ITUP
Insure the Uninsured Project

Notes from the Field

FEBRUARY 2019

ITUP REGIONAL WORKGROUPS TELL THE STORY

Improving Behavioral Health Services in California

"We can't be patient anymore – we need to find solutions." 2018 ITUP Regional Workgroup participant

Purpose of this Report

This report highlights key findings from 2018 ITUP regional workgroup discussions on behavioral health. The discussions were timely and intense, reflecting the magnitude of the behavioral health challenges the state faces.

About ITUP Regional Workgroups

Each year, ITUP convenes 11 regional workgroups throughout California. ITUP regional workgroups bring together local health care leaders for a half-day session of constructive dialogue, problem-solving and identification of creative policy solutions.

Typical participants include safety-net providers, state and local government agencies, legal assistance providers, health care foundations, health plans, legislative district offices, community organizations and health care advocates. ITUP workgroup participants discuss local collaboration opportunities and share emerging best practices with diverse colleagues in each region.

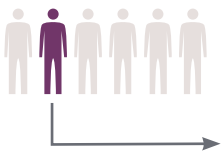
Workgroup findings provide ITUP with information and timely updates from the field to inform ITUP research and communications.

Discussion topics are responsive to the changing health care environment. In 2017, workgroup participants discussed timely concerns with immigration policy and health care access (see ITUP publication, *Notes from the Field: Immigrant Communities in California Under the Cloud of Immigration Enforcement*).

ITUP Workgroup Regions and Counties

FAST FACTS

1 in 5



60%

Almost one in five Californians reported needing help for a mental health condition or substance use disorder (SUD). Of those who needed help, only 60 percent saw a health professional for their condition.[1]

The California Story: Public Mental Health Services

The delivery of public mental health care services in California has evolved over time into a complex, decentralized system. California counties are the primary providers of public mental health services for both Medi-Cal and low-income uninsured clients. California transferred most financial and administrative responsibility for mental health services to the counties as part of a state-county realignment in 1991. Prior to realignment, mental health programs competed for limited funding in the annual state budget.

In the early 1990s, California significantly expanded Medi-Cal managed care (MCMC) and pursued a similar path for the provision of Medi-Cal specialty mental health services. Under the terms of a federal Medicaid 1915 (b) "freedom of choice" waiver, California consolidated inpatient and outpatient mental health services into one program through county-administered mental health plans (MHPs). The waiver allows the state to require that all Medi-Cal beneficiaries obtain specialty mental health services through the local MHPs. Counties provide the nonfederal match for Medi-Cal specialty mental health services, and draw down federal Medicaid funds, using realignment funding, Mental Health Services Act funds and other local revenues.

Each local MHP directly provides or contracts specialty mental health services for Medi-Cal patients that meet diagnostic and impairment medical necessity criteria. Specialty mental health services for Medi-Cal beneficiaries are only provided through the county MHP and include: inpatient hospital, psychiatric health facility, adult residential treatment, crisis residential treatment, day rehabilitation, case management, linkage and brokerage, mental health services, medication support, and crisis intervention. Given that specialty services are managed by county MHPs, they are "carved out" of MCMC plan contracts for medical care. MCMC plans are not responsible for covering specialty services to Medi-Cal beneficiaries.

The Affordable Care Act (ACA) expanded access to behavioral health care services, including treatment for mental health conditions and SUDs, including behavioral health as one of the 10 essential health benefits that health plans must cover for enrollees with individual or small group coverage. California opted to cover all essential health benefits in the Medi-Cal program. With coverage for behavioral health services greatly expanded, MCMC plans assumed greater responsibility for mental health services for adults with mild-to-moderate conditions (primarily short-term outpatient services), while counties remain responsible for providing specialty services (inpatient, residential and intensive outpatient services) for children and adults with severe mental health conditions. Prior to the ACA expansion, Medi-Cal beneficiaries had very limited access to mental health services other than those provided by counties.[2]

MCMC plans are also required to cover mental health assessments by licensed mental health professionals. County MHPs and MCMC plans are required to coordinate services, and the determination of impairment and medical necessity, through a county-level memorandum of understanding. For more information on mental health services in California, see the CHCF report, *The Circle Expands: Understanding Medi-Cal Coverage of Mild-to-Moderate Mental Health Conditions*.

The California Story: Public Substance Use Disorder Treatment Services

Counties currently administer public SUD treatment services under contract with state Department of Health Care Services (DHCS) for individuals eligible for Medi-Cal and low-income uninsured. However, there is no local organized delivery system like county MHPs (except for Drug Medi-Cal Organized Delivery System (DMC-ODS) pilots described below).

Prior to ACA implementation, and DMC-ODS, SUD services in Medi-Cal were extremely limited. Services typically focused on social model recovery approaches (i.e. 12-step and outpatient peer counseling services) and medication assisted treatment (i.e. methadone maintenance), with residential treatment services available only for pregnant women and individuals under age 21. Funding for non-Medi-Cal services was generally limited to local funds and federal Substance Abuse and Mental Health Services Administration grants.

Drug Medi-Cal. The Drug Medi-Cal (DMC) program provides medically necessary SUD treatment services to Medi-Cal beneficiaries provided by or under the direction of a physician at a treatment site certified by DHCS. The adoption of EHBs for all Medi-Cal beneficiaries makes additional outpatient SUD services available to all Medi-Cal eligible persons for whom treatment is medically necessary. Medi-Cal also provides limited medication assisted treatment in outpatient settings with providers certified to offer the service.

As with specialty mental health services, SUD services are generally "carved out" of MCMC contracts, but health plans are required to use the Screening, Brief Intervention, and Referral to Treatment (SBIRT) tool and assess the need for SUD services among Medi-Cal enrollees.

Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver. Under the terms of California's Medi-Cal 2020 waiver, the state is implementing a pilot to expand SUD benefits and develop an organized delivery system for Drug Medi-Cal. The waiver is operational only in counties that choose to opt-in.

Counties that choose to participate in DMC-ODS must:

- Provide services based on the American Society for Addiction Medicine (ASAM) guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions, covering a broad continuum of SUD treatment and support services;
- Act as a MCMA plan for SUD treatment services, including providing SUD services only through certified and contracted providers subject to quality and access standards;
- Promote and reimburse for delivery of evidence-based care; and
- Coordinate with physical and mental health services.

As of this writing, 24 counties have begun implementing DMC-ODS and an additional 16 are in various stages of the DHCS approval process. If all 40 counties implement DMC-ODS, 97 percent of Medi-Cal beneficiaries will have access to DMC-ODS services.[3] For more information on DMC-ODS, see the CHCF issue brief entitled *Medi-Cal Moves Addiction Treatment into the Mainstream: Early Lessons from the Drug Medi-Cal Organized Delivery System Pilots*.

This section summarizes the findings from the ITUP regional workgroup discussions, including some specific examples from among the many stories and insights shared at the meetings.

Finding: Fragmentation of Services

A common theme that repeated in the workgroup discussions is that fragmentation of services –physical health, mental health and SUD services – complicate service delivery and frustrate the goal of meeting the needs of clients.

Participants noted that the MCMC carve outs for both mental health and SUD services make it difficult for providers in all sectors to make referrals, track the services and coordinate to meet patient needs. Workgroup members emphasized that most individuals with severe mental illness, SUDs, and those who have co-occurring mental illness and SUDs, are likely to have other medical problems. There is an increasing imperative to integrate and coordinate all levels of care, including physical and behavioral health services, and in some cases social services or corrections. An individual with complex needs might be utilizing services through multiple different systems.

Medi-Cal mental health services are provided by either the beneficiary's MCMC plan or the county, depending upon the severity of an individual's condition. An individual whose condition improves or worsens could shift back and forth between the two delivery systems, depending upon the severity of the condition at any given time. Given the likelihood that an individual might be served by both programs over time, as well as needing to access care for medical conditions, coordination between the county and the MCMC plans is paramount.

A consistent theme throughout ITUP workgroup discussions was a desire to coordinate care and align all services to better serve individuals in need. However, workgroup participants consistently identified coordination between MCMC plans and counties as challenging and often ineffective.

Participants acknowledged that the trend toward value-based payment and pay-for-performance will require more integration and better cross-sector data sharing. However, according to participants, there are several barriers impeding efforts to coordinate and integrate care.

- ***Fragmentation and silos.*** The primary challenge of coordinating and integrating care is the siloed nature of service delivery systems, reflecting funding streams that often focus on delivery of a single service.

  One example provided by a workgroup participant is the Access Increases in Mental Health and Substance Abuse Services (AIMS) grant for community health centers, administered by the federal Health Resources and Services Administration. AIMS grant funds are intended to expand access to mental health services, and substance abuse services, focusing on treatment, prevention, and awareness of opioid abuse. AIMS grants can support medication-assisted treatment (MAT)[4] but grantees must have separate mental health and SUD counselors. Participants repeatedly confirmed that, for this reason and other system challenges, mental health and SUD providers are often disconnected from each other.

  Care coordination is especially important for Medi-Cal beneficiaries with complex needs, yet the complexity of their conditions, and the need for different types of services, place them in the center of the fragmented delivery systems. For example, when a dual-diagnosis patient makes progress on their primary condition and shifts into a new primary diagnosis (e.g., SUD is well-controlled so mental health becomes the primary issue), medical necessity rules mandate that the initial provider refer the patient to a different specialist for their new primary diagnosis, further fragmenting their care.

Participants noted challenges transferring a patient from one county to another when the patient moves. Intercounty transfers in Medi-Cal can take up to 45 days to take effect, and in the meantime, providers may be hesitant to provide treatment services until the transition is complete.

Care teams experience challenges in transitioning patients between systems of care. Many patients do not speak English, and some are undocumented, with complex needs involving every level of care within the community. Care teams struggle to navigate the complex systems on behalf of these vulnerable patients.

- ***Creation of new silos.*** While the new DMC-ODS has dramatically increased access to SUD services for Medi-Cal beneficiaries, participants noted that the new program is essentially a silo itself. Many of the rules that apply to DMC-ODS services complicate coordination and collaborative use of resources with mental health and MCMC plans. For example, federally qualified health center (FQHC) participants pointed out FQHCs are challenged to participate in DMC-ODS because SUD services must be provided at standalone FQHC facilities to ensure compliance with state and federal laws. FQHCs would be required to prove no federal dollars were spent on SUD services. Participants expressed concern that building separate facilities for DMC-ODS would fragment the patient population and reinforce existing stigma around drug treatment.
- ***Integration bandwidth.*** Workgroup participants noted the significant effort and resources required to integrate and coordinate care. One participant from the rural north described substantial behind-the-scenes efforts in finance and development to identify resources for coordinated care. A participant from the Bay Area noted that efforts to integrate or coordinate care add an additional layer of tasks on top of existing program responsibilities. For example, the participant's county has four different programs working on behavioral health integration with primary care.
- ***Data sharing challenges.*** A significant challenge in coordinating between systems of care is privacy rules surrounding the sharing of patient data. Patient confidentiality and information release requirements pose a barrier to getting patients into care quickly. In an ideal situation, a health plan can connect a patient to a referral via a three-way phone call to avoid the data restrictions; otherwise, the health plan is not allowed to release even the patient's phone number to a provider without a signed release form from the patient. In addition, there is a need to streamline data collection between delivery systems, which often collect the same data for the same individuals multiple times.
- ***Breakdowns between the systems of care.*** One FQHC in the rural north reported working with their county for over a year to develop a Memorandum of Understanding (MOU) relating to the transfer of patients whose conditions fluctuated between mild-to-moderate (treated by the FQHC) and severe (treated by the county). Another participant noted that it can take up to 90 days to fully transition a patient from treatment at the plan level into the county system because of contractor assessment requirements.

  Even in counties with well-established MOUs between the county and the MCMC plan, there can be disagreements over which system is responsible for a patient's treatment. Several participants throughout the state noted that the distinction between severe and mild-to-moderate mental health conditions is not always clear, raising potential for the plan and the county to disagree over which is responsible for the treatment.

- ***Services difficult for vulnerable patients to navigate.*** As described behavioral health services are bureaucratically complex making it especially challenging for vulnerable patients with behavioral health needs to effectively advocate on their own behalf. Community organizations reported working with patients to help them navigate the systems, noting that it can be difficult to determine if the patient's condition would be most appropriately served by the MCMC plan or the county.

Workgroup participants throughout the state almost universally expressed the need for navigation services, particularly when the challenges of a complex delivery system are combined with other social challenges. One participant described a school-based navigator that had a 45 percent success rate in connecting children to behavioral health services. The other 55 percent had persisting challenges accessing services, including parental stigma about seeking mental health services for their children, and parents who didn't have time to take their children to appointments.

Finding: Insufficient capacity for special populations

Workgroup participants repeatedly identified the access challenges for special populations, such as children and those with complex needs (e.g., co-occurring disorders, homelessness).

- ***Services for children.*** Several workgroup participants reported insufficient access to children's behavioral health services. There is a lack of mental health providers trained to treat children. Both the Whole Person Care (WPC) Pilot, which seeks to better integrate services for high-risk patients in local communities, and DMC-ODS focus on adults, leaving children out of these significant efforts to expand services. As one attendee noted, SUDs often arise during adolescence. While every county is required to allocate 51 percent of Mental Health Service Act[5] funding for children's services, participants argued that this requirement is not well monitored.

  In some counties, there are no SUD services for children. For instance, there are no residential programs for child alcohol or drug treatment within San Mateo County; children who need these services are sent to a nearby county for treatment. There is also a gap in integration services for the transition years between adolescence and adulthood.

  Many local agencies are working with schools to improve child access to behavioral health services. Fresno County awarded local schools $111 million to serve students with severe mental illness/ serious emotional disturbance with the goal of integrating mental health services at all schools. However, the program has encountered challenges with privacy laws, in both health and education policies, and recruiting providers.

- ***Services for seniors.*** Participants identified other gaps for special populations, including the need for social workers trained specifically to treat clients with complex medical needs, including older adults. There are no specific incentives for providers to focus on services for seniors, a problem that is worsening as the population is aging.

Finding: Inadequate Workforce

Across the state, all workgroups expressed concern over workforce challenges in all health sectors with acute shortages in behavioral health. All regions are struggling with an insufficient supply of providers, snowballing demands on the existing workforce, and gaps in workforce training opportunities.

- ***Workforce shortages.*** Workgroup participants consistently reported a shortage of behavioral health staff at all levels of licensure. Compounding the problem, one participant noted a high percentage of existing behavioral health providers will soon retire from the workforce. Statewide, there are not enough providers to meet increased demand for behavioral health services. Participants in mostly rural communities commented that although Medi-Cal behavioral health benefits were expanded, access to services remains the same – there simply aren't enough providers to meet the demand or to add the expanded benefits. (For additional information on behavioral health workforce needs in California, see the Healthforce Center at UCSF report, *Assessing the Adequacy of the Behavioral Health Workforce in California*.)

The existence of several new and expanded programs increased competition for the limited number of behavioral health professionals in the workforce. In addition, some programs, like DMC-ODS, are designed around a workforce of licensed professionals that doesn't yet exist. Safety-net providers with limited resources struggle to compete with health plans and other providers who may have more to offer a prospective behavioral health professional. A rural clinic described offering a position to a physician just finishing residency in their facility. The physician had already received another offer from a large provider with pay exceeding that of the rural clinic's Medical Director.

- ***Barriers to expanding the workforce.*** Workgroup participants described policy and resource barriers that inhibit workforce growth. For instance, providers from other states often face significant challenges obtaining licensure in California. There are also challenges for those aspiring to join the workforce, including limited internship opportunities for social workers working toward licensure. Some students interested in becoming physicians don't qualify for highly competitive medical school spaces, and those who do complete medical school must compete for a limited number of residency slots. Beyond policy barriers, according to participants, increasing the workforce requires significant investment. Substantial time and resources are needed to recruit additional staff, train those newly hired, and replace staff that have moved on, all while ensuring effective service delivery with existing providers and facilities.
- ***High Pressures on existing workforce.*** Workgroup participants noted that the increasing demand for services strains the already overstretched workforce. Patients are often referred to providers that may not be the most suitable for their condition because there aren't enough providers available. According to a participant in the rural north, prior to the expansion of Medi-Cal eligibility and behavioral health benefits, local behavioral health providers primarily treated children. Now, the same set of providers is tasked with providing an expanded set of benefits to adults. Providers are struggling to keep up with demand. A participant from Riverside County reported during the workgroup the county behavioral health services call center at that time was receiving 4,000 additional calls per month since DMC-ODS began. Riverside had more than tripled the number of inpatient SUD treatment beds (from 200 to 670 over the course of two years) but there is still demand for more.

  The heavy demand on the short supply of workforce is burdensome for both patients and providers. Medi-Cal beneficiaries often wait extended periods of time for an appointment. Workgroup participants reported that patients often don't show up for appointments scheduled far in the future and there are long waits in clinics. Providers are feeling the strain as well; burnout is a growing concern.

- ***Insufficient workforce training opportunities.*** Workgroup participants identified several gaps in existing workforce training programs. A participant in the rural north stated that training programs tend to focus on therapy and do not train clinicians to consider a broader set of environmental factors that affect patients. Many behavioral health professionals end up struggling in the clinical setting serving patients with complex needs. There are some efforts to boost training for behavioral health students. For instance, UCLA is working with the California Consortium of Addiction Programs and Professionals to help incorporate additional elements into training for SUD counselors. Most need additional training after completing their programs before they can start working in DMC-ODS (e.g., training in ASAM standards).

- ***Telehealth.*** Participants generally agreed that telehealth services can help to address workforce shortages and reported that many communities are extending telehealth to behavioral health. Unfortunately, participants noted that telehealth also requires resources and technology that may not be readily available in remote or rural areas. Telehealth service delivery requires two sites: the practitioner site and the patient site. Medi-Cal only reimburses for one site, while costs are incurred at both. One workgroup participant shared that some providers are reluctant to bill for services provided via telehealth, citing uncertainty about billing Medi-Cal for telehealth services. In addition, there can be challenges associated with patients who prefer to see a provider in-person rather than via telemedicine, and telehealth providers that are reluctant to participate in Medi-Cal.

Promising Strategies

Despite numerous challenges posed by the fragmented health, mental health and SUD treatment systems, participants around the state offered many examples of local innovation and promising strategies. This section highlights just some of the best practices shared by workgroup participants.

- ***Coordination between county MHPs and MCMC plans.*** Despite the challenges described above, local communities are focusing on improving coordination between county and health plan.
  - In the Central Valley, a MCMC plan representative described a bi-directional referral form that helps facilitate patient transitions between the health plan and the county. Quarterly meetings help maintain ongoing relationships to further bolster coordination efforts. In addition, the health plan works to align its provider network with the county's network to promote continuity of care when individuals move between the two treatment systems.
  - The local Shasta Health Assessment and Redesign Collaborative (SHARC) convenes county government, hospitals, SUD providers, and other delivery system stakeholders. SHARC is currently working to build a strong understanding of Shasta's delivery system and identifying its strengths and weaknesses.
  - In Lompoc, nearly every health care and mental health provider attends the Local Behavioral Collaborative, which has strengthened community efforts. Providers now feel comfortable and can bridge gaps to get patients into treatment, making sure county mental health is in the loop when a diagnosis has already been made.
  - In Orange County, the local MCMC plan, CalOPTIMA, provides mental health services for mild-to-moderate conditions. CalOptima staff help assess and refer clients to the appropriate provider or to county mental health depending on the severity of their condition. Because the mental health delivery system is otherwise bifurcated, CalOptima and the county collaborate on care coordination for individuals that need to step down to mild-to-moderate services or those that need to step up into specialty mental health. CalOptima and the county use similar screening processes and tools.
- ***Provider co-location.*** As part of the implementation of DMC-ODS, in some counties SUD providers are co-located with county mental health providers, which is particularly beneficial for patients with co-occurring mental health and SUD conditions. In addition:
  - San Diego County reports they are taking a person-centered approach to DMC-ODS, building in flexibility by utilizing additional county funds to integrate services outside the scope of DMC-ODS.

  - San Benito County formed a homeless and housing services collaborative. Support services, WPC and transitional housing units are all located in the same facility under the Health and Human Services department. The programs emphasize jobs placement, using Good Will as the model for a county Commercial Services Training Center. The county is also working with developers to build affordable and low-income housing.
  - Hub and Spoke Program: "Hubs" serve as addiction centers of excellence working with multiple different "Spokes" that act as clinical service providers. DHCS is dispersing $20 million to expand access to medication assisted treatment (MAT). The goal of the program is to increase access to treatment for opioid use disorder. Acadia-based local hub is working with other providers, including 11 spokes in Riverside, to increase MAT. Counties across the state are working with the hub and spoke model.

- ***Technology.*** Many regions, especially in rural areas, are implementing telehealth as one strategy to cope with provider shortages. Telehealth can be especially helpful in alleviating access challenges in remote areas. Participants noted that telehealth can be used to provide better access to care for patients in crisis and works well for patient follow-up. Counties are also exploring innovations like Ellipsis, a depression screening tool based on voice analysis, and the 7 Cups app, which works similarly to smart speakers Alexa and Siri but provides mental health information, access to peer support, and crisis intervention.
- ***Maximizing funding from other sources.*** Another creative approach to workforce challenges discussed was the use of alternative funding streams to support additional personnel. For example, FQHCs reported using revenues from the federal 340B drug discount program to hire auxiliary staff, such as nurses and case managers, who are not directly reimbursed by Medi-Cal. FQHCs are only able to bill for services provided by a licensed clinical social worker or other staff with higher levels of licensure. Other approaches identified by workgroup participants include the use of certified health education specialists as support staff to licensed providers and tuition and loan assistance programs that encourage health professionals to practice in underserved areas after their training is complete.
  - Along with UCLA, Community Health Association Inland Southern Region is developing a MAT waiver training for providers.

California Hub and Spoke System

The California Hub and Spoke System (CA H&SS) is a component of the state's Medication Assisted Treatment Expansion Opioid State Targeted Response grant program. The goal of the program is to improve, expand, and increase access to MAT services through the state.

MAT is the use of medications, combined with counseling and behavioral therapies, to treat SUDs and prevent opioid overdose, primarily used for the treatment of addiction to opioids such as heroin and certain prescription pain relievers.

Each CA H&SS consists of one hub and multiple spokes. Existing Narcotic Treatment Centers or Medication Units serve as hubs and work closely with federally-certified clinical service providers that serve as spokes.

Spokes can be an FQHC, mental health center, private practice or community clinic where a certified buprenorphine prescriber or potential prescriber is available. Federal law requires clinicians to seek certification in order to dispense opioid treatment medications.

DHCS awarded grant funds to 19 hubs across the state as part of the initial two-year program funded by the federal Substance Abuse and Mental Health Services Administration.

  - CalOptima is funding a comprehensive community needs assessment and also developing a grant program to address children's mental health needs and the opioid epidemic in Orange County.

- ***Data sharing solutions.*** Several communities are developing solutions to overcome barriers in sharing data. The WPC Pilot programs typically connect several service delivery systems and many feature solutions for sharing participant information.
  - Alameda County reported developing a single Community Health Record for all service entities participating in its WPC Pilot. Alameda County is also working on a universal consent form that seeks to address privacy concerns and still allows for adequate information sharing.
  - The North Coast Health Improvement and Information Network is developing a local health information exchange that will connect local organizations including FQHCs, law enforcement, education, mental health, and SUD treatment.
  - San Diego County is creating an interface with the homeless management system that can be shared with MCMC plans.
  - Humboldt County is launching a suicide prevention program using the Zero Suicide framework. Electronic health records prompt doctors to ask suicide risk screening questions during primary care appointments.

- ***Law enforcement field teams.*** In many communities around the state, local law enforcement deploys field teams of specially trained officers, often paired with social service and behavioral health providers. Several officers involved in teams participated in ITUP regional workgroups. The officers highlighted the importance of meeting individuals in behavioral health crises "where they are" and being available with service and treatment options when individuals are ready to get help. The teams focus on preventing unnecessary incarceration and getting those who need treatment connected with services.
  - The San Luis Obispo County (SLO) Sheriff's Office Community action team reaches out directly to at-risk individuals connecting the homeless, mentally ill and those with SUDs to community services and resources to help reduce recidivism. The SLO team successfully prevented incarceration of all those they encountered in community, except for one individual who committed a property crime. The team also worked with 20 local agencies and the behavioral health department to develop a Crisis Intervention Training Program for local sheriff deputies and employees.
  - The San Diego Police Department staff act as a link between individuals in need and available services. They have officers and sergeants in the field every day of the week and created a Homeless Outreach Team and a Psychiatric Emergency Response Team. Officers coordinate with other local agencies and service providers. An eligibility worker from the county Health and Human Services Agency accompanies the officers to facilitate getting individuals eligible and connected to services quickly.

- Alameda County provides services and connections for the incarcerated, including job coaches and navigators within the jail. For each client, program staff develop a reentry plan and collaborate with the criminal justice team to follow and support each individual when they are released. When people are released from incarceration, they are assessed and referred depending on the severity of their

condition(s). Clinicians are located at the probation facility.

- ***Whole Person Care.*** Many workgroup participants are involved with and aware of the impact from local WPC Pilot programs.

  Workgroup participants described local experiences and successes generated by the WPC Pilots and the community collaboration they generate, including:

  - Alameda is working on case management services that are bundled and tiered based on need, including case management service bundles to support the homeless. The county intends to have a single care plan for each client, with a significant portion of the funding directed to housing services.
  - Siskiyou Health Care Collaborative administers a subcommittee on behavioral health and builds community health teams with partners from health care and social services. The teams coordinate a broad spectrum of safety-net services, including health care and housing.
  - In Riverside County, probation offices are the entry point for the WPC Pilot. Each probation office is located near a FQHC that provides mental health and SUD services. Nurses screen potential participants for health issues and social service needs. Housing outreach members help individuals get necessary documentation, services and transportation to appointments. A multi-part consent form is used.

Whole Person Care Pilot

Authorized through California's Section 1115 federal Medicaid waiver, Medi-Cal 2020, WPC Pilots coordinate health, behavioral health, and social services, in a patient-centered manner with the goals of improved beneficiary health and wellbeing. WPC Pilots receive support to integrate care for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes.

Through collaborative local leadership and coordination among public and private agencies, WPC Pilots identify target populations, share data between systems, coordinate care in real time, and evaluate individual and population health progress.

- ***Mental health clinicians on first responder teams.*** Humboldt County has experimented with placing mental health clinicians on first responder teams. These teams have the option to move a patient back home if they are stable, avoiding crisis escalation through emergency department admission. This project also allows first responders to place an involuntary mental health hold (Welfare and Institutions Code Section 5100) on a patient without a law enforcement officer present since the embedded clinician can do a full assessment.
- ***Incentivizing workforce growth.*** California State University, Stanislaus developed a curriculum for registered nurses to become family nurse practitioners. Legacy Health Endowment, a local nonprofit that provides funding and technical support for health care solutions in Stanislaus and Merced Counties, partnered with local health centers to pay tuition for 25 students, who committed to doing their precept at the health centers. Efforts are underway to establish a direct partnership with the University of California, Merced.

Conclusion

In 2018, over a six-month period, ITUP held 11 regional convenings around the state and invited participants to focus on behavioral health services in California. Participants described the challenges, the barriers and the emerging best practices, as communities work through and around resource and provider shortages, bifurcated delivery systems and complex, unmet client needs.

This report highlights key findings from the workgroup discussions to honor and share at least a small portion of the conversations. The discussions were robust, passionate, thoughtful and energizing. Participants revealed the extent of the crises communities face in meeting the behavioral health needs of their residents, as well as the depth of commitment and innovation they bring to overcoming the challenges. ITUP will build on the workgroup funding and continue to research opportunities to improve behaviorial health services in California.

Endnotes

1. UCLA Center for Health Policy Research, "*2017 California Health Interview Survey (CHIS)*," October 2018.
2. Kim Lewis and Abbi Coursolle, "*Mental Health Services in Medi-Cal*," National Health Law Program, January 12, 2017.
3. State of California, "*Department of Finance, E-4 Population Estimates for Cities, Counties, and the State, 2011-2017, with 2010 Census Benchmark*," May 2017.
4. Medication Assisted Treatment is the use of medications with counseling and behavioral therapies to treat SUDs and prevent opioid overdose, primarily used for the treatment of addiction to opioids such as heroin and prescription pain relievers.
5. The Mental Health Services Act, an initiative passed by California voters in 2004, provided dedicated funding to develop, through an extensive stakeholder process, a comprehensive approach to providing community-based mental health services and supports for California residents. For additional information, visit the *Mental Health Services Oversight and Accountability Commission*, which oversees implementation of the MHSA.

Resources

California Health Care Foundation (CHCF), *Medi-Cal Moves Addiction Treatment into the Mainstream: Early Lessons from the Drug Medi-Cal Organized Delivery System Pilots*, August 2018

CHCF, *The Circle Expands: Understanding Medi-Cal Coverage of Mild-to-Moderate Mental Health Conditions*, August 2016.

Janet C. Frank, Kathryn G. Kietzman, and Alina Palimaru, *California's Behavioral Health Services Workforce is Inadequate for Older Adults*, January 2019.

Janet Coffman, Timothy Bates, Igor, Geyn, and Joanne Spetz, *California's Current and Future Behavioral Health Workforce*, Healthforce Center at UCSF, February 2018.

Wendy Holt, "*California Health Care Almanac: Mental Health in California: For Too Many, Care Not There*," California Health Care Foundation, March 2018.

Wendy Holt, "*California Health Care Almanac: Substance Use in California: A Look at Addiction and Treatment*," California Health Care Foundation, October 2018.

About ITUP

Insure the Uninsured Project (ITUP) is a Sacramento-based nonprofit health policy institute that for more than two decades has provided expert analysis and facilitated convenings for California policymakers and decisionmakers focused on health reform.

The mission of ITUP is to promote innovative and workable policy solutions that expand health care access and improve the health of Californians, through policy-focused research and broad-based stakeholder engagement.

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- Blue Shield of California Foundation
- California Community Foundation
- California Health Care Foundation
- Kaiser Permanente
- The California Endowment
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