Integrated Behavioral Healthcare Project: County DMH and Primary Care Clinic Collaboration

Shasta County: Constructing a County/Clinic Contract

Catherine Camp

Community Environment

- Hospital closures
- Anti-managed-care environment
- Little positive public/private collaboration
- Strong network of primary care clinics

Shasta Mental Health Services Act Plan

- Unserved/underserved rural areas
- Large access problems countywide

MHARC Process

- Mental Health Assessment/Redesign Collaborative funded by foundation, led by the Shasta Consortium of Primary Care Clinics
- MHSA planning and MHARC process overlapped
- MHARC reviewed private and public mental health systems
- Products included proposals for crisis care and rural access, among other issues

Process to County/Clinic Contract

- Rural Policy Council established
- Pilot test of outstationed case management/linkage staff and crisis service in rural hospital
- Contract group established: county consultant, clinic consultant, legal support
- Decision maker negotiations over outcomes and cost
- Review by DHS and DMH

Project Strengths

- Clinics are trusted, non-stigmatized community partners
- Clinics have independent, non-capped Medi-Cal billing capacity
- Clinics have telemedicine infrastructure
- Clinics provide physical (sometimes dental) health care to mental health clients

Project Cautions

- Clinics have regulatory barriers to full recovery service
- Mental Health and FQHC speak different languages
- Data systems are separate
- Trust is a requirement