

APPENDIX E – WORK GROUP DETAILS

Below is the complete listing of the ideas generated by the Work Groups. The **Resources/Assets** Section, as well as the **Policy** Section, combines the responses from all of the groups. **Strategies** are identified for each of the six Work Groups, as well as Area Action Plans for each issue.

RESOURCES/ASSETS – Work Groups identified the following resources and assets in the North State that can be used to improve mental health services:

- Community clinics-primary care providers- School based RHC/FQHC
- Substance abuse – Community Based Organizations and county
- County Behavioral Health Departments
- Policy information and technical assistance for county mental health from the State of California/DMH
- Insight into indigent health coverage
- Wellness and prevention services
- Lobbying and coalition building
- Contract monitoring
- Networking/Networks/Consortiums
- Telemedicine/Telepsychiatry
- Intercommunity (individual) Advocacy and Activism
- Grassroots Community Development/ Community people working together
- Integration Projects/Plans
- Hospital Services – ER – inpatient- psychiatric hospitals
- Integrating resources
- Resource Acquisition
- Spiritual – Creative – Visionary - Enthusiasm
- Financing, including CMSP
- Tenacity “bulldog”
- Staff, personnel and Human resources
- Group homes
- Advocacy
- Outreach
- Rural Health Departments, Community Health, Social service, Adult and Child Protective Services, etc.
- Non-profit Adult Day Health Care
- Foundations/funders/Philanthropy
- Urban rural perspective
- NAM 1
- Children & Family 1st Commission
- Elected policy makers
- Prescription data

- Case management Services
- Home based services/ Home Mental Health Care (including home detox)
- Associations/Lobbyists
- Consultants/Instructors
- Caregiver Resource Centers
- Commitment to collaboration
- Attention to and help for dementia
- Money to make a “bigger pie”
- Naiveté (Ability to do the impossible simply because you don’t know you can’t)
- Creativity from working in frontier and rural areas
- Represent unique needs of Native American (and other ethnic) populations
- Wide Experience
- Interagency cooperation
- Youth services

POLICY ISSUES

Participants were asked to list anything that was “beyond your control” or things that were clearly regulatory or governmental in nature under “policy issues.” By listing policy issues separately, facilitators hoped to encourage unlimited brainstorming, but to also freely identify any barriers and possible future areas for change as well.

- Reimbursement rates inadequate to provide services/ Restrictive regulations that affect reimbursement
- Lack of genuine mental health parity
- Control of mental health delivery by HMOs, Medi-Cal, etc. (payment source gate keeping despite eligibility, physician recommendation and covered services. May include red tape and billing nightmares to discourage providers)
- Restricted and limited criteria for eligibility for county mental health consumers
- Cost shifting
- Implementation enforcement of Knox-Keene
- County Medical Services Program (CMSP) patients seen in primary care clinics
- More covered mental health services for CMSP
- Policy/ billing/funding strategy of fee for service may need to make a return
- Allow MFT’s to practice in all Medicare/Medi-cal settings
- Invest in mental health support
- Hospitals involved in consultative services
- Hospitals need to invest/commit in psychiatry as a specialty
- No more local control – centralization of services
- Local sensitivity – anti-stigma regulations
- Legislation for inpatient psychiatry services/ Facility issues
- Children’s policy council

- Geographical isolation/allow for transportation and creative solutions for rural distances. Consider the effects of isolation and the population(s) who may seek it out. Effects of geography on access
- Limitations on realignment
- Mandates without funding
- Bureaucracy overload “one size fits all” (learning curve/community problems for new state. Administrator)
- Liabilities related to using volunteers
- Healthy Families benefits are not being utilized
- HIPAA re information sharing
- ICD9 vs. DSMIV
- Number of approved visits for behavioral health
- Narrow definition of scope of responsibility
- Share of cost
- Reimbursement for telemedicine in primary care settings
- Too much paperwork
- Conflicting agency policy
- Barriers created by confidentiality
- Paid consumer peer support

1. LACK OF PROVIDERS: group 4 representing Butte, Tehama, and Glenn Counties. Facilitator: Pam Tupper, Executive Director, Shasta Consortium of Community Health Centers and group 6 representing “friends of the North State” with a number of participants from Modesto, with Mary Jane Alumbaugh, Ph.D. CIMH facilitating.

STRATEGIES

Methods for improving the problem include:

- Access recent retirees for part time positions/ Draw upon large pool of skilled retirees – pay them to mentor students
- Education in middle schools/elementary schools for career opportunities in mental health (K-12)
- Job fairs
- Use technology for supervision component of licensing
- Develop partnerships to “grow your own” personnel in rural communities
- Financial incentives (stipend bonus)
- “Better” Coordination between departments and other providers
- Collaborative “friendly” policies
- Parity between county & Community Based Organizations
- Develop infrastructure of Community Based Organizations
- Form collaboratives with university and training facilities
- Transport patients to providers
- Mental health shortage designation
- Regionalize behavioral health care
- Educate around disciplines and requirements (MFT, LCSW, etc).
- ROP for high schoolers in mental health
- Develop “Community Mental Health” curriculum
- Integrate dementia treatment/care into multidisciplinary trainings
- Ask Department of Mental Health to look at training County Behavioral Health Departments and Community Based Organizations in issues of licensing requirements for billing purposes
- Educate layman volunteers
- Professionals need to be trained to graciously allow outsiders into their busy systems
- Improve educational standards – and cross training - opportunity
- Develop more educational opportunities

COLLABORATIONS & PARTNERSHIPS

Key providers ripe for possible collaborations and/or partnerships to improve the access to all/any providers in rural northern California were identified as primary care, county behavioral health and community based organizations seeking staff and:

- Tertiary care centers
- CEU sponsorships
- Chamber and recreations organizations

- Advocacy groups
- Associations
- Universities
- Foundations
- Private corporations

AREA ACTION PLAN

Work group participants created Area Action Plans that included:

- Increased use of telepsychiatry
- Increased utilization of Family Nurse Practitioner/Physician's Assistants
- Develop conferences/trainings to take place in rural areas
- Advertise in recreational magazines
- Hiring partnerships such as Local hospitals and clinics recruiting together
- Communication w/universities
- Develop support for stipend program funding for rural training
- Bring together a national mental health conference on rural services
- CIMH offer scholarships to residents
- How do we impact training of practitioner groups who might be partners?
- National Alliance for Mentally Ill (CAMI), NASW, CSWE, CAMFT, Assoc of Ad. Boards, National MH Assoc, Board Behavioral Science, Superior California MH Directors, CIMH – Cathy Wright and squeaky wheels- let them know that lack of providers is an issue we are serious about solving and seek their active assistance
- University job fairs
- School (8th grade and other) job fairs
- Health fairs
- Mentoring programs in high school
- Licensed providers by Education. Grants/loans/\$ incentives for commitment to rural practice
- More collaboration in creative use of provider resources
- Increased volunteer use
- Certification of mental health workers/MHRS
- Non-economic incentives and active provider outreach
- Cross training of staff

- 2) LACK OF RESOURCES: Group 1 representing Sacramento, Yolo, El Dorado and Placer Counties. Facilitator: Jack Tanenbaum LCSW, Department of Mental Health, and Group 3, from Nevada, Plumas and Sierra counties with Sharon Avery Rural Health Center facilitating.

STRATEGIES

Suggestions for ways to improve the issue of lack of resources in rural northern California include:

- Paid internships (cross-issue impact with lack of providers)
- Improved behavioral health training for primary care providers
- Increased use of Telepsychiatry and Telemedicine
- Linkages w/Universities/Medical Schools
- More equitable/equal cost reimbursement
- Collaboration – primary care and mental health providers
- Outreach – public education regarding mental health inadequate resources
- Education about severe mental illness to sources of funds. “Feedback for Sanity”
- Grants to fill holes and pilot projects to effect change
- Reduce paperwork requirements
- Integrated system changes in service delivery system
- Simplifying billing codes
- Accurate documentation of service costs
- Increase the number and availability of Crisis Beds – Children/Adults (increased funding for liability, etc)/ Children treatment facilities
- Increase human services and adequate housing for Children and adults in crisis
- More \$
- Geriatric training for multidisciplinary services
- Coordinated treatment models
- Regionalize services
- Collocated case manager/Collocated services
- Volunteers/paraprofessionals/interns
- School outreach
- Repeal Prop. 13
- Cross-training

COLLABORATIONS & PARTNERSHIPS

Suggested collaborations and partnerships that might improve the lack of resources in Northern California include:

- Foundations – Community Based Organizations and Counties
- Primary care, Department of Mental Health, and Community Based Organizations
- Coordination w/Medical Centers/Universities
 - Training
 - Telemedicine Services
 - Residency Rotations

- State-County-Community Partnerships
- Public education – Through all of the above partnerships
- Lobbyists
- Elected Officials
- Media
- Faith-Based Providers

AREA ACTION PLAN

The area action plans for these two groups included:

- Mental Health benefit reform
- Investigate barriers to services and work to actively solve access issues
- Lobbying task force
- Collaboratives: public/private partnerships to fill gaps
- Educate potential referrers
- Define variables and standardize data collection
- Utilize Rural Health Centers and Federally Qualified Health Centers for behavioral health needs
- Strategies for dementia
- Identify new \$
- Placement of mental providers in primary care clinics/ Primary Behavioral Health Care
- Get a demonstration project funded (to maintain and enhance services for the indigent population)
- Lobby for stronger enforcement of Knox Keene (access)
- Explore regional approaches to increase access to services

- 3) CHALLENGES TO COORDINATION ALONG THE FULL RANGE OF BEHAVIORAL HEALTH CARE SERVICES. Group2 covering Shasta County was facilitated by Liz Mantle, LMFT NSRHN Network Coordinator and Group 5 representing Siskiyou, Modoc, Trinity, Del Norte, Lassen, Humbolt and Mendocino Counties with Susan Ferrier, NSRHN Telemedicine Coordinator facilitating.

STRATEGIES

Solutions to improve coordination along the full range of services included:

- Move out of county department of mental health and go where the client is
- Anti-Stigma – satellite clinic located in the community
- Locating services in primary care clinics where consumer could be seeking services for a variety of reasons
- Psychiatrists in Federally Qualified Health Centers/ Psychologists in Federally Qualified Health Centers. Coordinated effort to employ mental health and medical providers in one organization, such as LCSW & LMFT at primary care clinic
- Improved community-wide cross or inter-communication
- Full list of phone numbers and services for all community, county, primary care non-profit etc. services. And have the list available on-site at all those services
- Resources list also available on website
- Clinician to clinician exchange
- Change in billing strategies
- Cross training
- Collaboration – partnerships. Revive collaboration group in our local area
- Sharing of information
- Develop multi-agency release form to allow easy collaboration on hi-risk patients
- Work with local pharmacies to track medical usage/compliance
- County mental health staff sees patients at primary care clinic site
- Increased communication between P/C providers and county mental health
- Decentralization of mental health services due to geography/distance
- Funding puts barriers to expanded care – change funding structure to allow flexibility and exceptions
- Use grant funding to help fill gaps

COLLABORATIONS & PARTNERSHIPS

Possible links to improve coordination of services include:

- Work with community partnerships through Emergency Rooms (as they may still be locally owned, and most hospitals are not any longer)
- Community coalition to increase county inpatient psychiatric beds and provide pediatric and youth beds
- For-profit private sector may be a significant partner
- General community involvement
- Expose students to model of interdisciplinary collaboration

- Regional effort to create release of information w/in HIPAA
- Regular meeting of primary care, mental health, substance abuse
- Have local psychiatric expertise present information to primary care providers
- Have a county liaison w/psychiatrist to reduce calls from providers
- Representation of mental health at primary care provider meetings and vice versa

AREA ACTION PLAN

- “Call Barbara Walters and Diane Sawyer” (community/state/national ed)
- Patient sharing/networking/collaboration
- Web page of resources and referrals that can be self-updated via passwords for providers
- “Healthcare for the Homeless” – intergenerational planning group
- Broaden our partnerships – legal, social services, mental health, primary care, community non-profits, for profits, service organizations, individuals, etc.
- Offer to collaborate with school outreach and education (e.g. arts and local history diversity program to teach tolerance and appreciation of ethnic cultural contributions as non-intrusive way to improve mental health and decrease racial violence)
- Community involvement in school life skills/stress management/substance abuse prevention
- Countywide recruitment and coordinated scheme to improve responses to all three top mental health / primary care issues
- Provider responsibility to achieve outreach with key community collaborators i.e.: county behavioral health should know about primary care mental health services and telemedicine services and local primary care providers would like to know more about how county behavioral health works
- Provide cross county behavioral health department and primary care clinic/provider trainings (such as NSRHN is doing)
- Develop HIPAA friendly consent to reduce barriers to wrap-around services
- Commitment to formal and informal meetings to discuss and surpass conflicting regulations policy and practices
- Continued countywide and region wide meetings of County mental health and primary care providers
- Remove barriers to reimbursement for services through legislative efforts