The Mental Health Assessment and Redesign Collaborative (MHARC): Community-based Effort to Strengthen the Mental Health Safety Net in Shasta County, CA

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SUMMARY

This case study describes a multi-year initiative undertaken by the Shasta Consortium of Community Health Centers (SCCHC)—***The Mental Health Assessment and Redesign Collaborative (MHARC)***—funded in part by The California Endowment's Clinic Consortia Policy and Advocacy Program. The benefits of adopting a community-based approach to addressing gaps in the County's mental health system include a stronger behavioral health care safety net and increased local capacity to address complex issues. Several key findings emerge from the analysis of SCCHC's role in working with stakeholders to address the mental health care needs in Shasta County, CA:

- Tackling local systems change is doable but it requires significant staffing resources and expertise in facilitating a community-based process, e.g., convening multiple work groups;
- County efforts to achieve reforms in the mental health arena are greatly enhanced by partnerships among primary care and mental health providers and agencies; and
- Integrating behavioral health and primary care is feasible in rural areas where there is high stakeholder commitment and expertise.

INTRODUCTION

In 2001, The California Endowment provided funding to 15 local and regional community clinic consortia and four statewide community clinic organizations through the Clinic Consortia Policy and Advocacy Program to strengthen the capacity of consortia to engage in advocacy on behalf of their member clinics. Clinic consortia are statewide, regional, and local associations of primary care clinics that undertake activities that individual clinics may not be able to do on their own. In 2004 and 2007, 18 grantees were refunded for three years to undertake or continue a similar set of activities. To achieve their goals, clinic consortia engaged in multi-year initiatives during the grant period to:

- Expand coverage (insurance and/or services) to low-income adults and/or children;
- Strengthen the local or regional health care delivery system, such as securing local funding under the Mental Health Services Act to integrate mental health and primary care; and
- Target policies to strengthen California's safety net, such as averting cuts to statewide and local public funding.

Shasta Consortium of Community Health Centers (SCCHC) is a clinic consortium that represents five Federally Qualified Health Centers (FQHCs) with 17 sites in Northern California (Shasta, Siskiyou, and Lassen Counties). In 2007, SCCHC member clinics provided over 233,246 visits for 65,791 patients.

SCCHC's ability to convene stakeholders to collectively refashion Shasta County's mental health system resulted in a system that is better able meet the needs of consumers and health care providers. It has resulted in increased access to mental health services as well as a successful model for pursuing future safety net initiatives.

METHODS

To characterize SCCHC's initiative, UCSF staff conducted open-ended interviews in 2009 with a sample of member clinics, clinic consortia staff, local decision makers, and partner organizations that were involved with each initiative. Informants were asked to describe their involvement in the initiative, challenges encountered, and benefits to clinics and their target populations.

FINDINGS

THE ISSUE: DESIGNING A MENTAL HEALTH SYSTEM IN RURAL CALIFORNIA

In 2004, the County Board of Supervisors in Shasta County voted to close the County's in-patient psychiatric facility due to reductions in state financial support. The closure was contingent on having another system in place to provide emergency psychiatric care to those who were previously using the facility. However, the result was a near-collapse of the mental health system and handling of crisis care services. There was a commingling of differently diagnosed mental health patients in the ERs and many patients were sent out of the County for services. It was difficult to keep up with the demand for services: The wait time for a mentally ill individual in the ER ranged from 4 to 36 hours, with longer wait times escalating the level of the crisis. Local providers were struggling to treat acute care patents. In May 2005, the Board of Supervisors held a community forum during which it became clear that a process was needed to assess the mental health system and to identify solutions.

PROMISING SOLUTION: CONVENING A COMMUNITY-WIDE COLLABORATIVE

SCCHC offered to create an ongoing dialogue among stakeholders about the current mental health system and potential solutions. In 2006, it convened representatives from approximately 25 organizations, including multiple county agencies, consumers, safety net providers, and the Board of Supervisors. This group, the Mental Health Assessment Redesign Collaborative (MHARC), met monthly and focused on increasing its knowledge of the current mental health system as well as identifying alternative models for providing mental health services.

MAJOR MILESTONES: SCCHC RISES TO THE OPPORTUNITY

SCCHC was responsible for the planning, project management, and relationship building components of the process. It served as the lead agency and coordinated the group's activities, developed and submitted grant applications, solicited contributions from community partners, managed funds received through grants, and coordinated the five Workgroups. A 23-member Steering Committee comprised of key stakeholders, such as the Board of Supervisors, primary care and mental health providers, community members, county agencies, consumers, was identified in 2006. A Project Management Team was formed to monitor the Collaborative's work plans and report progress to the Steering Committee. A Community Advisory Council was formed to communicate MHARC activities and to create a consumer advocacy framework. Five Workgroups were formed: Access, Emergency Psychiatric Care, Finance, Rural, and Substance Abuse – Detox. For example, the Access Workgroup focused on the feasibility of a single point of entry to mental health services and coordinated training for primary care and behavioral health providers. The Rural Leadership Work Group includes all five SCCHC member clinics and focused on mental health services for rural communities. In sum, the Collaborative was an opportunity to break down barriers among agencies and stakeholders as well as facilitate "out of the box" thinking in developing solutions.

The MHARC Vision was:

Our community will provide a full range of trusted and responsive mental health services that are locally accessible and delivered with dignity and respect to the whole person.

Additionally, SCCHC worked with a County Analyst to collect and analyze emergency psychiatric care data from emergency rooms, law enforcement, clinics, and the Shasta County Mental Health Department. The findings of this analysis were presented to the Shasta County Board of Supervisors with recommendations for service improvement in 2005. SCCHC also created an electronic list serve to educate stakeholders about the progress of the county's mental health system. SCCHC secured additional funding from The California Endowment in a matching grant to assess the local mental health systems, identify promising models, and develop policy recommendations.

Partnerships and collaborations: Participation in the Collaborative required ongoing involvement by many players. However, the key partner organizations included: SCCHC member clinics, Shasta County agencies (mental health, alcohol and drug programs), County Board of Supervisors, the North Valley Medical Association, and law enforcement. In addition to participating on the Steering Committee, the representatives from these organizations kept the issues visible and devoted significant time and resources to maintaining the process.

OVERCOMING CHALLENGES:

A key hurdle was addressing historical tensions among stakeholders and creating consensus. The closure of the facility in 2004 exacerbated an already difficult situation. Additionally, clinic providers had varying positions on the role of the primary care clinic in treating mental health patients. However, SCCHC asked the Board to develop a collective resolution in regards to SCCHC's position. Board members agreed that SCCHC should be responsible for developing a systems approach and focusing best practices while clinics would take their own position on integrating mental health independently.

Throughout the process, the Collaborative had to overcome several obstacles to identifying and implementing changes to redesign the county's mental health system, including:

- Consensus on what the model would look like;
- Regulations such as coordinated policies among the county agencies and local mental health providers;
- The need for standardized data to monitor mental health outcomes; and
- The lack of health information technology to track patients.

Lastly, there was the need to counter negative media coverage, such as engaging a community relations person to draft talking points, and educating and including diverse media to get accurate and unbiased coverage.

ACCOMPLISHMENTS AND BENEFITS

The Steering Committee met 20 - 30 times over two years and accomplished most of its objectives. The group made significant progress in identifying key problems that might warrant interventions. For example, the group discovered that 42 percent of mental health contacts were frequent users of mental health and emergency room services. Additionally, most of the mental health services are in Redding, CA but many people (50 percent) reside in outlying rural areas. As a result of these efforts, the Collaborative was able to develop and implement targeted policy recommendations, such as establishing the 24/7 crisis intervention center. Other achievements include:

Expanded SCCHC advocacy capacity: SCCHC expanded its capacity to facilitate community-based processes, including: Creation and implementation of collaborative, community-wide planning process that increased the visibility of SCCHC; Successful implementation of Team leadership approach with Collaborative participants; and Facilitating team building with the stakeholders as well as working as a team.

***Increased policymaker awareness of safety net and clinic policy issues*:** SCCHC conducted ongoing presentations to the Board of Supervisors on community mental health issues. A knowledgeable and supportive Supervisor served on the Steering Committee. Last, SCCHC worked with the Collaborative to advocate for mental health services, e.g., sent a letter to Board of Supervisors to maintain detox services.

***Increased policymaker support of safety net and clinic policy issues*:** The Collaborative resulted in financial and partnership benefits to SCCHC member clinics, such as two county contracts with Hill Country Community Clinic and one to Shasta Community Health Center.

Strengthened clinic operations: Member clinics benefited from being a key partner in the Collaborative and participating in the 2-year process. Key improvements to clinic operations included the development of Standards of Recovery, a 10-point quality improvement checklist to integrate behavioral health and primary care. Additionally, there was increased visibility of clinic services and the integrated behavioral health model. A county contract was awarded to Hill Country Community Clinic to expand its mental health services and provide a coordinated system of care to severely and persistently mentally ill patients on July 1, 2007. The goal is to develop similar contracts with the other SCCHC member clinics (e.g., a contract was awarded to Shasta Community Health Center in 2008 and another county contract was awarded to Hill Country Community Clinic in 2008 to launch and operate a Wellness Center for people with mental illness);

Increased services for the underserved and uninsured: Significant progress was made in establishing a continuum of care for mental health patients, including providing more patients with a medical home. There was a shifting of resources to fund new services, such as 23-hour crisis center to stabilize patients and connect them to other services; and

Improved health outcomes for targeted communities and populations: MHARC activities contributed to improved health outcomes for users of mental health services. For example, there is evidence that the 24/7 crisis intervention center reduced the use of hospital care in Shasta County. Psychiatric hospital admissions declined from an average of 50 hospitalizations per month to an average of 35 hospitalizations per month in the two years following the opening of the 24/7 crisis intervention center. Additionally, psychiatric inpatient hospitalization days declined from 436 days per month to 344 hospitalization days per month in the three years after the opening of the center.

Clinic Experience – Hill Country Health and Wellness Center. Located in Eastern Shasta County, Hill Country achieved significant visibility through the MHARC process. Consequently, it was awarded two multi-year contracts by Shasta County to expand its mental health services. The Center hired a full-time Licensed Social Worker and a Case Manager to provide intensive care management services, e.g., housing assistance. Through expanding services, the Center has increased provision of behavioral services, from 279 behavioral patients (1,503 visits) in 2006 to 410 behavioral health patients (3,135 visits) in 2009.The second contract was for wellness services using the "recovery" model or where mental health patients play an active role in determining their course of treatment. In 2009, 110 individuals participated in wellness activities, with many people participating many times each month. Last, the Center added a full-time Mental Health Nurse Practitioner in November 2009, increasing patient access to psychiatric services and increasing the quality of the Center's primary care and behavioral health services.

FACTORS FOR SUCCESS

Significant staffing and resources were required to work with the many stakeholders and Workgroups. SCCHC had two dedicated part-time staff members that were in charge of the overall planning and technical issues, such as identifying financial resources. Additional funding ($138,000) was secured from the 17 local investors, such as the clinics and county. A separate grant from The Endowment for $149,000 also was secured. An outside consultant was hired to conduct grass-roots activities and work with the many stakeholders. Upwards of 70 people representing nearly two dozen organizations participated in the Collaborative.

LESSONS LEARNED

Bringing diverse stakeholders together and creating a dialogue around a seemingly intractable problem such as repairing a dysfunctional mental health system is no small feat. SCCHC had to overcome many challenges—historical and systemic. Different stakeholders bring different issues and perspectives to the table. However,

SCCHC was successful in creating a unified voice to better use limited resources to meet the mental health needs of Shasta County residents. As the convener of the group, SCCHC learned some key lessons about mobilizing, coordinating, and educating stakeholders:

- It takes time and energy to cultivate the trust that is required to move a collaborative forward, as well as a facilitator that is well versed in building and leveraging this trust. Early on, SCCHC focused on team building and creating a safe, friendly environment that helped build trust as well as keep the process on track;

- Creating a simple but well-supported process to which people respond well is critical, including the ability to adapt or change the process as needed. This entails significant staffing resources;

- It is important to create a team to coordinate the Collaborative. In this case, a Project Management Team was created that consisted of SCCHC staff and representatives from the North Valley Medical Association, the County Administrative Office, and the Mental Health Board to support the Collaborative. The SCCHC purposely did not have a Chair so there would be no perceived agenda by any one person;

- It is important to educate decision-makers and keep them in the loop throughout the process, such as regular, timely reports and inclusion in the group activities. A Supervisor was on the Steering Committee;

- Being a neutral player and separating the consortium from the participants is important for making the process work, such as having one point of contact; and

- Being "data friendly" or having the capacity to identify, prioritize, collate, and monitor quantitative and qualitative data is important for supporting the process and identifying potential solutions.

Lastly, it is important to devote adequate time to building a broad-based coalition that includes patients, community members, decision-makers, and providers. While it is not an easy task, it is more likely to result in a unified voice that is committed to change.

THE FUTURE

The MHARC initiative officially ended in 2008 when it was considered duplicative of the Proposition 63 or Mental Health Services Act (MHSA) allocation process. Passed in 2004, the MHSA addresses a broad continuum of prevention, early intervention, and service needs, as well as the necessary infrastructure, technology, and training elements to effectively support and transform California's mental health system. SCCHC has been involved in the local allocation MHSA process since 2005 and has ensured that member clinics are included in the local allocation plan, such as securing $650,000 for SCCHC member clinics. There are plans to continue the Community Advisory Committee and some of the Workgroups (such as the Rural Leadership Workgroup) as stand-alone committees, as well as to reconvene members of the Collaborative to do a temperature check on mental health services in Shasta County, including future policy initiatives, such as the Section 1115 Medi-Cal waiver.

SCCHC continues to be involved in other mental health arenas, such as engaging in a pilot project for short-term mental health therapy and substance abuse treatment for medically indigent patients. Lastly, SCCHC benefited from its role as a convener. There is the potential for this activity to become a fee-for-service business activity. SCCHC is now considered a "broker" of stakeholders and is being approached to undertake the planning process in other areas besides mental health.

CONCLUSIONS

The MHARC was successful in creating a community-based approach to resolving a complex and controversial problem. Despite major challenges, SCCHC was successful in working with the county, health care providers, consumers, and mental health experts to accomplish its goals. SCCHC member clinics are receiving resources to integrate mental health and primary care, including helping rural communities address their mental health needs. It was not a solo enterprise and internal staff expertise coupled with high commitment and support from partner organizations proved to be a successful approach.

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