Local Advocacy to Secure Funding Under California's Mental Health Services Act (Prop 63)

Prepared by:
Annette Gardner, PhD, MPH
Sara Geierstanger, MPH
Nell Marshall, MPH, DrPH-C

The Philip R. Lee Institute for Health Policy Studies
University of California, San Francisco (UCSF)
November 2010

INTRODUCTION

In 2001, The California Endowment (The Endowment) provided funding to 15 local and regional community clinic associations and four statewide community clinic organizations through the Clinic Consortia Policy and Advocacy Program (Program) to strengthen the capacity of consortia to engage in advocacy on behalf of their member clinics. Clinic consortia engaged in multiple activities to achieve their goals, such as educating policymakers, media advocacy, and forming local coalitions. Consortia focused on policies and issues at the federal, state, and local levels to increase or maintain clinic financial stability and increase access to care for community clinic target populations.

In recent years, consortia have successfully targeted local funding sources, such as from the Tobacco Master Settlement Fund, to support health care services for their member clinics. The Mental Health Services Act (MHSA), a state-level initiative to expand mental health services, is another opportunity for local consortia to parlay their planning, policy advocacy, and program management skills to secure funding for mental health services at member clinics. All grantees funded under Round 3 (2007-2009) of the Program participated in securing MHSA funding on behalf of member clinics. Most (10 grantees) were able to increase funding for community clinics to integrate behavioral health and primary care in their communities. Three others were heavily focused on monitoring their member clinic participation in the MHSA planning processes.

This Issue Brief describes these overall achievements of the grantees. UCSF monitored grantee advocacy targeting MHSA funding and implementation from 2007-2009, including the types of advocacy activities undertaken, key partners, policymaker support, as well as benefits to clinics and their target populations. Second, since grantee success in securing local funding varied, this Issue Brief describes the successful efforts of two clinic consortia—Alameda Health Consortium (AHC) and San Diego's Council of Community Clinics (CCC)—in advocating for and securing MHSA funds in their respective communities. It describes their policy advocacy activities funded under the Program, the outcomes of these activities, and factors for success. The impact on member clinics and their target populations was significant, providing $2.3 million in funding in Alameda County for integrated mental health and primary care programs and $5.6 million over two and a half years with the possibility of four additional one-year options in San Diego County.

BACKGROUND: THE MENTAL HEALTH SERVICES ACT

In November 2004, California voters enacted Proposition 63, the Mental Health Services Act (MHSA). The MHSA imposed a one percent surtax on incomes over $1 million and was projected to raise approximately $600 to $800 million per year. This represented a 26 percent increase in funding for all public mental health services in California with the intent of providing new funds for new services. Nearly half of the funding would be distributed to California counties for a Community Services and Support phase that focuses on the severely mentally ill from June 2005 - June 2008. The remainder would be spent on Prevention and Early Prevention (20 percent), Workforce, Education and Training (20 percent), Capital Facilities and Information Technology (10 percent), and Innovative programs (five percent).

Responsibility for implementing the MHSA is shared among the state and counties. The State Department of Mental Health (DMH) funds programs and personnel and provides resources to support state and county mental health programs for children, transition age youth, adults, older adults, and families. 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. Counties were required to develop an Integrated Plan for MHSA services, subject to state review and approval. County mental health departments would have primary responsibility for local allocations of the funds to community-based providers.

Comprehensive primary care clinics are ideally positioned to help patients address their mental health needs in addition to their physical health needs. Studies show that 60-70 percent of patients waiting to see primary care physicians also are in need of mental health services. When there is a "warm handoff" or coordination between a primary care physician and a mental health provider under the same roof, the individual is much more likely to follow up. However, clinics lack the stable funding needed to provide mental health staffing, and uninsured or undocumented patients usually do not have the means to pay sliding fee scale rates for ongoing therapy or psychiatry services. Despite these limitations, clinics recognize the need to provide integrated physical and mental health services as part of an effort to have a more integrated system of care at the primary care level.

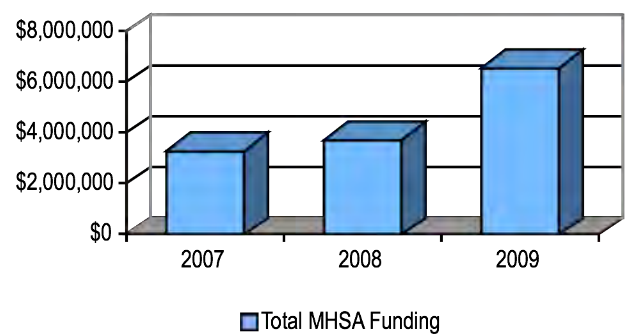
Clinic Consortia MHSA Advocacy and Achievements

In 2007, local allocation of MHSA funding was a key priority for many grantees. A policy issue that varies by county, county and regional clinic consortia served as local coordinating and central advocacy bodies for the MHSA planning process. Activities included facilitating member clinic involvement, early and active participation in county planning, such as educating and working with county Board of Supervisors and county mental health departments, and connecting with CPCA and other statewide advocacy and coordination efforts. Compared to advocacy activities on other key policies targeted by grantees, such as California Health Care Reform, grantees were more likely to *serve on advisory commissions and/or boards* or *help draft rules and regulations to secure funding*. They were less likely to *secure media coverage* or *contact elected officials directly*. They leveraged their partnerships with member clinics while expanding their networks to include partnerships with CBOs, consumers, and representatives from county mental health agencies. These activities remained constant from 2007 to 2009.

Grantees were moderately successful in establishing themselves as credible partners and securing local funding. Grantees reported they sustained strong decision maker support (30 percent "very supportive") and declining policymaker opposition to their position, from 41 percent in 2007, to 35 percent in 2008 and 12 percent in 2009. Some grantees reported resistance from county mental health departments to include clinics in local planning and contracts.

At another level, ten grantees secured approximately $13.6 million in new funding for member clinics from 2007 – 2009 (see **Figure 1**) from two MHSA sources. In 2007, four grantees secured funding under Phase 1: Community Services and Support (CSS) totaling $3.3 million. In 2008, three grantees secured $3.7 million in CSS funding. In 2009, seven grantees secured $6.6 million, mostly under Phase 2: Primary and Early Intervention (PEI). Much of this funding was in the form of county contracts with individual clinics except in the case of San Diego County where one clinic consortia, Council of Community Clinics, administers MHSA funds to nine participating clinics to provide mental health services. Four grantees tried but were unable to secure local funding, citing a slow and difficult local allocation process. In some cases, grantees reported cuts to already limited MHSA funding. To address these challenges, grantees pursued partnerships with the mental health community, regularly attending planning meetings on behalf of clinics, and developing materials demonstrating the role of primary care clinics.

Figure 1: Total Funding Secured by Grantees, 2007-2009



Two Grantee Cases – Factors for Success

Two cases—Alameda Health Consortium (AHC) and Council of Community Clinics (CCC)—illustrate the successful role of clinic consortia in educating local policymakers and health leaders about the need for increased funding for their member clinics, as well as working with member clinics to lay the groundwork for the successful integration of mental health and primary care services.

Alameda Health Consortium (AHC): AHC is a clinic consortium that represents eight community clinic corporations operating 35 sites in Alameda County. Together AHC member clinics provide health care services to over 148,000 patients with over 695,000 visits. Based on recent data, approximately 37,000 patients within the clinic system have had a mental health diagnosis. All member clinics offer various levels of mental health services and have contracts with Alameda County's Behavioral Health Care Services. Member clinics have developed and implemented integrated systems of care with the goal of providing appropriate care for patients with mental health illness within the scope of primary care. These integrated models include on-site mental health professionals, using psychiatric services on a consultant/contract basis, case management, and on-site counseling. Some member clinics are in the position to treat individuals with severe mental illness and others have the capacity to see individuals with moderate mental health problems.

Council of Community Clinics (CCC): CCC represents 16 community clinic corporations in San Diego County, providing services at over 60 sites. In 2002, CCC member clinics provided care to over 400,000 patients in one million patient visits. Of these, approximately 30,000 visits were for mental health services at 19 locations. Mental health programs differ by clinic organization, and vary from highly developed and integrated systems of care, to on-site mental health assessments and treatment, to complete reliance on private providers outside of the clinic network. Most clinics have at least one site that offers mental health services, and the other sites have identified agencies to which they refer patients needing services for serious mental illness, severe emotional disturbance, depression, posttraumatic stress disorder, and other mental health issues.

Both AHC and the CCC advocated for MHSA funding to help transform their local mental health systems. They specifically advocated for the integration of mental health and primary care and facilitated the active engagement of member clinics in the MHSA planning and implementation process. Both organizations engaged in a similar set of activities including: 1) early and active participation in county planning, 2) development of new partnerships and coalitions, 3) facilitation of member clinic involvement, and 4) consortium technical expertise. These activities are described below.

1. Early and Active Participation in County Planning

AHC and CCC were actively involved from the beginning of the planning process in 2004-2005, increasing their visibility and establishing themselves as key players.

AHC served as the coordinating and central advocacy body throughout the MHSA planning process by developing recommendations, facilitating clinic participation in advocacy and planning efforts, and developing written materials. AHC obtained a seat on the Alameda County Stakeholder Group, participated in town hall and community meetings to obtain community input, and facilitated the participation of member clinics at various meetings and hearings.

CCC leadership provided input on the planning and development process beginning with stakeholder groups conducted throughout San Diego County in late 2004. It provided information at stakeholder meetings about the need for additional mental health services in the clinics, and the role clinics can play in meeting the mental health needs of low income and uninsured patient populations. CCC also surveyed clinics about their mental health service needs and recommendations, and shared the findings with the County Mental Health Department.

2. Development of New Partnerships and Coalitions

For clinic consortia and member clinics, local planning activities are an opportunity to develop new partnerships with stakeholders who may not be familiar with the role of community clinics, such as the local mental health department. In addition, consortia can leverage existing partnerships and coalitions to increase community-wide input, improving the likelihood that a program's guidelines are successfully implemented. For example, AHC developed relationships with Behavioral Health Care Services leadership not only to educate policymakers about individuals presenting with mental health illness in the primary care setting, but also to promote the idea of integrating primary care and mental health.

Partner Perspective: Our relationship with AHC has only solidified since 2001 by working together for passage of the MHSA and integration of behavioral health care and primary care. The consortium and its individual member agencies have been on the front line at local, State, and Federal policy forums to promote integration of behavioral health care and primary care services. – *Bonita House*

CCC and clinic representatives formed a new partnership with the County Mental Health Department by working with departments such as Alcohol and Drug Services, Probation, and Child Welfare, as well as with contracted mental health providers and consumers. These partnerships served to expand the clinic network and the resources of community mental health providers.

Partner Perspective: The CCC's ability to disseminate statewide the lessons learned was critical to the development of trust and confidence in the primary care and mental health communities, in addition to providing a viable model to other counties trying to forge a new relationship with primary care clinics. The CCC serves as a "mentor" with organizations that are just starting up in the field of integrated behavioral health services. *Project Director, Integrated Behavioral Healthcare Project*

3. Facilitation of Member Clinic Involvement

AHC and CCC aggressively facilitated member clinic involvement throughout the planning process. As key allies, clinics can mobilize constituents, such as their providers and patients, as well as provide input on funding guidelines and service models.

AHC convened a clinic-wide mental health work group consisting of clinic staff to share information about mental health programs and integration efforts, to strategize and develop recommendations regarding the MHSA planning process, and to participate in more detailed discussions and frameworks regarding the integration of primary care and mental health. Clinic CEOs were supportive of AHC taking a leadership role in the area of mental health, with clinic mental health staff providing significant input.

CCC facilitated meetings with clinic members to develop collaborative mental health programs and strategies. In partnership with clinic leadership, CCC compiled an analysis of aggregated clinic mental health needs and also forwarded materials and messages to clinic executive directors and other clinic mental health directors and staff about how clinics could tie into the MHSA.

4. Consortium Technical Expertise

Clinic consortia offer significant resources that may be

beyond the capacity of their member clinics, such as staff trained in policy advocacy, finance, specific health issues, and research. These skilled staff members are able to attend meetings and events, pursue new funding opportunities, and manage projects that clinic staff would not be able to do on their own. Moreover, they provide the means for thinking about and developing sound financing guidelines that align with individual clinic needs.

For example, the AHC Policy Director took the lead in assessing clinic work and convened AHC's first mental health workgroup that serves as an advisory body to brainstorm, share best practices, and develop recommendations, as well as to serve as a peer network. The AHC Policy Director also was invited to sit on the Alameda County Stakeholder group given her expertise in mental health policy and advocacy. Similarly, CCC served as the central contact point for all MHSA advocacy activities, acting as the communication link between clinics and County Mental Health staff. The CCC and its member clinics have a positive history of working with the county on various projects in the health arena, and these examples were raised when appropriate to increase credibility.

ACHIEVING OUTCOMES: PERSISTENCE PAYS OFF

Both AHC and CCC were successful in their efforts to position member clinics to receive funding under the MHSA, although the two consortia had slightly different outcomes. The California DMH approved Alameda County's three-year CSS Plan under the MHSA in June 2006. Overall, AHC was able to secure $2.3 million in MHSA funding for four member clinics to expand access to culturally appropriate mental health services to the Latino community as well as Asian seniors.

As the sole source contractor, CCC will administer $1.8 million per year for three years (January 2007 through June 2009), with four additional one-year options. There are three main program components. First, clinics will provide services to children with serious emotional disturbance (SED) and serious mental illness (SMI), and will be reimbursed for therapy visits, medication, and psychiatry visits. Second, six clinics will implement the IMPACT (Improving Mood – Providing Access to Collaborative Treatment) program where a depression care manager provides therapy to clients with mild to moderate depression, and the primary care physician prescribes medication if needed. Third, five clinics will train promotoras to reach out to older adults needing mental health services, and link them back to the clinics.

CONCLUSIONS

Despite the limited funding and challenges in participating in local MHSA planning and allocation discussions, the availability of MHSA funding has been a significant policy opportunity for California's clinic consortia. Participating in discussions about health programs beyond the scope of community clinics helped to broaden grantees' perspective on the delivery of behavioral health care. They learned how the behavioral health system operates and the primary care needs of behavioral health patients. In addition, participating in local MHSA funding discussions provided an opportunity to educate decision makers and the broader community. Some stakeholders had either never heard of or did not understand the role of community clinics before they participated in these discussions. Moreover, the partnerships established through the MHSA allocation process will be important for future advocacy initiatives.

The comparison of two clinic consortia—AHC and CCC—provides some insights into how local consortia tap into their strengths and resources in similar ways to achieve a similar outcome—increased clinic financial stability. However, funding and expanding mental health services depends in large part on the local context and existing health care delivery system. Clinics come to the table with different approaches to providing mental health services and the MHSA planning process is not identical from county to county. There is no one model of integration, which affords clinic consortia and member clinics the opportunity to innovate while drawing on their strengths and experiences.

Last, the benefits to California's community clinics and their target populations of expanded grantee involvement in securing local MHSA funding have been significant. In addition to new funding to clinics and increased access to mental health services, other benefits to clinics include:

- Increased integration of behavioral and physical health services to deliver seamless and efficient service options for patients;
- Sharing of best practices that can be adopted by clinics; and
- Increased understanding of mental health services funding and clinic funding needs.

Unevenness in grantee success in securing local funding raises important questions about how to best achieve uniform access to appropriate mental health and primary care services. However, under the Patient Protection and Affordable Care Act, there will be new opportunities to further integrate mental health and primary care. Clearly, grantees are well positioned to work with community clinics to implement provisions, such as the mandated inclusion of mental health and substance abuse disorder services in state health insurance exchanges. Additionally, the renewal of California's Section 1115 Medicaid Waiver will provide additional opportunities to incorporate tenets of the integrated mental health/primary care model into Medi-Cal, the state's Medicaid program. Because consortia recognize the need to sustain a long-term commitment to the integration concept, they are working closely with county leadership to confirm that integration objectives are met while keeping the clinic role front and center in the dialogue.

THE UCSF EVALUATION:

Annette Gardner, PhD, MPH
Evaluation Director
Philip R. Lee Institute for Health Policy Studies
University of California, San Francisco
3333 California Street, Suite 265
San Francisco, CA 94118
Phone: (415) 514-1543
Annette.gardner@ucsf.edu
http://ihps.medschool.ucsf.edu/News/california_endowment.aspx