B-HIP | Behavioral Health Integration Project
San Luis Obispo County, California

INTEGRATING BEHAVIORAL HEALTH AND PRIMARY CARE SERVICES IN SAN LUIS OBISPO COUNTY:

Assessing the Shifting Landscape

Prepared by
San Luis Obispo Behavioral Health Integration Project (B-HIP)

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TABLE OF CONTENTS

TABLE OF TABLES

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INTEGRATING BEHAVIORAL HEALTH AND PRIMARY CARE SERVICES IN SAN LUIS OBISPO COUNTY: ASSESSING THE SHIFTING LANDSCAPE

INTRODUCTION

2014 heralded a new era in behavioral health[1] services in California. The Affordable Care Act was responsible for two major changes in behavioral health coverage and care. First, the ACA expanded the availability of health insurance to millions more Californians. Second, the ACA included behavioral health benefits in the list of Essential Health Benefits that must be provided in small group and individual plans nationally. The expansion of benefits was also applied to the Medi-Cal program. The federal Mental Health Parity and Addiction Equity Act (2008) which had previously provided that health plans could not treat mental health services differently than physical health services was also incorporated into the coverage expansions including small group, individual market and Medi-Cal plans.

With the reduction of many financial barriers to behavioral health care, this is an opportune time to develop systems for "whole person" care that more fully integrate behavioral health services with general medical care. The literature provides a compelling case for integrating physical health care with behavioral health care.

- People with serious mental illness treated by the public mental health system die on the average 25 years earlier than the general population; they live to age 51, on average, compared with 76 for Americans overall. They are 3.4 times more likely to die of heart disease; 6.6 times more likely to die of pneumonia and influenza, and 5 times more likely to die of other respiratory ailments.[2]
- Adults with mental illness are significantly more likely to have high blood pressure, asthma and stroke and more apt to utilize ER's and hospitals than others.[3]
- The presence of type 2 diabetes nearly doubles an individual's risk of depression and an estimated 28.5 percent of diabetic patients meet criteria for clinical depression.[4]

In July 2014 Transitions-Mental Health Association (T-MHA) received a grant from the Blue Shield of California Foundation to convene community partners in the San Luis Obispo County Behavioral Health Integration Project (B-HIP). The purpose of B-HIP is:

[1] Behavioral health is being used as the overarching term to encompass both mental health (MH) and substance use disorders (SUD).
[2] Colton, C, Mortality: Health Status of the Served Population, Sixteen State Pilot Study on Mental Health Performance Measures, 2003.
[3] National Survey on Drug Use and Health, Center for Behavioral Health Statistics and Quality (formerly the Office of Applied Studies), Substance Abuse and Mental Health Services Administration (SAMHSA). April 2012
[4] Lustman PJ, Clouse RE. Depression in diabetic patients: The relationship between mood and glycemic control. Journal of Diabetes and Its Complications, 2005; 19: 113-122.

To improve system-level integration of primary and behavioral health care in the safety net in San Luis Obispo County through collaborative planning and action among providers, county agencies and Medi-Cal managed care plans.

B-HIP partners include T-MHA, CenCal Health, Holman Group, Community Health Centers of the Central Coast (CHC), SLO County Health Agency -- Behavioral Health and Public Health, Tenet Health, Dignity Health and Cal Poly Health and Counseling. Diringer and Associates, a Central California health policy consulting firm, provides staff support and facilitation.

The group has had monthly convenings among partner agencies to develop a shared vision and collective accountability for advancing primary care and behavioral health integration in San Luis Obispo County. The group also conducted a community needs assessment, commissioned focus groups with behavioral health consumers, and participated in a statewide "learning community" in behavioral health integration. Drawing upon the Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Resources and Services Administration's (HRSA) Six Levels of Collaboration/Integration Tool, the group has developed a blueprint for system-wide integration with short, medium and long-term goals with key performance measures and identified leadership and roles in San Luis Obispo County.

This report is intended to explain the new behavioral health benefits, assess the system capacity to provide behavioral health services in San Luis Obispo County, present policy and delivery system challenges and highlight the blueprint for integrating physical and behavioral health services. The brief will primarily focus on services for San Luis Obispo County's nearly 50,000 Medi-Cal managed care recipients and those who receive services at County Behavioral Health and CHC.

- Part I discusses the scope of the expanded behavioral health benefits and which agencies are responsible for providing the services to consumers.
- Part II presents an analysis of the demand for behavioral care services in San Luis Obispo County.
- Part III reports on the capacity of San Luis Obispo County providers to meet the expected demand for services.
- Part IV provides an estimate of the current utilization of behavioral health services in San Luis Obispo County.
- Part V discusses the results of focus groups of behavioral health clients and their attitudes about current services and interest integrated services.
- Part VI analyzes the challenges to behavioral health integration in San Luis Obispo County.
- Part VI provides the 5 year blueprint for integrating services and recommendations for expanding efforts in San Luis Obispo County for meeting the behavioral and physical health needs of its residents.

I. EXPANSION OF BEHAVIORAL HEALTH BENEFITS

A. Newly covered populations

The implementation of the Affordable Care Act in San Luis Obispo County has resulted in over 30,000 additional residents receiving health coverage: 15,712 San Luis Obispo County residents were enrolled in Covered California plans through February 22, 2015 while nearly 14,000 residents were added to the Medi-Cal rolls due to the Medi-Cal expansion. An additional 2,250 San Luis Obispo County residents who were previously eligible for Medi-Cal, but not enrolled were also added to Medi-Cal. Medi-Cal recipients now total approximately 48,300, or two in 10 (17.2%) San Luis Obispo County residents.

B. Expanded scope of benefits

Beginning January 1, 2014, covered Medi-Cal benefits include those mental health services and substance use disorder (SUD) services contained in the essential health benefits package adopted by the state for the individual and small group market (i.e., the selected Kaiser Small Group product).

Medi-Cal managed care plans (CenCal Health in San Luis Obispo County) provide the mental health benefits covered in the state plan, excluding those benefits provided by county mental health plans under the Specialty Mental Health Services Waiver.

Expanded mental health benefits include:

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring drug therapy
- Outpatient laboratory, drugs, supplies and supplements
- Psychiatric consultation
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) for alcohol use (a primary care benefit).

In addition to the current SUD benefits of outpatient treatment and narcotic treatment funded through the 2011 Realignment, the expanded SUD benefits include:

- Intensive outpatient treatment (no longer limited to pregnant/postpartum/under 21 population)
- Residentially-based substance use disorder services (no longer limited to pregnant/postpartum population)
- Voluntary medically necessary inpatient detoxification.

For the new enhanced SUD benefits, the State will pay the non-federal share (50%) for the pre-2014 eligible populations. For the pre-2014 benefits, the counties are responsible for the non-federal share. For the new, expanded Medi-Cal populations, the federal government pays for all the benefits.

The Mental Health Parity and Addiction Equity Act (MHPAEA) requires many insurance plans that cover mental health or substance use disorders to offer coverage for those services that is no more restrictive than the coverage for medical/surgical conditions. The insurance plans covered by this requirement are all Covered California plans, small group and individual plans, and Med-Cal. This requirement applies to:

- Copays, coinsurance, and out-of-pocket maximums
- Limitations on services utilization, such as limits on the number of inpatient days or outpatient visits that are covered
- The use of care management tools
- Coverage for out-of-network providers
- Criteria for medical necessity determinations.

C. Responsible agencies and implementation

1. Mental Health Services

San Luis Obispo County Behavioral Health Department continues to be responsible for providing "specialty" mental health services for those with severe mental health disorders. It provides assessments, crisis intervention, case management, medication support, individual, family and group therapy, and inpatient services. It focuses primarily on Medi-Cal recipients and indigent clients and serves both adults and children. Its provider network includes county-employed therapists, as well as contract therapists. Clients can access services through directly contacting the County Behavioral Health Department, through referral by a provider, or potentially through CenCal and its contractor Holman Group.

To be eligible for County services, clients must meet one of 18 specified diagnoses.[5] Adults must also have a significant impairment or probability of significant deterioration in an important area of life functioning. Children under the age of 21 must have a probability that they will not progress developmentally, or when specialty mental health services are necessary to ameliorate the person's mental illness or condition. The intervention must address the impairment and be expected to significantly improve the condition. Additionally, to be eligible for County services, the condition should not be responsive to physical health care treatment.

Persons with mild to moderate mental health diagnoses are not treated by the County, but by community providers. Prior to the expansion of Medi-Cal, these services were limited to those provided by primary care clinicians, or therapists in the safety net clinics-- the Federally Qualified Health Centers (FQHCs) such as Community Health Centers of the Central Coast. Mental health services for mild/moderate conditions were very limited and generally not covered by managed care Medi-Cal.

With the expansion of Medi-Cal, the scope of services provided has expanded significantly and is covered by the County's Medi-Cal managed care plan, CenCal Health. CenCal has contracted with the Holman Group to administer the mental health benefits as its behavioral health organization.

[5] Eligibility criteria for County mental health services can be found at: http://www.slocounty.ca.gov/health/mentalhealthservices/howtoapply/eligibility_requirements.htm

Holman Group manages provider network and credentialing, a member call center, utilization management, claims processing, and some appeals and grievances. CenCal members may access services through their primary care provider, contacting Homan Group directly, or through the County Behavioral Health Department.

Holman Group services include:

- Individual mental health evaluation and treatment (psychotherapy)
- Group mental health evaluation and treatment services
- Psychological testing when clinically indicated to evaluate a mental health condition
- Psychiatric consultation for medication management
- Not included: Mental health services for relational problems are not covered. This includes counseling for couples or families for conditions listed as relational problems.

CenCal Health also covers behavioral health treatment (BHT) for autism spectrum disorder (ASD). This treatment includes applied behavior analysis and other evidence-based services. This means the services have been reviewed and have been shown to work. The services should develop or restore, as much as possible, the daily functioning of a member with ASD.

Primary care providers (PCPs) provide services for mildly impairing mental health disorders (e.g. anxiety, depression, mild ADHD) and mental health disorders that would be responsive to physical health care treatment. PCPs may also obtain psychiatric consultation, including consultation for medication management from a Holman psychiatrist. PCPs are also now reimbursed for alcohol Screening, Brief Intervention, and Referral to Treatment (SBIRT).

2. Substance Use Disorder (SUD) Services

The Administration and Legislature determined that counties would provide the expanded substance use disorder benefits as part of the Drug Medi-Cal Treatment Program, which was realigned to counties under 2011 Realignment. Medi-Cal managed care plans are not contractually required to include drug and alcohol treatment services; however, plans are required to assess beneficiaries for alcohol conditions in primary care settings (SBIRT) and refer them to county SUD treatment providers as appropriate.

Medi-Cal has two programs that treat individuals with SUD: the Drug Medi-Cal Treatment Program that includes a specialized set of SUD treatment services, and the broader fee-for-service (FFS) Medi-Cal program, which includes physician-administered outpatient services. A set of physician-administered services and inpatient detoxification for alcohol and opioid use is also available through the broader Medi-Cal fee-for-service program.

To overcome several policy barriers, the State Department of Health Care Services (DHCS) is requesting a waiver from the Centers for Medicare & Medicaid Services (CMS) to operate the substance use disorder (SUD) Drug Medi-Cal (DMC) program as an organized delivery system (ODS). The DMC ODS will provide a continuum of care modeled after the American Society of Addiction Medicine criteria for substance use disorder treatment services, enable more local control and accountability, provide greater administrative oversight, create utilization controls to improve care and efficient use of resources, implement evidenced-based practices in

substance abuse treatment, and coordinate with other systems of care. This approach will provide the beneficiary with the access to care and system interaction needed to achieve sustainable recovery. The DMC ODS will demonstrate how organized substance use disorder care increases the success of DMC beneficiaries while decreasing other system health care costs.

II. DEMAND FOR BEHAVIORAL HEALTH SERVICES

A. Demand for behavioral health services

In assessing the potential demand for behavioral health services, we reviewed published utilization rates, population estimates and Medi-Cal enrollment. According to the California Primary Care, Mental Health, and Substance Use Services Integration Policy Initiative:

- 26 percent of the U.S. population 18 years and over will need mental health services during a given year. Of those, an estimated 20.2 percent will have mild/moderate mental health diagnoses; 5.7 percent will have serious/severe diagnoses. The rate is higher for low-income uninsured.[6]

- 20 percent of children will need mental health services during a given year.[7]

- 12.7 percent of the U.S. population 18 years and over will need AOD services during a given year. (CA IPI Report, page 18.) Although data is not readily available for differentiating between mild/moderate diagnoses and serious/severe diagnoses, this report uses the mental health ratios as a proxy – 7.7 percent Mild/Moderate; 5.0 percent Serious/Severe.[8]

The California Health Care Almanac (2013) estimates that 15.9 percent of the adult population will need mental health services. For children, 7.6 percent have a serious emotional disturbance, and 4.3 percent of adults have a serious mental illness.[9]

The California Mental Health and Substance Use Needs Assessment (2012) estimates that 5.4 percent of the population has a serious mental illness (7.3% of children; 4.9% of adults). The percentage of persons with alcohol and drug diagnoses is 8.8 percent (3% of children; 10.2% of adults).

In addition, there is an overlap in the mental health and substance use disorder populations. Nearly 60 percent of individuals with bipolar disorder and 52 percent of persons with schizophrenia have a co-occurring substance use disorder. Approximately 41 percent of individuals with an alcohol use disorder and 60 percent of individuals with a drug use disorder have a co-occurring mood disorder.[10] An estimated 49 percent of Medicaid beneficiaries with disabilities have a psychiatric illness.[11]

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[6] California Primary Care, Mental Health, and Substance Use Services Integration Policy Initiative, September 14, 2009. p.18.
[7] Mental Health: A Report of the Surgeon General, 2000.
[8] California Primary Care, Mental Health, and Substance Use Services Integration Policy Initiative, September 14, 2009. P. 18.
[9] California Health Care Foundation, California Health Care Almanac: Mental Health Care in California: Painting a Picture, 2013.
[10] Verduin, M et al., Substance Abuse and Bipolar Disorder. Medscape Psychiatry and Mental Health. 2005.
[11] Kronick RG, Bella M, Gilmer TP. The faces of Medicaid III: Refining the portrait of people with multiple chronic conditions. Center for Health Care Strategies, Inc., October 2009.

Based on the above rates, the chart below estimates the range of San Luis Obispo County residents who will need behavioral health services.

Table 1: Estimated Demand for Behavioral Health Services

Estimates of demand for Behavioral Health services in SLO County	0-19	20+	Total population	<200%FPL--Medi-Cal***
Total County population*	62,879	213,564	276,443	
Total Medi-Cal population**	22,162 (35.2%)	25,472 (11.9%)	47,634 (17.2%)	47,634
Mental Health				
Children	12,576- 21,010			4,432
Adults-severe/serious		10,302 - 12,173		1,452 - 4,544
Adults-mild/moderate		43,140		5,154
Any mental illness		21,010 – 57,313	39,573 - 67,889	11,030 -15,698
Substance use disorders				
Children	1,666			524
Adults		22,349 - 27,122		3,235 - 7,214

Estimates based on Statewide and National prevalence estimates including CA Mental Health and Substance Use Needs Assessment, CA Primary Care, Mental Health and Substance Use Services Integration Policy Institute and CHCF California Health Care Almanac. Estimates may not add up due to different data sources.

*2013 Census ACS 1-year estimate

**October 2014 CenCal enrollment

***Assumes same prevalence rates for Medi-Cal as for general population

The full analysis of demand is located in the Appendix.

III. COMMUNITY CAPACITY TO MEET DEMAND

A. Mental Health Staffing Standards

The federal government sets standards for Health Professional Shortage Areas (HPSA). For Mental Health, the federal Health Resources Services Administration sets the number of core mental health professionals (which include psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists) that are needed to serve particular populations. An area is defined as being a Mental Health HPSA if the ratio of the population to core mental health professionals exceeds 6,000:1, or if the ratio of the population to psychiatrists exceeds 20,000:1. For communities that have "unusually high needs for mental health services," the ratio of population to core mental health professionals should not exceed 4,500:1, and the ratio of population to psychiatrists should not exceed 15,000:1. Under the HPSA criteria, San Luis Obispo County does not qualify as an area with unusually high needs.

In order to meet minimum staffing ratios, the county needs between 43 and 57 core mental health providers and between 13 and 17 psychiatrists. For the Medi-Cal population, the HPSA guidelines would require between 17 and 22 core mental health professionals and 5 to 7 psychiatrists for this low-income population. Using the HPSA standards, the table below estimates the number of mental health providers that are needed to serve the population.

Table 2: Federal Mental Health Staffing Standards

HPSA Mental Health Criteria	MH Professional Needs	
	County pop.	Medi-Cal
Core mental health providers (population to core MH professional ratio of 6,000:1)	46	8
Psychiatrist (population to psychiatrist ratio of 20,000:1)	14	2.3
Core mental health providers for high need population (population to core MH professional ratio of 4,500:1)	n/a	11
Psychiatrist for high need population (population to psychiatrist ratio of 15,000:1)	n/a	3.1

If each therapist saw approximately 900 patients a year, the projected demand of the adult Medi-Cal population with mild/moderate mental health needs (5,154) would require approximately 6 therapists. If we assume that 80 percent of 4,432 children on Medi-Cal projected to need mental health services require them for mild/moderate conditions, then an additional 5 therapists are required to meet the needs of children on Medi-Cal.

B. San Luis Obispo County Behavioral Health Services Staffing

Mental health services for the Medi-Cal population are provided by the County Behavioral Health, Holman Group and CHC. Their mental health staffing is as follows:

Table 3: San Luis Obispo County Behavioral Health Services Staffing

Provider	Community Health Centers (SLO)	Cen Cal -- Holman	Cal Poly Health and Counseling	County Mental Health Outpatient staff	County Drug and Alcohol Services
Psychiatrist	1	5	2	2 + 6 locum tenens	
PhD/PsyD		4	15	2	
LMFT/LCSW	8	47	1	75 incl. interns and trainees	18
NP/PA		2		1	1
RN/LVN/LPT				15	8
SA credentialed					28
Psych NP	3	2			
Lic. Prof. Counselor	1	1			
MSW intern	2	1			
Spanish speaking BH clinicians	2	6 Masters level 1 Psychologist 1 Psychiatrist		15	(included in Co MH)

As of March 2015, Holman Group has contracted with the following mental health providers to serve the Medi-Cal population in San Luis Obispo County: 5 psychiatrists, 9 licensed clinical social workers, 38 licensed marriage and family therapists, 4 psychologists, 2 psychiatric nurse practitioners, and 7 other practitioners. The number of Holman contracted providers exceeds the HPSA standards for core mental health professionals and psychiatrists assuming that each contracted therapist is always available to CenCal members.

Holman reports that its provider panel includes the following Spanish speaking providers including six Masters level providers, one psychologist and one psychiatrist.

Recruiting psychiatrists to serve County Behavioral Health and CenCal patients is difficult in San Luis Obispo County, as in most other counties in the California. There is high turnover and the use of visiting or "locum tenens" psychiatrists. Clients report that they see a different psychiatrist on each visit which inhibits relationship building and continuity of care.

C. Drug and Alcohol Services

The County is the primary provider of SUD services in San Luis Obispo County. Drug and Alcohol Services (DAS) offers screening and assessment, individual and group treatment, outpatient medication assisted withdrawal programs, case management and co-occurring disorders treatment. DAS clinics are located in four cities across the county; however youth can only be seen in two of the locations. SLOBHD also provides Drug Court Programs, DUI Programs, Youth and Family Services, and Sober Living Environments.

Drug and Alcohol services are limited in San Luis Obispo County as they are in other counties. There are no medical detox units in the County and no providers of residential services.

D. Community Mental Health Providers

Mental health services are provided by a few large public and nonprofit agencies, which are described below. Mental health services are also provided in a large part by private providers. However, we were not able to accurately determine the number of private providers available to the public, nor the number of clients that they served.

San Luis Obispo County Behavioral Health Department (BHD) works in collaboration with the community to provide a variety of services to improve the health and safety of individuals affected by mental illness and/or substance abuse. Their services are designed to assist the recovery process and achieve the highest quality of life by providing culturally competent, strength based, and client and family centered strategies utilizing best practices.

Behavioral Health Department offers the following outpatient mental health services: assessment, medication management, case management, group rehabilitation, individual therapy, and co-occurring disorders treatment. The clinics are located in three cities across the county. Behavioral Health Department also operates a Psychiatric Facility located in San Luis Obispo, and a clinic for children under five years old. Behavioral Health also offers mobile crisis services, a brief therapy program, inpatient services, and prevention and outreach services for veterans and the Latino community, and forensic programs.

CenCal Health and The Holman Group. As the Medi-Cal managed care plan, CenCal Health is responsible for providing mental health benefits to its members for mild to moderate conditions. CenCal has contracted with The Holman Group, a mental health managed care entity to administer the mental health benefits.

Community Health Centers of the Central Coast, Inc. (CHC) is a non-profit network of community health centers serving the residents of California's Central Coast, with locations throughout San Luis Obispo and northern Santa Barbara counties. CHC is a Federally Qualified Health Center, and offer fully accredited medical, dental and chiropractic care as well as health education and specialty care.

CHC began in Nipomo in 1978, and has since expanded to 25 clinics, providing more than 310,000 medical and dental encounters annually. Their professional staffing includes pediatricians, family practice, internal medicine, ob/gyn physicians, physician assistants, nurse practitioners, dentists, chiropractors, licensed clinical social workers and nutritionists. Other on-site services include cardiology/ pulmonary, neurology, orthopedics, podiatry, infectious disease, pain management, telemedicine, chiropractic and women's health. CHC's services also include two on-site pharmacies that fill more than 85,000 prescriptions per year.

CHC's behavioral health and medical staff provide behavioral health services to CHC's patients. Beginning November 2014, CHC does not need to refer its patients with mild to moderate mental health conditions to the Holman Group for screening and referral, but can refer patients internally to its own staff therapists.

Community Counseling Center (CCC) is a non-profit, community organization staffed by qualified, state-licensed, volunteer therapists or graduate-level supervised interns. The primary

purpose is to assist individuals and families to develop the ability to find choices and make changes when life becomes difficult during times of transition, confusion, depression or grief.

The program provides short-term psychological counseling services and counseling information to San Luis Obispo County residents whose circumstances are not appropriate for existing public mental health resources or who cannot afford private services. Fees are based on a sliding scale according to each client's ability to pay. Persons who are financially able, through income or insurance coverage, to use private services are offered referrals. No one is denied service on the basis of race, color, creed, religion, national origin, age, gender, sexual orientation, marital status, physical or mental disability.

Cal Poly Health and Counseling Services provides services to Cal Poly students. It provides individual, couples and group psychotherapy, as well as RIO (Recognition/Insight/Openness) which is a 3-week psychoeducational seminar designed to help students clarify their concerns and develop a clearer sense of what they would like to change in their lives.

E. Medical and Behavioral Health Services in the County Jail

Jail medical services are provided by SLO County Public Health's Law Enforcement Medical Care (LEMC) Program. The San Luis Obispo County Jail Psychiatric Services provides psychiatric treatment to inmates housed at the County Jail. Services include crisis intervention, suicide prevention, medication evaluations and general counseling as requested. Discharge medication is provided when indicated and access to behavioral health services is provided via the BHD's managed care department.

In FY 13/14 there were an average of 1,018 bookings monthly at the County Jail. The in-custody average daily population was 684, with another 764 persons placed in outside locations (e.g. hospital, home detention, other facilities).

There are an average of 4,110 medical visits per month through the LEMC program. 61 percent of inmates are on medications (both prescription and over-the-counter).

The Jail Counseling program has an average of 758 requests for services a month. Of the average monthly 588 unduplicated users of behavioral health services, 418 clients are on medications (71%). A monthly average of 3.2 inmates are transferred to the PHF.

The AB109, 2011 public safety realignment program serves an average of 170 clients monthly. They provide an average of 1,481 monthly services with include group treatment (740), individual treatment (79), case management (135) and mental health services (153).

F. Community Programs

Recently, several new programs have come on line in San Luis Obispo to address the issues of integrated care, case management, homelessness and health. Other efforts have focused on developing case management models to reduce hospital readmission rates of those with chronic diseases and substandard housing situations.

San Luis Obispo Health Integration Project (SLO-HIP)

The San Luis Obispo County (California) Behavioral Health Department (SLOBHD) is partnering with Community Health Centers of the Central Coast (CHC) and other health providers to provide health services at Behavioral Health sites to individuals with serious mental illness. If funded, the San Luis Obispo Health Integration Project (SLO-HIP) will provide a health home including medical exams, preventive screenings, health promotion and disease management and navigation services. A Peer Wellness Coach will assist participants and family members with navigation and facilitate access to services.

SLO-HIP will provide medical services to at least 280 of its 2,800 clients with serious mental illness in its first year, with increased goals 700, 1,120 and 1,400 clients in Years 2, 3 and 4, respectively. SLO-HIP projects providing services to an increasing percentage of Latinos and racial minorities from 27 percent in Year 1 to 30 percent (Year 2), 32 percent (Year 3) and 35 percent (Year 4), respectively. An estimated 25 percent of participants will receive tobacco cessation services, and 55 percent will receive nutrition/exercise education.

Project goals are to:

- Improve integration of physical and behavioral health care by providing medical services on-site to SLOBHD patients through a partnership with CHC.
- Reduce chronic disease among SLOBHD's adult, severely mentally ill patients through early detection, intervention, and prevention education.
- Improve access to a full range of integrated health services by employing a peer wellness coach, with lived experience, to support SLO-HIP patients.
- Enhance information sharing between providers through electronic health information exchange between diverse electronic health record systems.
- Evaluate cost benefit of integrated physical and behavioral health care through data collection and performance management.
- Develop a sustainable system of integration of services by identifying funding mechanisms and responsibilities.

An Integrated Treatment Team, including project staff and health care providers, will meet weekly to case manage, collect data, address barriers and improve program quality. A Coordination Team composed of agency executives, financial officers, medical directors and others will oversee SLO-HIP's operations and evaluation, and develop sustainability plans

Status: Funding has been sought from the federal Substance Abuse and Mental Health Administration (SAMHSA) for the project to potentially begin in October 2015 for four years.

50Now:

Goal: 50Now is a comprehensive program, which will leverage resources from existing programs in the community to place chronically homeless clients into housing and provide targeted, individualized supportive services to help them maintain housing. The goal of the 50Now Program is to house 50 of the most vulnerable homeless people in San Luis Obispo County over a period of three years. In following with the 100,000 Homes Campaign model, clients of the 50Now Program are prioritized for housing using a Vulnerability Index tool which evaluates the mental and physical health conditions and social status of identified individuals.

The list of prioritized individuals has been created and maintained by the County. Services will be provided in all regions of the County.

Agencies Involved: Transitions- Mental Health Association (T-MHA) (Lead Agency), Community Action Partnership of San Luis Obispo County (CAPSLO), El Camino Homeless Organization (ECHO), 5Cities Homeless Coalition, Community Health Centers of the Central Coast (CHC), HALSO, and County staff in the Department of Social Services and Health Agency.

Status: 3 years of funding from County of San Luis Obispo. As of April 2015, 27 persons have been situated in permanent housing under the program.

Supportive Services for Veterans Families:

Goal: To provide rapid rehousing, homelessness prevention and certain supportive services to homeless and at-risk veterans and their families, over the next three years. Thirty-five additional Housing Choice Vouchers will be awarded to SLO County for eligible homeless veterans. The program will also provide participating veterans with supportive services, including VA health care and case management services.

Agencies Involved: Community Action Partnership of San Luis Obispo (CAPSLO) (Lead Agency), Good Samaritan Shelter, 5Cities Homeless Coalition, and Veterans Association.

Status: Funded by VA.

IMPACT Project:

Goal: To create an effective, sustainable and possibly replicable program using a Master Case Manager (MCM) to improve a range of outcomes among patients at high risk for poor post-hospital outcomes. The MCM will help patients navigate the health care system and address key health barriers, such as housing instability or food insecurity. The MCM will be able to help breach potential breakdowns in communication between patients and their care providers, and address the socioeconomic and behavioral factors that affect health. The MCM will connect during a patient's hospital or emergency room stay and continue to partner with patients after they are discharged, helping to overcome barriers or issues such as scheduling doctor appointments, accessing medications, or finding child care or shelter. Patients meeting the criteria for the IMPACT model will also receive peer support such as empathy and active listening.

The new health care laws make health systems accountable for patient outcomes such as primary care access, quality, and hospital readmissions. To improve these outcomes, it is vital that health systems implement programs that reach beyond their walls and address the root causes of poor health.

Agencies Involved: Community Action Partnership of San Luis Obispo (CAPSLO) (Lead Agency); CenCal Health; SLO County Behavioral Health; Transitions Mental Health Association (TMHA); SLO County Department of Social Services; Dignity Health; Tenet Health; Transitional Food and Shelter; North County Connection; Community Health Centers of the Central Coast (CHC); Compass Health

Status: Funding is being sought for IMPACT.

G. Community Support Services

A number of community organizations provide essential behavioral health services in the County. These organizations include Transitions-Mental Health Association, Family Care Network, Wilshire Community Services, SLO Hotline, Community Action Partnership, and the Promotores Collaborative of San Luis Obispo County.

Transitions-Mental Health Association

Transitions-Mental Health Association (TMHA) is a nonprofit organization dedicated to eliminating stigma and promoting recovery and wellness for people with mental illness through work, housing, community and family support services. They operate 30 programs at over 35 locations in San Luis Obispo and North Santa Barbara counties. The emphasis of their innovative services is to teach vital independent living skills and help build a framework for community re-entry through personal empowerment and hands on experience. For over 30 years, TMHA has been dedicated to providing work, housing, case management and life-skills support to teens and adults with mental illness while offering support, resources and education for their loved ones.

Community Action Partnership of San Luis Obispo County

Community Action Partnership of San Luis Obispo County (CAPSLO) is a nonprofit agency that focuses on helping people and changing lives through serving nearly 40,000 persons across Central and Southern California. CAPSLO is committed to eliminating poverty by empowering individuals and families to achieve economic self-sufficiency and self-determination through a variety of community-based programs.

CAPSLO offers the following services:

Adult Day Center- An affordable adult day program that focuses on providing respite to family caregivers and quality care to aging loved ones with Alzheimer's or other forms of dementia. The program is designed to keep seniors safely independent for as long as possible.

Health & Prevention-This program offers services and education that foster personal health and empowerment through two no-cost reproductive health clinics; a case management and empowerment program for pregnant youth and teen parents; a gang and antisocial tattoo removal program; school-based health education and youth empowerment programs; and a mobile wellness screening program that serves low-income and uninsured adults at 17 sites across the county.

Homeless Services- Since 1989, the CAPSLO's Homeless Services program has been working to meet the needs of the homeless in SLO County, offering emergency shelter, on-site information and referral services, and assistance in finding permanent housing. It is a partner in the 50Now program and the lead agency in the Supportive Services for Veterans Families program.

Family Support Services - This program's mission is to strengthen and support families and help prevent child abuse and neglect in San Luis Obispo County. Through parent education, prevention, and intervention, family advocates work with schools and other service providers to assess the unique challenges of each family to create solutions for success.

Wilshire Community Services

Wilshire Community Services supports individuals and families throughout San Luis Obispo County who are facing challenging circumstances and difficult life transitions. Wilshire Community Services' has several organizations- Senior Peer Counseling, Caring Callers, Creative Mediation, Good Neighbor, and Clearings- which provide services to older adults for healing, connection, resolution and renewal. Services are provided at no charge to clients.

The target population for all Wilshire programs is older adults (60+). Through the Good Neighbor Program they also serve adults (18+) who have a disability. Annually Wilshire serves an average of: 77 clients in Caring Callers, 139 in Senior Peer Counseling, 106 in Clearings, and 200 in the Good Neighbor Program. They have one full time therapist on staff and two LCSW's who work per diem.

Caring Callers is a prevention social enrichment program targeted at Older Adults at risk for depression and other mental health issues due to isolation and loneliness. Caring Callers volunteers make weekly in-home visits that provide critical social opportunities and connection to the community for homebound older adults. Volunteers are of all age groups and walks of life. In the course of services they provide critical social support and referral to other resources when needed, thus decreasing the potential for mental health problems associated with isolated seniors.

The Senior Peer Counseling Program provides emotional and psychological counseling and supportive services to older adults who are experiencing emotional distress involving such issues as health problems, grief, care-giving, depression, anxiety, loss, or family difficulties. Professionally trained senior peer volunteers (age 55+) offer these services in the client's residence.

The Clearings Program provides Transitional Therapy to older adults in need of more intensive mental health services than can be provided by the Caring Callers or Senior Peer Counseling Programs. The goal of transitional therapy is to stabilize the client, improve functioning and quality of life, and engage them in Senior Peer Counseling or Caring Callers for continued support once therapy ends. If during early intervention therapy it is determined that the Older Adult needs a higher level of care, the Transitional Therapist will facilitate transition of the client to an appropriate setting (private insurance, County Mental Health, Veteran's Services, etc.).

The Good Neighbor Program provides critical in-home support to older adults and adults with disabilities. Volunteers 18+ assist with: transportation, shopping & errands, housework, yard work, minor home repair, and meal preparation.

Family Care Network

The Family Care Network is a nonprofit which serves foster and high-needs children, youth and families on the Central Coast. It provides 17 distinct programs within five service divisions:

- Therapeutic Foster Care;
- Family Support Services;
- Transitional Housing Services;
- Prevention and Early Intervention Services; and
- Community-Linked Services.

It employs approximately 25 licensed therapists in San Luis Obispo County, six to seven of whom are bilingual in Spanish and English.

In FY 13/14 is provided the following services in San Luis Obispo and Santa Barbara Counties:

- Overall – 1,577 children, youth and families served
- Therapeutic Behavior Services – 89 youth/families served
- Outpatient counseling services – 15 individuals
- MHSA – Full Service Partnership 58 youth/families served
- School-based Mental Health Program – 111 youth served

Cal Poly Community Counseling Clinic

The Cal Poly Community Counseling Clinic offers short-term counseling and consultation to San Luis Obispo County residents who do not qualify for County Mental Health Services or who cannot afford private psychotherapy.

Counseling is available to children, youth, families, individuals, and couples. This counseling service is staffed by well-educated and trained graduate students in the Master of Science Psychology Program under the supervision of clinically licensed psychologists in the Psychology and Child Development Department.

Counseling is provided as a service to the community for a modest fee based on a sliding scale that ranges from $3 to $15 per session. No one is denied services on the basis of race, ethnicity, religion, national origin, age, gender, sexual orientation, marital status, physical or mental disability, or ability to pay for counseling service.

The Cal Poly Community Counseling Clinic served 40 clients (14 men and 26 women) in 2014. The age of the clients ranged from 10 to 75 years. The median age was 26 and the average age was 34 years old. The median number of visits was 12 and the average was 18.

Of the presenting complaints addressed during treatment, 50 percent of clients were seen for depression; 38 percent anxiety; 35 percent stress or coping; 28 percent relationship issues (including couples counseling); 25 percent social integration problems; and 15 percent for family issues (including family therapy).

SLO Hotline

SLO Hotline is a suicide prevention and mental health crisis line that is staffed 24 hours a day, seven days a week. SLO Hotline supports the work of local government and mental health service agencies and relieves call volume for the local 911 service. SLO Hotline refers callers with other needs to 211, the resource phone number available for all other community information and referral needs.

SLO Hotline is a program of Transitions-Mental Health Association. It began as a local crisis support and resources referral hotline and continues its service to the community now with a new stigma-reduction and mental health recovery mission.

In FY 13/14 Hotline received 5,725 calls. Nearly all were from adults (85%) with 12 percent from seniors and fewer than one percent from minors. Approximately six percent of calls were from someone with a mental crisis, and four percent were from someone with a suicide crisis.

Approximately 44 percent of calls result in a referral to community resources. The most common agencies to which callers are referred: SLO Mental Health PHF (29%), SLO Mental Health (14%), T-MH (9%), Community Counseling Center (4%), Family Services (4%) and SLO Drug and Alcohol Services (3%).

Promotores Collaborative of San Luis Obispo County

The relatively new Promotores Collaborative seeks to promote equal access to community resources and services among all members of the Hispanic community in San Luis Obispo County. After completing 40 hours of training, the Promotores are provided with the tools needed to work as advocates, change agents, and partners with local agencies for positive change. There are approximately 30 trained Promotores. It is currently a project of the Center for Family Strengthening with an AmeriCorps coordinator.

With funding from the Mental Health Services Act, County Behavioral Health is providing for interpreter training.

Community Drug and Alcohol Services

In addition to the services offered through the county Behavioral Health Department, there are 16 sober living environments, residential treatment and outpatient services, nine of which have contracts with the county. These programs have a range of focuses and specific clientele and are offered throughout the county:

- Bryan's House, Paso Robles: Women and Children, Drug Dependency Court clients *
- Captive Hearts, Grover Beach: Faith-based facility for females over 18. Six beds. Sober living environment, six months-1 year.*
- Casa Solana 1 and 11, Grover Beach: Ten beds, females between 18-72. 12-step based program. 90 day program. Depending on space availability, patients may enter a six month transitional program in a separate facility. *
- Coastal Recovery Project, Pismo Beach, San Luis Obispo: Sober living facility for men over 18.*

- Gryphon Society, Atascadero, Grover Beach, San Luis Obispo, Paso Robles: Men homes in Atascadero, SLO, and Grover Beach. Women's homes in Paso Robles and SLO. For patients aged 18-72, with no serious mental disorders. 90 program.*
- Heal A Heart Ranch, Paso Robles: House with six beds for women, particularly those with open Community Service Work cases.*
- House of Serenity, Los Osos: Nine bed facility for women over 18.*
- Middle House, San Luis Obispo: Men's sober living house. Patients must have a job, and no serious mental disorders.*
- Restoration House, South County: Sober Living Environment*
- Alano Club, San Luis Obispo: Sober living quarters above the club.
- Cambria Connection, Cambria: Self-help groups, early intervention, treatment, prevention, and referrals service.
- Cottage Care Outpatient, San Luis Obispo: Outpatient treatment. Program is in three phases and may take up to one year.
- Lifestyles, Paso Robles: Drop in and prevention services for the underserved population. Classes and recover meetings offered.
- North County Connection, Atascadero: Self-help groups, early intervention and prevention referral service. Information clearinghouse.
- Sea View, Morro Bay: DESCRIPTION?
- Victory Outreach, Paso Robles: Faith based sober living environment.
- Central Coast Freedom Center, newly established treatment program built on a therapeutic community model. CCFC works with several addiction specialists and assists clients through family therapy, group therapy, 12-step recovery, alcohol and drug education, and holistic treatment. The services offered are: partial hospitalization program, relapse prevention, outpatient treatment, addiction treatment, alcohol treatment, intensive outpatient treatment, substance abuse, group therapy sessions, family therapy, and medical intervention.

*Providers with contracts with County for services.

In addition, there are a number of other community services for people with drug and alcohol problems, such as local Alcoholics Anonymous and Narcotics Anonymous groups, as well as support services for family members and friends of those with additions. There are over 325 AA meetings offered every week across the county with meetings for Spanish speakers, men, women, LGBT, and some with available childcare.

IV. UTILIZATION OF BEHAVIORAL HEALTH SERVICES

A. San Luis Obispo County Mental Health Services Utilization

As part of its assessment of community behavioral health services, B-HIP surveyed community providers on their service levels. The results are found in Table 4 which shows the number of persons obtaining behavioral health services at various agencies in San Luis Obispo County, including the number of visits, age breakdowns, and other data.

Table 4: Services provided by SLO Mental Health providers

Provider	Community Health Centers	Holman Group (CenCal)	County Mental Health Outpatient	County Drug and Alcohol Services	Community Counseling Center	Cal Poly Health & Counseling
Period	2014 (annualized)	2014	FY 13-14	FY 13-14	FY 13-14	2014
# MH contacts	8,510 SLO patients with MH diagnosis	1,833 authorized clients	79,854 contacts	71,653 contacts	1443 clients	
# MH visits/clients	SLO/SB 7,982 BH visits 3,599 patients	SLO 7,976 visits 1,537 clients with claims [Plus 210 CHC patients (870 visits) in November/ December 2014	3,972 clients received at least 1MH service 2,404 received 6+ services	2,318 clients received at least one SA service 1,506 received 6+ services	9,117 hours of service by 86 volunteer therapists	MH cases seen by Health Services: 930; 1615 appts. MH cases seen by Counseling Services: 1804/6856 appts
Ave # visits per patient	2.26 visits	5.16 visits	20 contacts	31 contacts	6.3 hours per client (including admin/supervision)	Counseling Services: 3.8
Ages of MH patients	0-18: 8.1% 19-40: 34.8% 41-60: 40.9% 61+: 16.1%	0-5: 1% 6-18: 20% 19-64: 78% 65+: 1%	0-5: 7% 6-18: 37% 19-64: 52% 65+: 4%	0-5" 2% 6-18 : 16% 19-64: 81% 65+: 1%	0-18: 27% Adult: 70% Senior: 3%	
Latino/ Spanish Language	n/a	39 requests for Spanish speaking providers	3,835 contacts 33,409 hours for Spanish speakers	n/a	28% Latino	

B. Hospital and Emergency Room Utilization

In addition to the behavioral health services provided by behavioral health programs, B-HIP also attempted to understand the demand put on hospitals and emergency rooms for behavioral health cases. San Luis Obispo County has four private general hospitals and one psychiatric health facility.

The California Hospital Association convened a panel of 15 leading psychiatric experts in 2013 to estimate the need for inpatient psychiatric beds in a community. The panel concluded that 50 public psychiatric beds per 100,000 individuals (or 1:2000) is the absolute minimum number required to meet current needs.[12] San Luis Obispo County has approximately 5.8 beds per 100,000 residents or only about 10 percent of the estimated need.

The County-operated 16-bed Psychiatric Health Facility (PHF) is the only inpatient psychiatric unit in the County. Services include psychiatric assessments, medication, crisis interventions, and individualized discharge plans. Over 1,000 individuals received care at the facility in the past year, with an average length of stay of approximately three days. The demand on the inpatient unit often surpasses its capacity. In 2012-13 there were 1,376 admissions to the PHF, and 47 percent of the overall admissions were from individuals who had been on the unit at least once.

An analysis of hospital utilization was performed for SLO B-HIP and revealed a high level of utilization for patients with mental health issues. In a one-year period, Sierra Vista Hospital reported seeing 584 patients on an outpatient basis (including the emergency room) who had a primary mental health diagnosis. Another 325 patients had a secondary mental health diagnosis. There were six inpatient admissions with a primary mental health diagnosis. At Twin Cities Community Hospital, in the rural north county area, there were 573 outpatients with a primary mental health diagnosis and 448 with a secondary mental health diagnosis.

Dignity Health did a separate analysis using different methodology and reviewed emergency room intake data. The analysis revealed that approximately 1,500 behavioral health related emergency room visits at French Hospital in San Luis Obispo and 2,000 behavioral health visits at the more rural Arroyo Grande Community Hospital.

Another survey of the four local Emergency Departments by the California Hospital Association reported an average of four behavioral health related visits per day at each hospital - and an overall increase of 25 percent between 2006 and 2011.[13] Local ED representatives estimate busy days may sometimes include five psychiatric crisis visits per hospital.

Data from the Health Services Advisory Group (2013) show there were 259 mental health discharges (ICD-9 codes of 290.xx - 319.xx) and 32 readmissions with a readmission rate of 12.4 percent for San Luis Obispo County. The readmission could have been for any diagnosis. The mental health rate is similar to the 30-day all cause readmission rate.

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[12] California Hospital Association, California's Acute Psychiatric Bed Loss, 2013, California Health Care Foundation, California Health Care Almanac: Mental Health Care in California: Painting a Picture, 2013.

[13] http://www.calhospital.org/general-information/investment-mental-health-wellness-act-2013

V. CONSUMER FEEDBACK ON BEHAVIORAL HEALTH INTEGRATION

The Behavioral Health Integration Project (B-HIP) invited patients from Community Health Centers (CHC) and consumers from Transitions-Mental Health Association (TMHA) to participate in a series of focus groups to discuss primary and behavioral health care in San Luis Obispo County. Nine focus groups were conducted during January and February, 2015 throughout the county. A total of 78 people participated. A consultant familiar with the local mental health system of care facilitated the eight English language sessions, and a T-MHA family advocate conducted the Spanish language session

The participants self-identified as having a mental illness or mental health difficulties. Their conditions, and the impact on their lives, range from mild to serious. In general, CHC patients reported mild to moderate conditions; TMHA consumers reported more moderate to serious conditions.

Most CHC patients receive both primary and behavioral health care from CHC, while most TMHA consumers get their primary care from CHC or private providers, and behavioral health care from County Behavioral Health Services and TMHA. A few participants have private insurance and do not see providers at CHC or the County, but do attend T-MHA programs.

Participants were asked six open-ended questions focused on their experiences accessing primary and mental health care, the quality of service delivery, and their opinions about the "integrated, whole person" care concept and suggestions as planning for an improved system moves forward.

A. Focus Group Findings

The concept and potential of better system-level integration were well-received and of interest to the participants; however, this was not their "burning issue" or greatest priority. The majority of their comments reflect a more basic-needs orientation: the desire to just get to see a provider (consistently); be treated in a respectful manner; and access care in a way that is not cumbersome.

Many of the participants' daily lives (especially those in the TMHA groups) revolve around treating and managing their physical and mental health conditions. Therefore, accessing simple, basic care is most pressing and on their minds. Participants welcomed the idea of system changes, and acknowledged that the "root cause" of problems they have could be addressed; but that high-level, future-focused view and planning does not seem on the forefront of their minds. Rather, their daily, immediate experiences and needs dominated the focus group conversations. However, those comments do lend great benefit to system planning efforts.

An overall feeling of having to fight, push, or work for care was reported. Participants have the impression that the system is not there to serve them. Rather, it is there if one can get to it, and get through it. Participants frequently commented that they do not feel a sense of, “They are here for me." "They care for me.” or "They are committed to me."

The following major themes emerged from all nine focus groups:

- Physician consistency
    - Keep their doctor/psychiatrist consistent. Do not change them.
    - Too much turnover. Have to start over frequently; disruptive to care.
    - "Doctor does not know me."
- See psychiatrist more frequently
    - Appointments are too short; and too long between appointments
    - More psychiatrists needed
- More time with primary care doctors
    - Appointments are too short; and too long between appointments
- Respectful treatment
    - Listen to patient; ask patient questions
    - Be courteous
    - "Believe us!"
- Improve customer service
    - Provider and ancillary staff's attitudes and respectfulness
    - Timeliness and follow through
    - Accuracy
    - Assistance in getting care and knowing options
- Providers change frequently - PCP, Psychiatrists, NPs, Social Workers
- Advocates ("System Navigators") are highly desired
    - Direct, very involved "hold my hand / get me to the care I need" assistance is wanted
    - Want assistance in knowing what is even available and then accessing it
    - Want someone to attend appointments with them to advocate and "not be intimidated" by the doctor
    - Opinion is that a provider "believes and listens" to an advocate more than the patient
- Getting care is cumbersome
    - "Hassles, hoops." Inconvenient processes often mentioned.
    - "Lots of steps" and "Lots of going back and forth."
    - Providers are spread out. "Back and forth." "Have to go all over the place."
    - Appointments are not scheduled for the same day
    - Patients/consumers not aware of all that is available
- Allow more than one doctor/therapist appointment/day
- Medication
    - Doctors not asking what they take
    - Doctors do not know them, do not know side effects or interactions
    - Often end up without medication, or gaps

B. Focus Groups Thoughts on Systems Level Integration

The idea of integration was well-received, even though it was not specifically noted as a priority. Obtaining immediate, basic care - such as just getting to see their primary care physician or psychiatrist - is a challenge for many of the participants, so system-level improvements may seem beyond their influence, unrealistic or too far-future. In no way should this deter the B-HIP partners from pursuing integration.

CHC patients, in general, were able to offer more system-focused comments and suggestions than TMHA consumers. (All participants could offer specific improvements, and some are connected to integration.) This may be due to lower-level mental health involvement or that CHC itself has some "one stop shops" and other tangible demonstrations of integration.

Of note is that the highly-desired System Navigators/Advocates/Resource Specialists are the de facto integrated system. These providers ease access across systems and facilitate "whole person" care.

When asked about benefits, possibilities, or drawbacks of a system more focused on "whole person" health care, the following emerged as the most positive aspects and desires of an integrated system:

- Want to see more than one provider in a day. Want to be able to "clump" appointments with primary care physician and psychiatrist.
- Overall, E-records are seen as a great benefit and help in getting more complete care.
- Co-location was preferred by most participants.
- Medications may be managed better. It would be easier for all caregivers to know what medications were being used, increase awareness of side effects (that may be misinterpreted or attributed to something else), and prevent negative drug interactions.

The concerns most often expressed in all of the focus groups were:

- Primary care physicians may treat patients differently/poorly if the PCP knows they have a mental illness. Many participants stated they have been stigmatized or doubted by PCPs or their doctor questions their credibility and competency. Participants would like mental illness awareness and sensitivity training to be provided and required.
- Concerns over the confidentiality of medical records were frequently mentioned. Participants believe that sharing records has great benefits, but are worried that some PCPs will treat them differently (as noted above) and that non-medical staff would see their mental health records and not keep that confidential. CHC patients expressed most concern about staff telling others (outside of the medical community) about their mental illness.
- Loss of privacy by being seen at a co-located facility was not of concern to most.

C. Focus Group Conclusions

The focus group participants shared their opinions and experiences willingly and candidly. They were also appreciative of being asked to comment, and for the opportunity to influence positive changes.

Of most importance to the participants are keeping their physicians consistent, spending more time with their doctor at each appointment, seeing their psychiatrists more frequently, improving customer service, accessing care more conveniently/less cumbersome, allowing more than one physician appointment per day, providing "system navigators," and treating patients with respect and kindness.

While system-level integration did not emerge as a primary theme or a priority concern, the benefits of collaborative planning and action among primary care and behavioral health providers would positively impact some of these major, most common themes.

VI. CHALLENGES TO BEHAVIORAL HEALTH INTEGRATION IN SAN LUIS OBISPO COUNTY

A. Equity in Service Delivery

Although San Luis Obispo County appears to have an adequate provider network to meet the overall behavioral health needs of its population, there are obvious gaps that affect certain groups of patients. The lack of psychiatrists available to low-income persons is a long-standing issue in the county, as well as statewide. Also, the small number of Spanish speaking therapists (and psychiatrists) makes it difficult to access services for the non-English speaking population. Many are referred to out of county therapists to receive services.

Community services abound but actual treatment services are lacking. As shown above, San Luis Obispo County has many community services available to mental health services such as short term counseling and support services. However, for those persons with mild to moderate conditions and non-English speaking persons, the availability of treatment services appears to be deficient.

The data shown in Table 1 are estimates of need for behavioral health services based upon state and national studies. Table 4 shows the number of individuals seen by providers in the County. For the most part, utilization data are only available for Medi-Cal patients since there are no readily available sources to track utilization by persons with private health insurance or who see private practitioners.

For low-income persons with serious/severe mental illness, it appears that County Behavioral Health is meeting the expected demand. There are an estimated 1,452 to 4,544 low-income residents with serious/severe mental illness needs, assuming the rate of mental illness is the same among the low-income population as the general population.[14] In Fiscal Year 13/14, The County saw 3,972 unique individuals, with 2,404 receiving at least six services.

For Medi-Cal recipients with mild/moderate mental health conditions, the expected need is not being met. Medi-Cal mental health benefits for mild to moderate conditions were newly added in January 2014, at the same time that the number of persons eligible for Medi-Cal was vastly expanded. CenCal health contracted with The Holman Group to administer the mental health benefit.

There are approximately 4,432 children and 5,145 adults (9,586 total) on Medi-Cal who have mild/moderate mental health conditions. In total, the Holman Group (CenCal's mental health managed care contractor) authorized services for a total of 1,833 clients in 2014.[15] Percentage-

[14] In actuality, the data would suggest that the incidence of mental illness and substance use disorders is much higher among the Medicaid (Medi-Cal) populations. See, e.g. T. Jost, Implementing Health Reform: Medicaid & CHIP Mental Health And Substance Use Disorder Parity, Health Affairs, April 8, 2015

[15] Approximately 385 of Holman's authorized clients were children and 1,448 were adults.

wise, only nine percent of Medi-Cal children and 28 percent of adults estimated to need services received them through Holman in the first 10 months of 2014.[16]

Overall, 21 percent of the persons on Medi-Cal estimated to need mental health services received them under the new benefits in 2014 when combining Holman and CHC utilization data.

For persons with substance use disorders, services are severely limited. Estimates show that 3,235 to 7,214 low income adults in the county have substance use disorders. County Drug and Alcohol Services reported 2,318 clients receiving at least one substance abuse services in Fiscal Year 13/14 with 1,506 receiving six or more services. Adults comprised 82 percent of County Drug and Alcohol clients.

Spanish speaking persons: CenCal reports that 18 percent of CenCal members in San Luis Obispo County prefer communication in Spanish. Among CenCal's children members, 29 percent speak Spanish compared to nine percent of adults. Holman reported receiving only 39 requests for Spanish speaking providers during 2014. County BHD reported 3,835 contacts by Spanish-speaking persons for mental health outpatient services in Fiscal Year 13/14, out of a total of 79,854 contacts or 4.8 percent.

One possible solution to the psychiatrist issue is the use of "tele-psychiatry" to increase access to services where there is a shortage of psychiatrists. Tele-psychiatry is a form of videoconferencing to provide psychiatric services such as diagnosis and assessment, medication management, and individual and group therapy. It also provides for the opportunity of consultation between primary care and other health providers and psychiatrists. The Holman Group is investigating tele-psychiatry services for San Luis Obispo residents. There has also been discussion of having out of county Spanish speaking therapists to work in the county on a periodic basis while being housed at a community provider.

Other innovative solutions for Spanish speaking clients may include peer navigators such as promotores, and enhanced interpretation services, while also encouraging the education and licensure of more Spanish-speaking therapists.

B. Siloed Funding

California has many siloes of funding and service delivery. There are both private and public funding systems. On the private side, a person's coverage depends upon their source of insurance and the type of policy they have. Some services may not be covered or the provider network may be limited.

On the public side, California has separate delivery and funding systems for those with serious and severe mental health conditions are the responsibility of County behavioral health agencies, while mild to moderate conditions are the responsibility medical side of Medi-Cal – either

[16] There were an additional 210 CenCal members who received mental health services through CHC in November and December 2014 when CHC patients no longer had to be screened by Holman to be seen by a CHC therapist. It is not known if these CenCal members had previously been screened by Holman.

managed care or fee-for-service. Substance use disorder services are under a separate system known as Drug Medi-Cal and administered by the counties and the State.

In addition, certain providers may be limited in their ability to provide or be reimbursed for certain services. For example, federally qualified health centers receive only limited reimbursement for services provided by licensed marriage and family therapists, or when mental health and medical services are provided on the same day.

There are strategies used by providers to improve patient services by what is referred to as "braided" funding. Agencies can work together while maintaining their separate identities and funding sources. For example, County staff can be outplaced in community health centers and bill for services that the clinics may not be able to. Conversely, community health centers can provide medical services by being co-located in county behavioral health clinics. In San Luis Obispo County, County Behavioral Health has applied with Community Health Centers for federal funding for CHC to provide medical services in County mental health clinics.

C. Data Collection and Sharing

During the course of the B-HIP project, a number of data collection and information sharing barriers were noted.

In preparing the utilization section of this report, it became apparent that collection of data on utilization of behavioral health services in the County was at times difficult to obtain from service providers, and the data were not always comparable. While some agencies were able to provide precise utilization data, others were not. These data are important on an ongoing basis to enable the measurement of penetration of services, particularly to underserved populations. Moreover, collection of data on a regular schedule will provide information on the impact and outcomes of programs.

The sharing of clinical information between agencies and providers has also been problematic. Several agencies and projects, such as 50Now, have developed interagency forms to facilitate the release of information, but they are not always accepted by some agencies. It is recommended that those agencies that provide behavioral health services develop release forms that, if appropriately signed by patients and clients, will allow for the sharing of information in accordance with the patient's wishes and HIPPA and other state and federal regulations.

The largest systemic issue facing the sharing of health records – both behavioral and medical – is the lack of a standardized health information exchange in San Luis Obispo County. While most of the providers have electronic health record systems, they are not interoperable to allow for sharing of information among providers.

The County Behavioral Health Department is developing the capacity to electronically share sensitive information, including substance use treatment, in a compliant form. The County also began exploring the possibilities of sharing information electronically with Community Health Centers as part of its efforts to obtain federal funding to provide medical services to County Behavioral health patients.

There have been a number of attempts between providers such as hospitals and primary care to allow for electronic transfer of information. There is also an ongoing attempt to develop a health information exchange for San Luis Obispo County using OCPRHIO, but its implementation has been delayed several times. OCPRHIO has developed CUnites, California's community-wide health information exchange initiative which electronically connects providers across California so that patient records can be easily accessed at the time and place they are needed for care. The two hospital systems, CHC, CenCal and the County Health Agency are engaged in working with OCPRHIO.

It is of vital importance that patient information is available to treating providers on a real-time basis to ensure the continuity and quality of care, particularly for those with both physical and behavioral health conditions. It is recommended that the primary stakeholders including CenCal Health, Community Health Centers, County Behavioral Health, County Public Health, hospitals and private practitioner groups come together to pursue funding and implementation of a health information exchange in the County.

D. Case Management and Navigation Services

While there are a myriad of services available within the County for behavioral and physical health services, finding, scheduling, and getting to them can be daunting, particularly for those with impaired physical and cognitive conditions. Coordination among the services requires knowledge and skills that elude many patients, to the detriment of their health while adding excess costs to the system.

San Luis Obispo County has a number of case management programs that focus on specific populations. For example, the 50Now program which provides housing and support services to high risk (formerly) homeless individuals. Community Health Centers has case managers to work with patients with complex conditions. On the other hand, the Behavioral Health Department does not have funding for case managers.

In coordination with homeless advocates and providers, CenCal Health developed the IMPACT concept to have a master case manager help patients navigate the health care system and address key health barriers, such as housing instability or food insecurity. This program remains unfunded, although the concept has been supported by a broad range of the provider community.

In developing its proposal to SAMHSA for integrated care for those with serious mental illness, the Behavioral Health Department proposed using peer navigators to assist patients in accessing preventive and health care services. The use of peers with lived experience has been shown to be effective both in gaining acceptance from patients and in navigating the complexities of the health system.

B-HIP has reviewed a promising, low-tech tool that could tremendously aid providers and navigators in coordinating services. The electronic tool, developed by Dr. David Duke of Dignity Health, allows varied providers to track both the needs of patients for a range of services, and to assess whether those services have been provided. The tool is being tested within the Dignity system, but holds promise for other programs, such as 50Now. Funding is

needed to adapt the tool for a range of providers and to train providers and navigators and to assess its usefulness.

E. Provider Engagement

The B-HIP collaborative has provided the opportunity for organizational engagement in developing a roadmap for integrating primary care and behavioral health. The next level of engagement must take place with the provider community – medical and behavioral health – in both the public and private sectors. Primary care providers are not necessarily aware of the value of integrated services for both themselves and their patients. Similarly, behavioral health providers do not often consult with other providers with whom they share patients.

Providers need to be on board with any systems change approaches and B-HIP has discussed prioritizing provider engagement in the coming year through expanding its steering committee and sponsoring continuing education forums with professional associations. Sessions can include topics such as stigma, empathy and communication with patients, families and providers.

F. Readiness for Federal and State Policy Changes

B-HIP has brought together a broad range of stakeholders concerned with behavioral health to assess conditions in the County and develop a roadmap to lead to the integration of behavioral and primary care services. Efforts in San Luis Obispo County are not occurring in isolation. Other California counties are also engaged in similar activities. At the State and federal levels, a number of initiatives will also affect integration efforts. The State has several separate, but interconnected, initiatives to improve the efficiency of the health system. These efforts include proposals to the federal government for a Section 1115 "Medi-Cal 2020' waiver for delivery system transformation, a Drug Medi-Cal waiver to operate the program as an organized delivery system, and an Affordable Care Act section 2705 Health Homes initiative to provide coordinated services to Medi-Cal recipients with chronic conditions and serious mental illness.

The B-HIP process has allowed for participants to stay aware of the State initiatives and to assess how they affect San Luis Obispo County. As a relatively small and isolated county without a direct health care delivery system, San Luis Obispo residents often miss out on many opportunities to improve their health system. The understanding of pending policy changes assists in preparing the County for their implementation and to mold them to fit the needs of the County. As these are multi-year initiatives, ongoing participation in their development is critical. Understanding where the State is heading also allows local agencies to begin developing complementary programs, in anticipation of state and federal initiatives.

G. Policy Barriers to Mental Health Provider Supply

While the CHC is the dominant provider of primary care services to low-income persons in San Luis Obispo County, there are a number of policy limitations that preclude them from optimally providing behavioral health services to their patients.

First, there is a limitation on federally qualified clinics, such as CHC, receiving their "encounter" rates from Medi-Cal for both a primary care visit and a behavioral health visit on the same day. They may receive reimbursement for the services from CenCal or the fee-for-service system

for same day visits, but they cannot receive their "wrap around" encounter payment for a second visit. For the clinic to be paid for the second service, the patient must be re-scheduled for a different day. This impedes the seamless "warm handoff" of having a primary care provider refer a patient directly to a mental health provider during a visit. It also increases the risk that the person may not return for a mental health visits. CHC often forgoes payment for the second service and sees the patient on the same day, but this places the financial sustainability of the behavioral health services at risk.

While the federal government gives permission to state Medicaid agencies to allow FQHCs to bill Medicaid for primary care and behavioral health visits on the same day, California has restricted its program to only allow same day billings in the case of a physical health care visit and dental visit.

Federal Medicare law permits reimbursement for same-day medical and mental health visits and for federal matching funds to be provided for states that choose to allow same-day visits.[17] California does not take advantage of these federal funds. There are no federal regulations regarding Medicaid reimbursement for billing mental health and medical visits on the same day. However, at least 30 states pay for two services on one day.[18] California allows for same day billing for primary care and dental visits, but not for primary care and mental health.

SB 1150 of 2013-14, authored by Senators Hueso and Correa, would have provided for the reimbursement of a maximum of two visits on the same day at a single location when the second visit is because the patient suffers an injury or illness after the first visit, or the patient has a medical visit and the second visit is with a dental or mental health provider. Having been unanimously passed in the Senate Health Committee, SB 1150 died in the Senate Appropriations committee as of May 23, 2014. A similar bill SB 260 (Steinberg 2007) was vetoed by Governor Schwarzenegger.

Second, there is a limit on reimbursement for services provided by a licensed marriage and family therapist (LMFT) in an FQHC or under Medicare. If LMFT services were fully reimbursed by Medi-Cal and Medicare, they could help to alleviate workforce shortages for mental health services.

Section 1861(aa) of the Social Security Act defines FQHCs/RHCs and the core services provided by them. These services include those provided by a physician, physician assistant, nurse practitioner, clinical psychologist, and clinical social worker. (See §1861(aa) (3)(A) and §1861 (aa)(1)(A)-(B).) Since the federal statute does not explicitly include LMFTs, Medi-Cal does not traditionally reimburse for licensed marriage and family therapist (LMFT) services. However, Medicaid does reimburse for LMFT services in other states, such as North Carolina, South Carolina, Oklahoma, Tennessee, and Washington.

Recently the State requested and was granted a Medicaid State Plan Amendment (SPA)[19] which adds licensed marriage and family therapists, registered marriage and family therapist interns,

[17] CFR Title 42 Volume 2, Part 405. Section 405.2463.
[18] SAMHSA-HRSA Center for Integrated Health Solutions
[19] SPA 14-012, approved on May 2, 2014 and retroactive to January 1, 2014.

registered associate clinical social workers, and psychology assistants, as providers of psychology services under the direction of a licensed practitioner within their scope of service. However, according to the State, SPA 14-012 would not make services provided by an LMFT a billable encounter in an FQHC, making the clinic eligible for its encounter based "wrap around" payment. The clinic can bill for the visit at the fee-for-service rate, or be reimbursed by CenCal at the contracted rate. But FQHC's cannot as of yet receive its full encounter rate. The California Primary Care Association is advocating for full billing for LMFTs and other providers.

H. Policy Barriers to SUD Services

There are several policy impediments to improved SUD services. One policy is a federal Medicaid rule enacted about 50 years ago that prevents many people with drug or alcohol addictions from accessing necessary treatment under the ACA. Under the 1965 rule, known as the Institutions for Mental Disease Exclusion, Medicaid covers community-based programs for residential addiction treatment only if they have 16 beds or fewer. The original intent was to avoid Medicaid from paying state mental hospitals, but it currently acts as a barrier to care throughout California.

Another federal impediment is in the release of information between SUD providers and other medical and mental health providers. The privacy protections for the release of information from drug and alcohol programs is much stricter than for other health providers under HIPAA. Drug and alcohol treatment programs may not share information with the client's providers who are outside the treatment program without patient authorization.[20] This includes sharing information with other providers within the integrated system of care and on the "team." The only three exceptions are for a police emergency, child abuse/neglect reporting, and a medical emergency.

[20] 42 CFR Part 2

VII. WHERE DO WE GO FROM HERE?

A. Roadmap for Integration of Behavioral Health and Primary Care

The SAMHSA-HRSA Center for Integrated Health Solutions has developed a standard framework for determining levels of integrated healthcare.[21]

It is designed to help organizations implementing integration to evaluate their degree of integration across several levels and to determine what next steps they may want to take to enhance their integration initiatives.

The B-HIP steering committee engaged in a review of the Six Levels of Collaboration with community partners in December 2014. The participants reviewed the current level of collaboration and identified the levels to which they aspired. The stakeholders assessed that the current system was at an average of 2.3 out of the six levels, with a system-wide goal of reaching a level of 4.5. However, for clinical integration of care, the partners desired to be at a level 6.

Having reviewed the data, engaged the provider community and listened to system users, the B-HIP steering committee has developed a roadmap to integrate primary and behavioral health care in San Luis Obispo County. This roadmap set out short, medium and long term goals with identified agencies and leadership, as well as mechanisms to measure progress towards the goals.

[21] http://www.integration.samhsa.gov/resource/standard-framework-for-levels-of-integrated-healthcare

The Six Levels of Collaboration/Integration are summarized by the Standard Framework as follows:

Coordinated Care

Level 1 — *Minimal Collaboration*

Behavioral health and primary care providers work at separate facilities and have separate systems. Providers communicate rarely about cases. When communication occurs, it is usually based on a particular provider's need for specific information about a mutual patient.

Level 2 — *Basic Collaboration at a Distance*

Behavioral health and primary care providers maintain separate facilities and separate systems. Providers view each other as resources and communicate periodically about shared patients. These communications are typically driven by specific issues. For example, a primary care physician may request copy of a psychiatric evaluation to know if there is a confirmed psychiatric diagnosis. Behavioral health is most often viewed as specialty care.

Co-Located Care

Level 3 — *Basic Collaboration Onsite*

Behavioral health and primary care providers co-located in the same facility, but may or may not share the same practice space. Providers still use separate systems, but communication becomes more regular due to close proximity, especially by phone or email, with an occasional meeting to discuss shared patients. Movement of patients between practices is most often through a referral process that has a higher likelihood of success because the practices are in the same location. Providers may feel like they are part of a larger team, but the team and how it operates are not clearly defined, leaving most decisions about patient care to be done independently by individual providers.

Level 4 — *Close Collaboration with Some System Integration*

There is closer collaboration among primary care and behavioral healthcare providers due to colocation in the same practice space, and there is the beginning of integration in care through some shared systems. A typical model may involve a primary care setting embedding a behavioral health provider. In an embedded practice, the primary care front desk schedules all appointments and the behavioral health provider has access and enters notes in the medical record. Often, complex patients with multiple healthcare issues drive the need for consultation, which is done through personal communication. As professionals have more opportunity to share patients, they have a better basic understanding of each other's roles.

Integrated Care

Level 5 — *Close Collaboration Approaching an Integrated Practice*

There are high levels of collaboration and integration between behavioral and primary care providers. The providers begin to function as a true team, with frequent personal communication. The team actively seeks system solutions as they recognize barriers to care integration for a broader range of patients. However, some issues, like the availability of an integrated medical record, may not be readily resolved. Providers understand the different roles team members need to play and they have started to change their practice and the structure of care to better achieve patient goals.

Level 6 — *Full Collaboration in a Transformed/Merged Practice*

The highest level of integration involves the greatest amount of practice change. Fuller collaboration between providers has allowed antecedent system cultures (whether from two separate systems or from one evolving system) to blur into a single transformed or merged practice. Providers and patients view the operation as a single health system treating the whole person. The principle of treating the whole person is applied to all patients, not just targeted groups.

Roadmap for Integration of Behavioral Health and Primary Care

GOALS/STRATEGIES	RESPONSIBLE AGENCY(IES)	TIMEFRAME	INDICATORS OF SUCCESS
1. Goal: [Collaboration] San Luis Obispo County's medical and behavioral health providers and agencies coordinate and track their efforts to improve integration of care for County residents.			
1.1. [Regular B-HIP meetings] County organizations including health services delivery, payor and mental health and social services organizations continue to meet on a regular basis to discuss and overcome systems-level barriers to integrated care.			
1.1.1. B-HIP continues to meet bi-monthly while expanding its memberships to including representatives from Latino and LGBT communities and organized medicine.	Lead: T-MHA	October 2015 – September 2016	Meeting agendas, attendance and minutes;
1.1.2. B-HIP will appoint liaisons to other community efforts including homeless health care and hospital re-admission reduction meetings.	Lead: T-MHA	October 2015 – September 2016	Meeting agendas, attendance and minutes

1.2. [Data collection and analysis] County organizations, including health service delivery, payor and community based agencies provide periodic data on provider capacity and utilization of behavioral health services to identify gaps and improve integration of care.			
1.2.1. B-HIP will update its community assessment (gap analysis) on a semi-annual basis by obtaining data on provider capacity and utilization of behavioral health services from County health agency, CenCal, CHC, and other behavioral health providers.	Lead: Diringer & Associates	October 2015 – September 2016	Semi-annual reports
1.2.2. B-HIP will develop a system to collect data on provider capacity and utilization of behavioral health services in the private sector.	Lead: Diringer & Associates	October 2015 – September 2016	Data collection checklist
1.2.3. B-HIP will track state and federal policy initiatives and examine opportunities for implementation in San Luis Obispo County.	Lead: County Behavioral Health	October 2015 – September 2016	Policy updates at Steering Committee meetings
2. Goal: [Communication] Medical and behavioral health providers have established and efficient modes of communication concerning mutual			

patients while respecting privacy			
2.1. [Health information transfer] A plan for the transfer of health information, leading up to a health information exchange, will be developed by September 2016 to facilitate transfer of information among hospitals, CHC and other primary care providers, County Health Agency, CenCal, laboratories, pharmacies and other health providers.	Lead: Diringer & Associates with CenCal	October 2015 – September 2016	Health information transfer plan and update on HIE
2.1.1. B-HIP participates in HIE efforts underway with CenCal, CHC, County health agency, hospital and others to ensure that behavioral health is part of the HIE with appropriate patient privacy protections.	Lead: County Behavioral Health	October 2015 – September 2016	Inclusion of behavioral health in HIE plan
2.2. [Case consultation] A system for case consultation and case management among hospitals, CHC and other primary care providers, County Health Agency, CenCal, laboratories, pharmacies and other social services health providers is developed by July 2016			
2.2.1. B-HIP will collaborate with other efforts, including homeless health care, 50Now and hospital	Lead: County Behavioral Health	October 2015 – July 2016	Case management plan

readmission reduction efforts to formalize case management processes in San Luis Obispo County.			
2.2.2. B-HIP will investigate the potential adaptation of case management software being developed by local Dignity Health physician for use with behavioral health clients.	Lead: T-MHA	October 2015 – July 2016	Implementation plan for software
2.3. [Release of information] A universal release of information form is developed in the County that will be accepted by hospitals, CHC and other primary care providers, County Health Agency, CenCal, laboratories, pharmacies and other health and social services providers by July 2016.			
2.3.1. B-HIP will work with appropriate agencies and providers including County health agency, CHC, CenCal, hospitals and social services providers to develop a universal release of information form.	Lead: County Behavioral Health	October 2015 – July 2016	Completed release of information form
3. Goal: [Coordinated care] Medical and behavioral health care is delivered in a coordinated manner, based upon			

standardized behavioral health screening tools and evidence based practices.			
3.1. [Health Home initiative] A plan for a "Medicaid Health Home" project to provide intensive care coordination of patients with multiple chronic conditions and serious and persistent mental illness is completed by July 2016.			
3.1.1. Upon federal approval of California's plan for the Health Homes project, B-HIP will work with CenCal to select an appropriate Community based care management entities (CB-CME) to operate the project and determine if County Behavioral Health is eligible to apply to serve the SMI population.	Lead: County Behavioral Health, CenCal	October 2015 – September 2016	Health Homes and CB-CME plans
3.2. [Standardized screenings] A consistent set of agreed upon behavioral health screenings is presented for adoption across disciplines in San Luis Obispo County by September, 2016 to guide treatment interventions.			
3.2.1. The existing Medi-Cal screening tool in use by County Behavioral Health and the Holman Group is	Lead: County Behavioral Health	October 2015 – September 2016	Presentation of behavioral health screenings to private

adapted for persons with private health insurance coverage by September 2016.			practitioners
3.3. [Evidence based practices] Evidence based practices are endorsed and distributed countywide to guide coordinated health interventions for medical and behavioral system users.			
3.3.1. County Behavioral Health [B-HIP?] will convene relevant behavioral health organizations to review and endorse appropriate evidence based practices for care of those who require behavioral health care by September 2016.	Lead: County Behavioral Health	October 2015 – September 2016	Presentation of evidence-based practices to private practitioners
3.4. [Trainings] B-HIP will sponsor "grand rounds" training on behavioral health integration in conjunction with County behavioral health and the medical society.			
3.4.1. B-HIP will provide 4 quarterly trainings to the medical, behavioral health and social services communities on behavioral health integration by September 2016.	Lead: Diringer & Associates	October 2015 – September 2016	Agendas, attendance lists and evaluations from trainings
4. Goal: [Patient experience] Patients receive coordinated medical and			

behavioral health care from a range of empathetic , culturally and professionally appropriate providers with relevant referrals to specialized care.			
4.1. [Empathy] Medical and behavioral health providers provide patient centered care with empathy and respect			
4.1.1. B-HIP sponsors provider training in patient empathy by November 2015 and encourages other providers to also sponsor such trainings.	Lead: T-MHA and Diringer & Associates	October 2015 – November 2015	Agendas, attendance list and evaluations from training
4.2. [Access to appropriate providers] Patients have a choice of culturally, linguistically and therapeutically appropriate providers.			
4.2.1. County behavioral health and CenCal contract with a sufficient number of medical and behavioral health providers to provide patients with a choice of quality providers to serve them with continuity of care in their community in their preferred language.	Lead: County Behavioral Health and CenCal	October 2015 – September 2016	Provider lists with breakdown of location, languages spoken and specialties
4.2.2. Alternative models to ensure	Lead: County	Lead: County	Development and

access to care are investigated including telemedicine and the scheduling of out of town providers in the county on a regular basis.	Behavioral Health, CenCal and Diringer & Associates	Behavioral Health and CenCal	implementation of alternative models
4.3. [Health consumer navigators] A system of health consumer navigators is developed to assist behavioral health consumers find appropriate care, services and support by September 2016.			
4.3.1. B-HIP will convene the navigator programs, including peer navigators, Promotores, cultural brokers and post-hospital navigators, to develop a system of assistors for consumers to find appropriate care, services and support by January 2016.	Lead: T-MHA, Diringer & Associates	January 2016 – September 2016	Agenda, attendance list and evaluations from convening
4.3.2. Peer navigators will receive appropriate certification and credentialing on an annual basis beginning in 2016.	Lead: T-MHA	January 2016 – September 2016	Certification of peer navigators
4.3.3. B-HIP will seek funding for sustainable navigator programs on an on-going basis.	Lead: T-MHA	January 2016 – September 2016	Summary of funding proposals
4.4. [Inpatient care] B-HIP supports efforts to increase inpatient capacity for those who persons who require higher levels of care	Lead: B-HIP steering committee	October 2015 – September 2016	Meeting minutes

due to co-occurring medical issues or psychiatric illness.			
5. Goal: [Funding] Funding sources are braided together among agencies to enhance patient outcomes.			
5.1. [Braided funding] County health services delivery and payor organizations develop plans to braid together varied funding sources to provide integrated services to patients in coordinated settings by September 2016.	Lead: County Behavioral Health, CenCal	October 2015 – September 2016	Plans for braided funding
5.2. [Fund development] Health services agencies continue to solicit funding to develop and expand innovative projects for integrating medical and behavioral health care.	Lead: County Behavioral Health, T-MHA, CHC	October 2015 – September 2016	Summary of funding proposals

CONCLUSION

There is a high need for behavioral health – mental health and substance use disorder – services in San Luis Obispo County. Recent health system changes have vastly increased coverage for those services. Yet, the system is not yet meeting the expected demand for those services. Moreover, the medical and behavioral health systems remain isolated from each other despite substantial evidence that integrated care will improve both mental health and physical health.

The San Luis Obispo County Behavioral Health Integration Project has developed a roadmap for agencies, organizations and providers throughout the County to more fully integrate services through expanded services to underserved populations, improved communications among providers, coordinated delivery of integrated care, enhanced patient experience in navigating the health delivery systems, and braided funding. Implementation of the roadmap for integration of care will result in improved outcomes, reduced costs and a better patient experience.

APPENDIX

San Luis Obispo County Mental Health and Substance Use Disorder Prevalence Estimates

Source		Ages	0-19	20+	All Ages
2013 Census ACS 1-year estimate and October 2014 CenCal Enrollment		County population	62,879	213,564	276,443
		On Medi-Cal	22,162 (35.2%)	25,472 (11.9%)	47,634 (17.2%)
CA Primary Care, Mental Health, and Substance Use Services Integration Policy Initiative (2009)	Mental Health	Population demand (%) (Mild/Moderate)		43,140 (20.2%)	
		Population demand (%) (Serious/Severe)		12,173 (5.7%)	
		Population demand (%)	12,576 (20%)	55,314	67,889
		Medi-Cal demand (Mild/Moderate)		5,145	
		Medi-Cal demand (Serious/Severe)		1,452	
		Medi-Cal demand	4,432	6,597	11,030
	Alcohol & Drug Diagnoses	Total population demand (Mild/Moderate)		16,444 (7.7%)	
		Total population demand (Serious/Severe)		10,678 (5%)	
		Total population demand		27,122	
		Medi-Cal demand (Mild/Moderate)		1,961	
		Medi-Cal demand (Serious/Severe)		1,274	
		Medi-Cal demand		3,235	
CHCF California Health Care Almanac (2013)	Mental Health	Total population demand (SMI/SED)	4,778 (7.6%)	9,183 (4.3%)	32,897
		Medi-Cal demand (SMI/SED)	3,620	2,048	5,668
		Total population demand (Any MI)		33,957 (15.9%)	
		Medi-Cal demand (Any MI)		4,050	

California Mental Health and Substance Use Needs Assessment (2012 draft)	Mental Health		**0-18**	**19+**	
		SMI	3,971 (7.3%)	10,302 (4.9%)	14,273 (5.4%)
		SMI <200%FPL	1,582 (8.7%)	4,544 (7.7%)	6,126 (7.9%)
		Broad definition - all population			39,573 (14.82%)
		Broad definition - all population <200%FPL			15,698 (20.28%)
	Alcohol & Drug Diagnoses	AOD	1,666 (3.1%)	22,349 (10.2%)	24,016 (8.8%)
		AOD <200%FPL	524 (2.6%)	7,214 (12.1%)	7,738 (9.66%)
	Alcohol diagnoses	All population			20,178 (7.4%)
		All population <200%FPL			6,110 (7.6%)
	Drug diagnoses	All population			7,234 (2.6%)
		All population <200%FPL			3,127 (3.9%)