year-old female that suffers from hyperlipidemia, hypertension and lower joint pain. After a follow-up with the provider and working with the wellness coordinator over the past 3 months, S.A. has gone from a sedentary lifestyle to walking at least 4 days per week, as well as some dramatic changes to her diet. As a result, S.A. has lost 20 pounds in 3 months and reports that she is feeling "great"!

KEY STAFF: *North Pairing:* At the NIMHC location, NHCare employs a 0.20 NP, 1.0 Nurse Care Manager, and 0.50 Wellness Coordinator. The NP also sees NIMHC patients at NHCare - Grand Avenue through other funding. NIMHC employs a .25 Case Manager. CCC employs a 0.40 Data Clerk who works at the NIMHC location. *South Pairing:* IBHC dedicated a portion of their funding to cover physician services at their site to see CRF patients. At CRF, IBHC also employs a 1.0 nurse care manager, .50 wellness coordinator, and a part-time case manager/data clerk.

REFERRAL PROCESS AND SERVICES: *North Pairing:* Any clinician, mental health nurse or psychiatrist can refer a patient to the program. A referral form is completed for interested NIMHC clients who are willing and able to participate in the program. The referral form is forwarded by the NIMHC nurse to the on-site NHCare nurse care manager. An individual is considered fully enrolled when they have completed the SD-PBHCI enrollment form, informed consent, and authorization to release and disclose protected health information.

South Pairing: Referrals are made by the case managers and psychiatrist. The IBHC onsite nurse care manager screens patients at CRF, and links them to IBHC for primary care services. The case manager is available to transport clients to IBHC to eliminate any transportation barriers that could arise.

MEDICAL RECORD: *North Pairing:* Since NHCare implemented E.H.R. (eClinicalWorks), NHCare staff placed at NIMHC have access to the NIMHC client records. All NHCare data is tracked in their E.H.R. NP notes and lab results are printed and placed in the NIMHC records. *South Pairing:* The CRF case manager makes copies of a portion of the CRF medical record including the medication list and the last MD note to place into the IBHC chart. Medical services provided at the mental health agency are captured on a paper encounter form and submitted to Imperial Beach Health Center's billing staff to be entered into the practice management system. I2iTracks is being used to track all clinical related information on a client, such as lab results and vitals.

TRAINING: The CCC offers at least three trainings per year to educate primary care and mental health staff on strategies to effectively work with and support program participants to make behavioral /lifestyle changes to improve their physical health.

SUCCESS STORY: IMPROVED HEALTH OUTCOME MEASURES

E.V. is a 31 year old male that suffers from hypertension, hyperlipidemia and type 2 diabetes. E.V.'s initial blood work revealed an A1c value of 8.4, well above the normal limit of 4.8-5.6. By working with the provider and case manager, the appropriate medication was prescribed and funded through the Patient Assistance Program and has helped in reducing E.V.'s A1c to 5.8.

SUCCESS STORY: A MAGNIFICENT TRANSFORMATION!

M.C. is a 62-year-old female with major depressive disorder, elevated blood glucose, hypertension, and chronic shoulder pain. Her psychiatrist stated that "the client is taking charge of doing things that are good for her and that she is aware of the positive choices that she is making in her life." The client had shared information that she learned in the nutrition class with her psychiatrist. She regularly attends the project's Stretch Fit class. She reports feeling better, experiencing less shoulder pain, and feeling more motivated. The psychiatrist said he has never seen a more magnificent transformation in a person!

STRENGTHS: The relationships between pairings overall is very positive, and care is better coordinated. The NIMHC staff can do a warm handoff to the nurse care manager, which results in more patients obtaining health care. NHCare - Grand Avenue is a good site for follow-up physical health services because it is smaller than other sites and very personable.

CHALLENGES: There is a perception that mental health programs are "dumping" uninsured patients who cannot afford to pay for services onto FQHCs. Over half of the SD-PBHCI program participants are uninsured for physical health care. This makes provision of health care for uninsured SD-PBHCI program participants difficult, though LIHP funding will help.

The program faces additional challenges. The program is making strides to engage all of the clinical providers who will see patients in this program. The uptake of group wellness programming still remains lower than anticipated. Additional information sharing is needed between the nurse care manager at the mental health site, and the primary care provider about services. Because computer software is incompatible, there is a lot of printing of hard copy information to place into the other organization's medical record, which at times becomes too voluminous. Some mental health providers have been somewhat resistant to adding physical health goals (i.e. to quit smoking or lose weight) into the chart since they view wellness goals as outside of their scope of practice.

LESSONS LEARNED: Physician champions are absolutely essential in order for this program to work. Uninsured patients need a source of funding since they cannot afford care. Continuing to refer unfunded patients will result in a sense of resentment from the receiving clinic, and could degrade partnerships.

SMARTCARE

PARTNERS:

- Vista Hill
- North County Health Services - Ramona Health Center
- Neighborhood Healthcare - Pauma Valley
- Mountain Health and Community Services - Mountain Empire Family Medicine (Campo)

DESCRIPTION: In the SmartCare program, a team of Vista Hill consultants, educators and therapists work hand-in-hand with health center physicians and staff to provide behavioral health screening, evaluation, education and short term counseling to patients in rural areas. Program psychiatrists are available to PCPs via teleconferencing to consult on issues of diagnosis and psychotropic medications. Qualifying patients can be evaluated by a psychiatrist via telemedicine. Program staff conduct community educational forums and presentations to improve health and to encourage people needing services to seek care early.

FUNDING: 1/1/10 to 12/31/15. Wellness activities and events started in March 2010 and behavioral health integration services began in May 2010. The program is funded by MHSa PEI Innovations funding.

TARGET POPULATION: The target population is patients of all ages at rural health clinics. As of June 2011, a total of 661 patients (533 adults and 128 children/adolescents) were screened and received additional SmartCare services such as behavioral health education and/or case management services. A total of 16 patients have received care under CSS funding for uncomplicated serious mental illness through primary care visits. An additional 1,150 health center patients were screened but did not need a mental health referral or declined services. Psychiatric consultations have been provided for 168 patients.

PARTNERSHIP: Vista Hill had established linkages in the North Inland community through the Vista Hill Learning Assistance Center (VHLAC), which offers school- and home-based assessment and mental health interventions for students at risk of out-of-home placement. The County of San Diego's request for proposals spurred additional partnerships that led to SmartCare. The SmartCare program manager meets 1-2 times monthly with the clinic managers, and as needed with

clinic health providers, to ensure continued successful integration. Staff members meet weekly to address policies and procedures and all other administrative issues.

START-UP: SmartCare staff and clinic providers worked together to clarify screening and referral processes. A new T1 line was installed at NHCare - Pauma Valley to assure adequate connectivity since SmartCare staff members enter all screening and assessment data into Vista Hill's Internet Based metrics system.

KEY STAFF: The project is supported by 3 FTE MFTs, 1 FTE LCSW, 7 FTE behavioral health educators who are bachelors level providers and represent the members of the communities they serve, and a 0.25 FTE psychiatrist (three individuals with two bilingual/bicultural in Spanish). Administratively, the program supports a 1.0 FTE program manager, and a 1.0 FTE Administrative Assistant.

REFERRAL PROCESS: The patient is given the SmartCare Integrated Behavioral Health Care screening tool at intake (see Attachment 8). This tool is based on the tool called My Mood Monitor (M3), which is a three-minute assessment for anxiety, depression, PTSD and bipolar disorder. An MA or nurse reviews the form and notifies the provider if the score is high. The physician recommends the treatment plan. The role of the SmartCare staff is to support that plan. The PCP prescribes any needed medication, and consults with the program psychiatrist if needed.

MEDICAL RECORD: One example of clinic integration is that NCHS credentials the Vista Hill mental health providers and gives them access to their E.H.R. SmartCare staff use the secure NCHS email system which makes it easy to update providers. For patients with SMI seen for short-term psychotherapy and for psychiatric consultations, SmartCare prints a summary note to attach to the medical record.

TRAINING: SmartCare staff's training plan includes motivational interviewing and other strength-based and evidence-based practices that support prevention and early intervention services, as well as health and behavioral health topics to enhance wellness events in the community. SmartCare staff in turn provide cross training to health care staff on many of these behavioral health topics. Consulting psychiatrists provide cross training to health care staff on mental health topics, psychotropic medication and related issues.

HEALTHIER LIVING SERIES

SmartCare, in partnership with the County of San Diego, offers the Healthier Living Series for those managing and/or supporting others with ongoing health conditions, such as diabetes, arthritis, high blood pressure or other conditions and diseases. Residents have learned to better manage their health conditions and lessen its impact on their lives; reduce fatigue, anxiety, sleep loss and pain; communicate better with their doctors, friends and family; and set goals and problem solve to make positive changes. The series is led by peer trainers who also experience on going health issues.

"When I first agreed to come into the program I wasn't aware that it actually applied to me. I was still having difficulty thinking of myself as ill or having a chronic disease. I couldn't be more pleased with this program or the other people that participated. I also cannot imagine the group without the excellent facilitators that aided us in our discovery tools." ~ Ramona Resident

STRENGTHS: Clinic physicians and staff have been very receptive to the program. Psychiatry consultation services have been well received by patients as well as the health providers. Physicians appreciate that SmartCare staff can manage 5150 referrals to psychiatric inpatient services. Patients also like the telepsychiatry, in part because there is less stigma to confer with a psychiatrist from the primary care clinic rather than go to a psychiatrist's office. One

consulting psychiatrist can do back-to-back appointments with patients from any of the three participating sites, which maximizes his or her time.

Wellness activities and events have also been well received, with very positive responses on their satisfaction surveys. Staff utilize evidence-based curricula whenever appropriate, and provide activities in both English and Spanish. SmartCare launched a social media campaign as another means of connecting to the community.

CHALLENGES: Some sites have taken longer to start up than others. In some cases physicians are still reticent to refer patients to the telepsychiatry services. Electronic connectivity is challenging because sites are located in rural areas and do not have easy access to T1 lines. Space at one clinic is not always available for telepsychiatry so the patient goes to the nearby Vista Hill satellite office on certain days for telemedicine services. There were challenges initially in identifying patients that may qualify for SMI or SED services, as most patients either have Medi-Cal or other insurance, or are not residents and therefore do not qualify.

LESSONS LEARNED: Each community has unique needs, requests, cultures and community members. It is important to match staff teams with clinicians and educators that represent the communities they serve to maximize effectiveness.

PSYCHIATRIC CONSULTATION TO PRIMARY CARE (PC²)

Psychiatric Consultation to Primary Care (PC²) program will provide psychiatric consultation to primary care providers. It is an augmentation to the SmartCare program, and will become operational by September 2011. It will offer psychiatric consultations on-demand 40 hours per week, through an open phone hour that will take place at noon daily, and through HIPAA compliant e-Consults using the system set up previously by the San Diego County Medical Society Foundation with the CCC. A clinical triage officer will provide behavioral health triage recommendations to providers as an adjunct to the on-demand psychiatric consultation process to direct patients to the appropriate level of care. Training will be offered to providers in person and via webinars. Staffing will include a program director, clinical triage officer, and child-, adolescent- and adult-certified psychiatrist. Services will be offered to CCHCs. This program is funded through the County of San Diego MSHA dollars.

CONCLUSION

By now it is clear that private and public providers throughout the county have employed quite a variety of programs in the name of integrated physical and behavioral health. Some programs are aimed at improving the mental health of patients in receiving services in CCHCs. Others are aimed at improving the physical health of individuals receiving services in County-contracted specialty mental health settings. New partnerships have been forged between organizations that had never before collaborated. County BHS is hosting forums countywide to further increase and support communication and referral arrangements.

While all of these efforts are moving in the right direction, they continue to be disjointed, and they are impacting small numbers relative to the number of uninsured and low income people needing physical and mental health services.

Barriers to a large-scale integrated services system include the following:

- There is a lack of adequate funding. Many integrated behavioral health services such as physician consults, case management, and data collection are not reimbursable.
- Medicaid does not reimburse for same-day mental health and physical health visits (though it does support same-day medical and dental visits). This needs to change to better support the value of a warm handoff.
- Medicaid does not reimburse for MFT services. Bilingual MFTs are more available than LCSWs, but they have to be reimbursed through the sliding fee scale or hired through grant funding.
- Information exchange is crucial to better integrated services, but IT systems are lacking or incompatible. A good IT system could enhance communication between providers and make staff time more productive. Sustainability of these programs beyond the grant-funded period will require an infrastructure for information exchange.
- It is difficult to fill positions required for integrated behavioral health, such as behaviorist and nurse care manager positions, because the required practice is so different than what they were trained in or what they are interested in doing.

- Some uninsured patients shifting from County-contracted specialty mental health programs cannot afford to pay for services at CCHCs, even when provided on a sliding fee scale. The sliding fee scale at CCHCs is higher than the sliding fee scale at the specialty mental health program.
- The physical health and specialty mental health cultures are very different. Partnership building efforts need to continue, and clear referral processes need to be put into place that providers can bank on.
- Change is difficult, especially for providers who are already stretched to the limit! PCPs need additional training to become more comfortable with mental health issues and with prescribing psychotropic medications.

Despite these challenges, the San Diego community of providers has embraced integration to a large degree. Lack of funding will always be a limiting factor, but even without adequate funding, organizations are continuing to make good progress. Progress will be made as stakeholders continue to work with each other, put new systems in place, get to know each other's organizational cultures, learn new approaches to care, receive training, and commit to working together to do what is best for the patient or client.

ATTACHMENTS

1. Environmental Scan Interviewees
2. County of San Diego, Health and Human Services Agency, Behavioral and Physical Health Integration: The San Diego Vision, July 1, 2011
3. Physical and Behavioral Health Coordination of Care Guidelines, Healthy San Diego
4. Coordination of Physical and Behavioral Health form, Healthy San Diego
5. County Integration Support Documents
 - a. County Mental Health and Primary Care Pairings by Region
 - b. Pairing of Primary Care and Mental Health Clinic Guidelines
 - c. Clinically Stable Clients Guidelines
 - d. North County Referral Decision Tree, August 2010, and San Diego County Mental Health Clinics - North County
 - e. Referral to Primary Care, San Diego County Behavioral Health Services
6. Community Clinics with Mental Health Services as of 3/1/11
7. MESA Program Participating Clinics
8. SmartCare Integrated Behavioral Health Care Screening Tool