

CMSP Behavioral Health Pilot Project

Interim Report, April 2009

About the CMSP Behavioral Health Pilot Project

California's County Medical Services Program (CMSP) provides health care services for indigent adults that are not eligible for Medi-Cal, the state's Medicaid program.

CMSP has covered mental health and substance abuse treatment for 25 years but only on a limited basis. In 2007, the CMSP Governing Board designed a new behavioral health pilot project to test the effectiveness of short-term mental health and substance abuse treatment, integrated into the primary care delivery system. The pilot offers new CMSP reimbursement of individual and group counseling services for mental health (up to 10 sessions per year) and substance abuse conditions (up to 20 sessions per year).

Through a competitive process, the Governing Board selected 14 organizations as pilot sites. These 14 grantees serve 15 of the 34 CMSP counties.

The pilot projects officially began in March 2008, although some sites did not assess any CMSP members until later in 2008. The pilots are scheduled to run through 2011.

About The Lewin Group

The CMSP Governing Board contracted with The Lewin Group to evaluate the behavioral health pilot project.

This report is the second in a series of three interim reports to present initial findings to the Governing Board. A final analysis of the pilot projects will be complete in 2011.

Introduction

This report is the second in a series of three interim reports to document the status of the CMSP behavioral health pilot project. Our October 2008 report used data reported by pilot sites through July 2008. This report includes data through the end of January 2009. In the six months that have passed since the first report, the number of people assessed by the pilot sites has more than doubled. While the numbers served through the project have grown, many of the enrollment trends and diagnostic characteristics have not markedly changed since last summer.

The first interim report documented that enrollment in the pilot project was well below the numbers that the pilot sites projected in their applications. This was true for all 14 grantees, and staff to the CMSP Governing Board, in collaboration with The Lewin Group, scheduled and conducted telephone interviews with all grantees to better understand each site's experience in implementing the pilot project. A summary of the interviews is attached to this report.

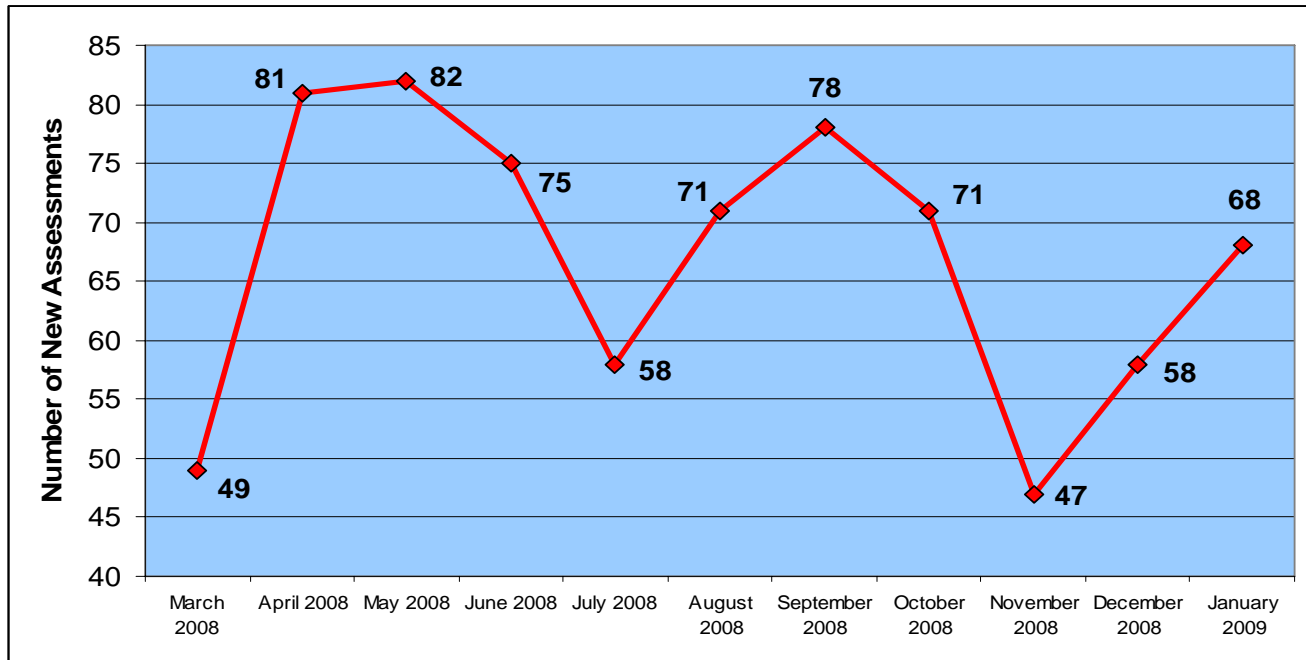
Among the major findings:

- Pilot sites are implementing their initiatives in very different ways across the CMSP service area
- Most sites are continuing to struggle to achieve the level of beneficiary participation projected in their original proposals
- Substance abuse treatment continues to be only a minor component of the pilot project
- The pilot project is reaching CMSP beneficiaries who face complicated and overlapping mental health, substance abuse, and environmental challenges.

How many people are receiving services through the behavioral health pilots?

The behavioral health pilot project requires that sites conduct an initial DSM IV assessment to evaluate mental health and substance abuse treatment needs of CMSP members and determine the appropriateness of short-term mental health or substance abuse treatment. Through January 31, 2009, grantees had received referrals to the behavioral health pilot project for 774 CMSP beneficiaries and completed 738 DSM assessments. **Exhibit 1** shows the number of new assessments by month since program inception.

Exhibit 1: Initial DSM IV assessments since program inception



Note: Excludes thirty-six assessments that occurred prior to program inception or were missing or invalid due to data-entry errors.

Who is receiving services through the behavioral health pilots?

The DSM IV assessments include the Global Assessment of Functioning (GAF), which determines an individual’s functional state on a scale of 0 to 100. CMSP members engaged in the behavioral health pilot project averaged a GAF score of 52. **Exhibit 2** shows the frequency of GAF scores among CMSP members assessed through the pilot projects. The table groups the respective GAF scores into deciles as categorized in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Approximately 78 percent of all the individuals served through the behavioral health pilot project fall between the GAF scores of 41 to 60. This group experiences moderate to serious mental health problems with moderate to serious impairment in social, occupational, or school functioning. The minimum GAF score selected by the CMSP Governing Board for the behavioral health pilot projects is 41. Grantees assessed 65 CMSP beneficiaries with GAF scores below that minimum.

Exhibit 2: Frequency of GAF scores among CMSP members in pilot project

Global Assessment of Functioning (GAF)	GAF Score Range	Total	Percent of Total
Persistent danger of severely hurting self or others/Serious suicidal acts	1 - 10	0	0.0%
Some danger of hurting self or others/Gross impairment in communication	11 - 20	1	0.1%
Serious impairment in communication or judgment/Inability to function in almost all areas	21 - 30	7	1.0%
Major impairment in several areas/Some impairment in reality testing or communication	31 - 40	57	7.9%
Serious symptoms/Serious impairment in social, occupational, or school functioning	41 - 50	294	40.5%
Moderate symptoms/Moderate difficulty in social, occupational, or school functioning	51 - 60	274	37.7%
Some mild symptoms/Some difficulty in social, occupational, or school functioning	61 - 70	84	11.6%

Symptoms are transient and expectable reactions to psychosocial stressors	71 - 80	8	1.1%
Absent or minimal symptoms/No more than everyday problems or concerns	81 - 90	1	0.1%
Superior functioning/Life's problems never seem to get out of hand/Sought out by others	91 - 100	0	0.0%
Total GAF Scores		726	100%

Note: Excludes forty-eight cases where the pilot site did not report a GAF score.

The clinical assessment also establishes one or more behavioral health diagnoses for each participant. **Exhibit 3** includes the principal and secondary diagnoses for 738 CMSP members that have been assessed for the pilot project. About half of the assessments indicated a single diagnosis while the remainder showed multiple disorders. More than half of the beneficiaries have a principal diagnosis of depression or anxiety. It is important to note that the second most common secondary diagnosis, if one is identified, is substance abuse. The relatively low rate of substance abuse as a principal diagnosis does not accurately reflect the need for substance abuse treatment since approximately 15 percent of participants have a secondary diagnosis of substance use disorder. The frequencies reported in Exhibit 3 have been consistent throughout the pilot project.

Exhibit 3: Frequency of clinical behavioral health diagnoses

DSM IV - Axis 1 Clinical Disorders	Principal Diagnosis	Secondary Diagnosis	Principal or Secondary Dx
Depressive Disorders	34%	9%	43%
Anxiety Disorders	23%	16%	36%
Bipolar Disorders	16%	3%	19%
Substance Disorders	10%	15%	23%
Adjustment Disorders	7%	1%	7%
Psychotic Disorders	4%	1%	5%
Other	6%	8%	n/a
No Diagnosis	n/a	47%	n/a

Note: Some CMSP members have been diagnosed with anxiety or substance use disorders as both a principal and secondary diagnosis. (Individuals can be diagnosed with two distinct conditions of anxiety disorder, for example.) This effectively lowers the overall rate for those categories in the last column of Exhibit 3.

For CMSP members participating in the pilot project, behavioral health disorders correlate to other psychosocial and environmental challenges. **Exhibit 4** shows the frequency of psychosocial and environmental problems experienced over the course of the preceding year among those assessed for behavioral health treatment. Psychosocial and environmental problems are negative life events, a lack of social support and resources, and interpersonal or environmental difficulties. These challenges are identified through the DSM IV assessment in a series of discrete categories. For each category, the clinician notes if a problem is present. The most prevalent were economic problems (e.g., inadequate finances, extreme poverty) and occupational problems (e.g., unemployment, stressful work schedule, job change). More than half of the participants experienced problems with their primary support group and problems related to the social environment, such as neglect, discrimination, disruption of family by separation, or the death of a family member or friend. The frequencies reported in Exhibit 4 have been consistent throughout the pilot project with the exception of the education domain, which rose from 13 to 20 percent since our prior report.

Exhibit 4: Frequency of psychosocial and environmental problems

DSM IV - Axis 4 - Categories	Percent reporting problems
Economic	78%
Occupation	72%
Primary Support	58%
Social Environment	54%
Housing	39%
Legal	21%
Education	20%
Access to Health Care	16%
Other	24%

Note: As defined in the DSM manual, “other” includes exposure to disaster, war, other hostilities; discord with nonfamily caregivers; and a lack of access to social service agencies

The Duke Health Profile (Duke) is a 17-item instrument. Grantees are asked to administer the Duke prior to every treatment session. **Exhibit 5** displays the average initial Duke scores for 615 participants. The averages are presented for all eleven dimensions of Health Related Quality of Life (HRQOL), where the Duke measures an individual’s health and dysfunction on a scale of 0 to 100. There are five items of dysfunction where a lower score is desirable and reflective of good health. The six items of the function scale denote positive health measure – a higher score indicates better health. When compared to standard scores in the primary care setting, participants in the pilot project are significantly worse off on all dimensions of the Duke.

Exhibit 5: Initial Duke Health Profile Scale Scores

HRQOL Dimension	Item Response Rate	CMSP BHPP Average	Reference Group: Primary Care Adult Patients	Point Difference
Dysfunction		(lower is better)		
Anxiety	570	60.1	25.4	34.7
Anxiety/Depression	550	61.6	24.1	37.5
Depression	569	63.7	26.2	37.5
Disability	600	41.2	12.5	28.7
Pain	601	69.9	46.1	23.8
Function		(higher is better)		
General Health	551	41.9	72.7	-30.8
Mental Health	582	41.3	80.7	-39.4
Perceived Health	602	48.5	75.2	-26.7
Physical Health	580	36.8	62.8	-26.0
Self Esteem	565	52.7	82.5	-29.8
Social Health	569	47.2	73.7	-26.5

Note: includes 24 Duke assessments with ID numbers that do not yet match to the ID numbers for people who received DSM assessments. The reference group for the Duke Health Profile is based on 1,997 adult ambulatory primary care patients randomly selected from a primary care clinic in North Carolina. The group is a reference point only; it is not intended to be a perfect match to the CMSP population.

What services are CMSP beneficiaries receiving?

Of the 774 individuals referred to the CMSP behavioral health pilot sites through January 31, 2009, pilot sites reported receiving 716 referrals for mental health treatment and 31 for substance abuse. The type of treatment for 33 individuals is currently unknown. There are six individuals that were referred for both mental health and substance abuse treatment. (They are included twice in Appendix A, once for each treatment type.) As a percentage of the total, the substance abuse referrals increased slightly over the last six months, but they have remained consistently low since the inception of the project.

Appendix A shows the distribution of service types and the average and range of GAF scores for all grantees.

What health-related outcomes has the pilot project achieved?

With less than a year of experience, it is still too early to draw strong conclusions about the health-related outcomes from the pilot project. However, the Duke Health Profile scores collected to date give us glimpse of the early outcomes. Exhibit 6 below compares the first and last scores on the Duke scales for the 162 CMSP beneficiaries who reported at least five Duke profiles since the inception of the pilot project. We chose this subset to exclude those who are still very early in their course of treatment.

The results in Exhibit 6 show modest positive progress on nine of the 11 Duke scales. It is not clear whether these findings are attributable to the pilot project or some other phenomenon (e.g., regression to the mean).

Exhibit 6: Changes in Duke scores for participant with five or more Duke assessments in 2008

HRQOL Dimension	Average First Score	Average Last Score	Change
Dysfunction			(negative is better)
Anxiety	64.1	62.4	-1.7
Anxiety/Depression	65.9	64.2	-1.7
Depression	66.4	65.5	-0.9
Disability	42.9	42.1	-0.8
Pain	71.7	70.6	-1.1
Function			(positive is better)
General Health	38.6	40.2	1.6
Mental Health	37.9	37.9	0
Perceived Health	45.7	47.2	1.5
Physical Health	34.2	35.9	1.7
Self Esteem	49.0	48.8	-0.2
Social Health	44.2	46.7	2.5

How are CMSP beneficiaries referred to the pilot projects?

The pilot projects were designed to promote integration of primary care and behavioral health delivery. To date, the referral patterns for the program suggest a close relationship to primary care. In fact, approximately 75 percent of CMSP members were referred for behavioral health treatment by medical providers at the pilot sites. Just under 11 percent were self and family referrals.

How does utilization compare to projections by pilot sites?

The competitive process to select behavioral health pilot project grantees required that applicants project the number of CMSP beneficiaries they would serve through the new initiative. Collectively, the grantees estimated that they would assess more than 2,600 individuals per year and over 7,800 individuals over the length of the three-year grant period. **Exhibit 7** converts each grantee's projected annual number of initial assessments into a monthly rate. The table also includes the actual number of new beneficiaries by each grantee per month.

The number of CMSP members served during the first eleven months of the pilot project is well below the initial projections. Among all CMSP behavioral health grantees, Open Door Community Health Centers (144) and Petaluma Health Center and partner clinics (188) have assessed the most beneficiaries since March 2008. El Dorado County Community Health Center and Sierra Family Medical Clinic were the only other grantees to exceed 50 individuals through the end of January. **Appendix B** summarizes interviews with grantees, including discussion of the factors contributing to the lower-than-expected participation rates.

Exhibit 7: Projected and actual initial assessments

Lead Agency	Projected Monthly	Monthly through July 2008	Monthly through Jan 2009
Chapa-De Indian Health Program	9	2	2
Community Health Clinic Ole	9	6	5
Del Norte Clinics	15	4	4
El Dorado County Community Health Center	30	6	7
McCloud Healthcare Clinic	9	1	<1
Open Door Community Health Centers	21	17	14
Petaluma Health Center	44	15	17
Redwood Rural Health Center	4	1	1
Shasta Consortium of Community Health Centers	23	4	4
Sierra Family Medical Clinic	33	6	6
Sonoma Valley Community Health Center	6	3	4
Sonora Regional Medical Center	13	5	5
Southern Mono Healthcare District	6	1	2
Tehama County Health Services Agency	26	6	5
Total	248	75	74

Note: The monthly rates were calculated based on the individual grantees' program start dates as documented in **Appendix A** and the reported number of new assessments in the following months. Monthly through July 2008 is as reported in the October 2008 interim report, except for the addition of data for Del Norte and a technical correction. Data submissions after July 2008 have included assessment dates prior to July 2008, but we do not show those changes here to allow for a fairer comparison. Totals do not add due to rounding.

Are pilot sites adhering to assessment and reporting requirements?

To facilitate an evaluation of the behavioral health pilot project, the CMSP Governing Board required that grantees collect and report information on a regular basis. To date, grantees have largely complied with the evaluation requirements and are working collaboratively with the evaluation team at The Lewin Group. All grantees have submitted data through January 2009.

To collect information on clinical outcomes, grantees are required to administer the Duke Health Profile. To date, more than two thousand Duke Health Profiles (2,009) have been completed by participating CMSP members, and grantee records indicate that they have completed at least one profile for about 80 percent of all people assessed for the pilot project. **Exhibit 8** shows the number of individuals that have completed at least one Duke Health Profile. However, these metrics are

imperfect proxies for compliance because we do not yet know the number of visits, and there are legitimate reasons not to have Duke Health Profiles for some individuals (e.g., they were assessed but never pursued treatment, they refused to complete the form, etc). El Dorado County Community Health Center is the only grantee that has not submitted electronic Duke information to date.

Exhibit 8: Number of people with at least one Duke Health Profile

Lead Agency	# with at least one Duke	Total DSM assessments	Percent
Chapa-De Indian Health Program, Inc.	15	23	65%
Community Health Clinic Ole	30	48	63%
Del Norte Clinics, Inc.	38	40	95%
El Dorado County Community Health Center	-	62	-
McCloud Healthcare Clinic, LLC	4	4	100%
Open Door Community Health Centers	98	144	68%
Petaluma Health Center	181	188	96%
Redwood Rural Health Center	7	7	100%
Shasta Consortium of Community Health Centers	30	39	77%
Sierra Family Medical Clinic, Inc.	57	57	100%
Sonoma Valley Community Health Center	35	42	83%
Sonora Regional Medical Center	46	46	100%
Southern Mono Healthcare District	14	17	82%
Tehama County Health Services Agency	54	57	95%
Total	615	774	79%

Note: includes 24 Duke assessments with ID numbers that do not yet match to the ID numbers for people who received DSM assessments, distributed by site as follows: Sonora (8), Petaluma (7), Tehama & Sierra Family (2 each), and Del Norte, Open Door, Sonoma Valley, Southern Mono, and Shasta (all 1 each).

Appendix A: Summary of treatment type and GAF scores for all CMSP pilot sites

CMSP Behavioral Health Pilot Project Lead Agency	Program Start	Treatment Type			Referral Source				Referral Reason			Global Assessment of Functioning		
		Mental Health	Substance Abuse	Unknown	One of Grantee's Medical Providers	Outside Medical Provider	Self or Family	Other or Unknown	Positive Screening from PCP	Patient Seeking Care	Other or Unknown	Average	Minimum	Maximum
Chapa-De Indian Health Program	March 2008	23			13%	13%	26%	48%	9%	82%	9%	48	35	63
Community Health Clinic Ole	April 2008	48	Not offered		100%				100%			48	35	60
Del Norte Clinics	March 2008	40	Not offered		90%		10%		3%	95%	2%	61	45	89
El Dorado Community Health Center	May 2008	62			95%		5%			95%	5%	56	45	70
McCloud Healthcare Clinic	April 2008	4			75%		25%			100%		62	55	70
Open Door Community Health Centers	April 2008	144	Not offered		100%				100%			53	40	71
Petaluma Health Center	March 2008	162	2	24	69%	1%	9%	21%	47%	24%	29%	49	20	80
Redwood Rural Health Center	April 2008	7	Not offered		14%	29%	43%	14%	43%	29%	28%	53	45	68
Shasta Consortium	March 2008	30		9	20%		44%	36%		64%	36%	55	42	70
Sierra Family Medical Clinic	April 2008	51	6		70%	9%	18%	3%	40%	51%	9%	60	50	70
Sonoma Valley Community Health Center	March 2008	39	3		81%		19%		69%	26%	5%	47	41	57
Sonora Regional Medical Center	April 2008	46	1*		53%	28%	11%	8%	34%	49%	17%	46	30	60
Southern Mono Healthcare District	March 2008	15	2		24%	29%	35%	12%		82%	18%	53	51	62
Tehama County Health Services Agency Clinic	March 2008	45	17*		77%	16%	7%		11%	31%	58%	48	28	58
Total	--	716	31	33	75%	5%	11%	9%	46%	37%	17%	52	20	89

Note: The program start date refers to the initial assessment closest to the program inception date of March 2008.

* The numbers under "treatment type" include six individuals (one for Sonora Regional and five for Tehama County) that were referred for both MH & SA counseling. Sonora Regional, however, is not approved to provide SA services through the pilot project.

Appendix B:

CMSP Behavioral Health Pilot Project Interviews Summary Brief

Take-home messages

- Grantees are implementing their initiatives in very different ways across sites
- Most sites are continuing to struggle to achieve the level of beneficiary participation projected in their original proposals
- Some sites are successfully integrating primary care and behavioral health; others appear to be struggling to achieve meaningful systems change and may need guidance or technical assistance
- Relationships with the local county mental health departments vary among grantees. Some have well-established and collaborative relationships; other grantees express frustration with the county.
- Substance abuse treatment continues to be only a minor component of the pilot project
- Several grantees noted that the program is starting to take shape and that collaboration between providers and administrators is improving. Many see positive developments, and most sites have a positive outlook for the remainder of the grant period.

Overview of the interview process

Alison Kellen contacted behavioral health pilot project grantees in late 2008 to conduct informal check-in calls with each grantee. The first call was conducted on November 25, 2008 and the final conference call concluded on February 10, 2009.

Alison Kellen organized and led the discussions with a focus on the following topics:

- Staffing
- Caseloads/participation
- Referral sources & patterns
- Collaboration with the county mental health department
- Billing & reimbursement
- Data collection
- Early surprises
- Training & 2009 grantee conference

The notes below summarize each of the topics and grantee experiences implementing the program in the first year of the pilot project.

1. Staffing

- *Grantees use a variety of staffing models, and staff size differs between participating grantees.* Some grantees have established organizational support systems and care teams. At other sites, a single therapist takes on several roles for the pilot project: administrative, treatment, and/or evaluation.
- *Assessment and counseling services are provided by a wide range of practitioners:* psychologists, psychiatrists, licensed clinical social workers, marriage and family therapists, and drug & alcohol counselors. Many of the psychiatrists are only available part-time and some as infrequent as twice a

month. Counselors are also often only part-time and provide services as needed. At least four grantees have considered using or have experience with telemedicine. However, reimbursement for telemedicine services is only offered through traditional CMSP and aims to enhance services and improve access to psychiatrist for its target population.

- *Turnover is a challenge.* Several grantees are in the process of hiring new staff to either replace recent departures or in order to expand services. Others would like to expand service offerings but lack the funds and space to accommodate new staff. In addition to hiring and training new providers, some of grantees have also experienced turnover in organizational leadership.

Implications: Staff turnover – among both direct service and administrative staff – presents challenges for program development, compliance, and data collection.

2. Caseloads/Participation/Treatment

Participation in the pilot project has thus far been lower than expected. Grantee projections from the initial grant application have not been realized in the early stages of the pilot project.¹ Grantees suggested a variety of reasons for the lower-than-expected utilization:

- *Lack of provider capacity.* Staff shortages and turnover, as well as changes in leadership have made it more difficult to formalize outreach activities and to successfully target CMSP beneficiaries in need of counseling services.
- *Characteristics of the target population.* Clients are often difficult to contact because of their transient living situations, homelessness, and lack of reliable telephone access. Chronic pain and the lack of access to transportation also make it difficult for some patients to attend all scheduled sessions. All these factors combine to make it difficult to get people back into treatment and to adhere to a structured treatment/counseling regimen.
- *Short-term and irregular CMSP eligibility.* Grantees reported that eligibility processing delays and lack of continuity in CMSP eligibility make proactive planning for on-going counseling very challenging.
- *No-shows.* Grantees expressed concern about no-shows rates for counseling session. In some cases the initial assessment is the only meeting between the practitioner and the client. Two of the larger providers report an approximate no show rate of 20 to 25 percent but also stress that the rates for behavioral health are lower than clinic wide no-show rates. Shingletown noted that strong adherence is partly ascribed to the detailed explanation of services at the onset of treatment.
- *Stigma associated with treatment.* In an attempt to explain the low utilization rate, grantees cited the stigma associated with mental health and substance abuse treatment.
- *Lack of understanding and commitment from primary care providers.* Some may view the pilot project as just “another program with more rules.” That lack of awareness and nonchalance may contribute to low referrals rates and thus the low usage rate program wide.

¹ See *CMSP Behavioral Health Pilot Project – Interim Report, October 2008*. The Lewin Group. Data reported through July 31, 2008 indicate an actual rate of 69 new participants per month. In aggregate, the grantees projected a monthly rate of 249 initial assessment per month.

- *The diagnostic assessment is a challenge for some grantees.* One site noted that the length of time needed to complete the complete DSM-IV assessment, generally accepted to be an hour, is not feasible within its current treatment model which relies on brief meetings to provide services to more beneficiaries. Several grantees suggested a programmatic policy change to allow for an intervention (i.e. counseling session) prior to the assessment.
- *Annual service limits:* Despite lower-than-expected participation and challenges with no-shows, several grantees also expressed concern about the service limitations in the program. One grantee stressed that certain individuals would benefit from weekly counseling sessions but instead follow-up appointments have been strung out over several months to provide longer-term treatment within the current service limits (i.e., 10 mental health and 20 substance abuse treatment sessions per calendar year). Stringing the counseling sessions over longer periods of time has enabled grantees to provide services throughout the year.
- *Case management:* Finally, some grantees expressed concerns about the lack of continuity of care and proposed that CMSP provide increased funding for administrative and case management services.

Implications: The grantee approaches to spreading out counseling visits and suggesting higher annual service limits may be at odds with the CMSP Governing Board’s intent for a short-term intervention, but they appear to be driven by meaningful gaps in the mental health system.

3. Referral Sources & Patterns

- *Internal referrals:* Many grantees note that most referrals come from internal sources.² Sites generally promote the pilot project internally during staff meetings and individual reminders for all clinicians (e.g. one-on-one visits and clinic intranet).
- *Outreach to provider community:* Most grantees have conducted some form of outreach to local providers and social service agencies. However, the number of referrals from local agencies has also been less than anticipated (e.g., El Dorado). Many grantees continue these outreach efforts (Open Door brown-bag) but others have been unable to match and sustain their advertising (Corning) while another providers fears that the message has “worn thin” (Sonora).

Implications: Sites seem to be struggling to create successful outreach strategies to generate new referrals. Some may need guidance or technical assistance.

4. Collaboration with County Agencies

The relationships between grantees and their respective county mental health departments vary in scope from nearly non-existent to extensive collaboration between both entities. The following are examples of existing dynamics in the pilot project:

² The first interim report to the Governing Board, based on data through July 31, 2008, noted that 77% of referrals had come from pilot sites’ own medical staff

- Joint efforts between pilot sites and the county mental health department (e.g., El Dorado, Mono, TCHSA, Sonora). In these instances, patients are referred back and forth easily and case consultations occur on a recurring schedule.
- Other grantees do not have a great history of collaboration with the county. There is generally some communication and collaboration but not a fundamental commitment to collectively address the needs of the local target population. Occasionally, patients originally referred by the county for counseling services become mentally unstable, and in those instances referrals back to the county for more intensive treatment have been difficult.
- Some grantees are frustrated by a lack of collaboration. The county system is perceived as too fragmented and a sense pervades that the county “dumps” complex patients into the safety-net provider system – patients that overwhelm the resources and expertise of the local system.
- In some locations, the county does not currently offer a full range of mental health services because of staff shortages. In these instances, referrals to the county have been difficult and restricted only to crisis patients and those perceived to be outside the scope of services provided by grantees.

5. Integration

The grantees have different levels of experience and expertise in structuring and implementing an integrated model of care for medical and behavioral health services. Five grantees also participate in the Integrated Behavioral Health Program (IBHP). The following are brief summaries of existing integration models currently in use among grantees:

- Three grantees (Open Door, Shasta Consortium, and Sierra Family Medical Clinics) have a strong history of care integration. Co-location of physical and behavioral health services, warm hand-offs between medical and behavioral health providers, formal referral mechanisms, and feedback loops and information sharing are the hallmarks of integrated care for this group of grantees. Mental health practitioners are routinely available to assist primary care providers and actively participate in clinical staff meetings. New providers are introduced to the integrated care model and receive training when they first join the staff. Additional practice innovations are currently in the early phases of implementation or under consideration.
- Other grantees are still in an earlier phase of development. These pilot sites use some of the same techniques (e.g., co-location of medical and behavioral health services, warm hand-offs). Tehama has been able to reduce the stigma associated with mental health treatment and has experienced a “very, very positive change” in care integration.
- Other grantees are struggling to operationalize the integration of primary care and behavioral health.
- Co-location of primary care and behavioral health staff emerged as an important factor in integration. At least two grantees recently moved into new facilities that now house medical and mental health services in the same location, further facilitating collaboration in care integration at those sites.

Implications: The diversity of experience among pilot sites will offer opportunities to share best practices and lessons learned in forums like the upcoming pilot project conference. It also suggests that site-specific differences in implementation may be an important factor in the evaluation of the pilot project.

6. Billing & Reimbursement

In general, grantees are successfully billing and receiving CMSP reimbursement through the pilot project. Grantees expressed concern over some billing-related issues, such as:

- Limits for the total number of visits per year
- Barriers to access associated with CMSP share of cost (SOC) requirements
- Lack of electronic billing for the pilot project.

7. Data Collection

- Most grantees have adapted to the processes for collecting and reporting data.
- During the calls, two grantees expressed concern about the appropriateness of the Duke Health Profile and the necessity for completing the instrument at every visit.
- A few grantees have experienced problems with the data collection template (a Microsoft Excel spreadsheet) due to processing limitations on their computer systems. [Lewin has subsequently created a new version of the template designed to address these concerns.]

8. Early Surprises

Near the conclusion of every interview, grantees were asked to share their early surprises in implementing the behavioral health pilot project. They included:

- Early promises of referrals from community providers never materialized; lower-than-expected program wide participation
- Lower-than-expected referrals to substance abuse counseling
- Five grantees noted that the population was tougher to serve than originally envisioned due to co-morbidities, family dysfunction, homelessness, etc.
- Continuity of care is interrupted because of different funding streams and cyclic eligibility.

9. Grantee Conference

The following are suggestions by grantees for possible session topics at the August 2009 grantee conference in Sacramento:

- Site reports & case studies: Mental Health Care Integration
- Billing & reimbursement policies
- Public program eligibility
- Review study findings
- Marketing & outreach strategies
- New treatment modalities: sensorimotor psychotherapy, short-term treatment approaches, stress management and substance abuse eye movement desensitization and reprocessing.

