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AN EVOLVING MANAGED CARE SYSTEM: PUBLIC MENTAL HEALTH SERVICES IN SAN FRANCISCO

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ABSTRACT: This article describes the San Francisco Division of Mental Health's evolution toward managed care for its Medicaid eligible population. The reorganization of services reflects a local reform initiative documented in the Division's strategic plan. In addition to responding to federal mandates for serving the seriously mentally ill and the state guidelines for the managed mental health carve-out, the author also discusses the obstacles to implementing managed care as well as the future issues to be addressed.

Reorganization of public mental health services in the city and county of San Francisco is taking place in the context of federal, state, and local initiatives moving the state of California toward managed care for its Medi-Cal (California's Medicaid program) eligible population. San Francisco is a community of nearly 724,000 that reflects substantial ethnic and cultural diversity, with about 50% of the population white, 28% Asian, 14% Hispanic and 11% African-American (Bureau of the Census, 1991). A monthly average of about 12% of the population of San Francisco (89,865) is eligible for Medi-Cal (Kehew, 1993). San Francisco's initial county allocation from the California Department of Mental Health for fiscal year 1990–91 was $11,585,002, about

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2.4% of the $473,698,575 state total (California Department of Mental Health [DMH], 1991).

A case study methodology is employed in this analysis so that the transition of the San Francisco public mental health system toward managed care is placed in the context of related federal, state, and local policies. The primary components of the case include San Francisco's 1990 *Strategic Plan,* 1991 state realignment policies, and the 1993 reorganization of the local mental health department. Many of the initiatives discussed in this case provide the foundation for building a managed care system, such as the pooling of funds, local gatekeeping authority, and service coordination.

Local public mental health system adoption of managed care may appear to follow an orderly sequence of decisions when using hindsight, but actually occurs in piecemeal fashion, and as a response to multiple directives, including calls for system reform, consumer advocacy, and budget cutbacks. Communities such as San Francisco are now in transition to capitated managed mental health care as envisioned by the state of California.

BACKGROUND

In compliance with the Community Mental Health Centers Act of 1963, San Francisco organized its public mental health services into five districts based on the National Institute of Mental Health Epidemiological Catchment Area designations. Although mental health services operated as a Division under the Department of Public Health, the districts were relatively autonomous, with their own administrative offices and management information systems. (As the full title of the Division of Mental Health and Substance Abuse within the San Francisco Department of Public Health has changed over the past years, for purposes of clarity it will be referred to as the Division or the DMS.)

California's extensive deinstitutionalization policies, resulting in an 84% reduction of the state hospital population between 1957 and 1988 (Elpers, 1989), drew increasing attention to gaps in community-based services, particularly in urban areas such as San Francisco, where homelessness and illicit drug use made untreated severely mentally ill more visible and problematic. In the 1980s, the federal Community Support Program (CSP) initiative began pushing local mental health departments to better coordinate services for the severely mentally ill. In 1985, probably to some extent in response to CSP provisions, administrative functions and managers were centralized in an attempt to resolve problems in service delivery. One ongoing issue was the lack of continuity of care; when the client's condition changed, so did the providers. For example, a client in a residential program changed primary therapists if inpatient care became necessary, and changed therapists again when dis-

charged for outpatient care, so services became fragmented and clients were lost in the complex system (DMS Officials, personal interviews of seven upper level administrators and program managers, April 27, 1993—February 24, 1994).

Another problem revolved around integrating and monitoring private contractors and other outside providers of public mental health services. Private contractors wielded considerable power; for example, programs serving special populations often had strong lobbies, making it difficult to establish and enforce performance standards consistently. When resources were more freely available, private contractors established innovative and highly specialized programs, frequently serving only a small number of clients. Residential programs often kept clients for up to two years, creating a financial burden for the public payors. San Francisco General Hospital, provider of much of the publicly funded acute psychiatric care, operated relatively independently of the county mental health system, thereby limiting the successful linkage of patients with community-based services on discharge. Attempts to better organize the system tended to be driven by emerging crises, such as the excessive use of hospital and locked facility beds (DMS Officials, personal interviews, 1993–94).

THE 1990 STRATEGIC PLAN

The 1980s represented a shift from planning and regulation to reliance on market forces to control rising health care costs in both the public and private sectors. However, the State Comprehensive Mental Health Services Plan Act of 1986 (P.L. 99-660) required states to develop a mental health plan beginning in 1988, and every year thereafter. One effect of this federal mandate was to expand stakeholder representation in the state planning process; half of the 66 members of the California mental health planning council represent consumers.

In 1989, the San Francisco County Board of Supervisors adopted a resolution requiring detailed planning for mental health services. In responding to this mandate, the Division took the opportunity to move from crisis management to a comprehensive needs assessment upon which to base objectives for improving and better coordinating services. The Division employed a participative planning process involving mental health officials, providers, advocates, consumers and families. For the first time, the Division delineated its mission and objectives with the contribution and consensus of all of the stakeholders in the system. The *Strategic Plan* that resulted from this process emphasizes three operating principles regarding services: that they are community-based, culturally competent, and consumer guided (City and County of San Francisco,

Division of Mental Health, Substance Abuse, and Forensic Services [DMSF], 1990; DMS officials, personal interviews, 1993–1994).

Some changes resulted from this comprehensive planning effort, such as identifying target populations and expanding case management, but despite the gains made by planning and consensus building, problems remained in the delivery of services. For example, it was difficult to prioritize the objectives generated for the many target groups, particularly since the Division continued to face budget cuts. However, the *Strategic Plan* principles of community-based, culturally competent and consumer guided services strongly influenced the design of the recently reorganized system (DMS Officials, personal interviews, 1993–94).

FUNDING REALIGNMENT

At the same time that San Francisco conducted its strategic planning process, the California Legislature, with advice from state and county mental health officials, advocates and other stakeholders designed the Program Realignment Bill (AB 1288), effective July 1, 1991. Realignment changed the funding for public mental health services in California counties by shifting revenue sources from the state general fund to revenues generated by increases in the sales tax and vehicle licensing fees. These new tax revenues are distributed from the state to county "trust funds" with matching funds deposited by the county. The intent of this shift was to provide a more stable and increasing revenue base for county mental health services in order to increase local control over mental health funds (Masland, 1993b).

The funding changes were designed to increase local discretion for pooling mental health services funds at the county level; before realignment, counties controlled funds for community-based services, but the state funded care at the state hospitals and Institutions for Mental Disease (IMDs), locked facilities that provide subacute care. Under realignment, counties may contract with the California Department of Mental Health for the use of state hospital beds, or counties may contract with private providers for hospital services, or use these funds to support alternative community care. State guidelines (which are not binding) also encourage counties to better integrate mental health clients with local social services, shifting the mental health system from institutional to client-centered care (Masland, 1993b).

While the *Strategic Plan* laid the groundwork for coordinated services, realignment merely reinforced the new directions related to combining acute care with community-based funds which increased the county's flexibility to respond to budget cutbacks (M. Masland, personal interview, October 12, 1993) and helped reduce the use of the state hospital and IMDs (DMS Officials, personal interviews, 1993–94).

CAPITATION OF LOCAL MENTAL HEALTH SERVICES

The shifting of financing and authority to local communities via realignment, and the experience gained by pilot demonstrations on capitated adult mental health services paved the way for capitated managed care in public mental health. Pilot demonstrations were funded by state legislation (AB 3777) for three counties that contracted to provide comprehensive adult mental health and rehabilitation services at a negotiated cost and to assume risk, beginning July 1990 (California Department of Mental Health [DMH], 1991). Preliminary evaluation of these programs indicates that capitation can allow for more flexible financing and service delivery and help severely mentally ill clients remain in the community, with no adverse effect on client outcomes (Lewin-VHI, 1993).

In San Francisco, the children's services section is the closest to full implementation of managed mental health care, particularly for seriously emotionally disturbed (SED) children. About 2,700 children and youth receive direct, billable services in the San Francisco mental health system; another 4,000 children are served by programs located in the schools and other community settings. Children's services are more closely linked to other city and county services (for example, juvenile justice and special education) than adult or geriatric programs, largely because for over a decade the state has supported the development of collaborative local systems of care for troubled children (Jordan & Hernandez, 1990). In San Francisco, this has resulted in more centralized access and planning for children requiring extensive care, as well as an emphasis on fostering child-centered programs, so that the provider "stretches" to accommodate the child's needs (DMS Officials, personal interviews, 1993–94).

Capitated managed care for SED children has been implemented by the Family Mosaic program. This integrated services project serving about 200 children and youth was funded for the last five years by the Robert Wood Johnson Foundation. The program, with an approximately $5.3 million annual budget, will now be funded from federal, state, and county sources, capitated via the California Department of Mental Health (Administrator, personal interview, February 14, 1994).

A major goal of Family Mosaic is keeping the SED child in the family and community setting, by identifying and providing both traditional (such as mental health counseling and substance abuse treatment) and non-traditional (such as tutoring) services. The client is assigned a case manager who coordinates a plan of care, including inpatient hospitalization if required. There is a comprehensive assessment of the child's condition and needs; an interdisciplinary team periodically reviews the care plan to ensure that interventions are appropriate and effective. Intensive discharge planning is conducted with hospitals and providers, and the program has developed a quality assurance

system for reviewing charts and authorizing hospital reimbursements. In addition, Family Mosaic involves the community in participating planning, collaboration and service contracts, so that care is available in the child's neighborhood, and community needs (such as violence or teen pregnancy) are identified and addressed. Preliminary outcome data indicate that school performance and attendance are improving, and rates of hospitalization and incarceration are decreasing among the clients served by Family Mosaic (Administrator, personal interview, 1994; DMS Officials, personal interviews, 1993–94).

REORGANIZATION OF SAN FRANCISCO MENTAL HEALTH

Clearly, local as well as federal and state initiatives have been moving the mental health system toward a more coordinated, accountable model for some time. One other important factor is the local government budget deficit; in the spring of 1993 there were threats of San Francisco mental health cutbacks that would have removed 5,000 adult clients from a system serving about 13,000 (DMS Officials, personal interviews, 1993–94). Therefore, it became necessary to target scarce resources toward the most needy clients, changing what had been a philosophy of universal access to an emphasis on eligibility and gatekeeping; the reorganization of the San Francisco mental health system, initiated July 1, 1993, represents a response to cutbacks and another attempt to establish system reform, as well as a move toward managed care.

Also beginning July 1, 1993, modifications to the state Medi-Cal program changed the way services are targeted and delivered. A needs assessment conducted by the state found that seriously mentally ill clients frequently identify housing and jobs as their most important service priorities (DMH, 1991), rather than clinical treatment services; this finding helped shift state official thinking from a clinical services oriented "medical model" to less traditional alternatives, emphasizing service coordination and the rehabilitation of the seriously mentally ill. The Medi-Cal Rehabilitation Option expanded the billable range of services in order to support a rehabilitation model; the Medi-Cal Coordinated Services program helped to reform care planning, services delivery, and outcomes monitoring (DMH, 1993b).

Under Coordinated Services, an individual may enter the local mental health system via any provider, then must be referred to a coordinator responsible for ongoing care management. Intake assessment identifies the individual's needs and desires, as well as immediately necessary care. If ongoing care is needed or desired, the coordinator, client, and significant support persons (as identified by the client) mutually develop a Coordination Plan (DMH, 1993b). The plan identifies the results the client desires from mental health services and the types of services required, specifies service providers ap-

proved by the coordinator and documents medical or service necessity. Planned services include case management, outpatient, medication and day care services; emergency services are not documented in the plan (DMH, 1993b).

Each client also has a Service Plan documenting each planned and billable mental health service received. This plan identifies specific outcomes for which services are authorized and summarizes the activities the client, significant support persons, and provider staff will perform to achieve plan outcomes. All Service Plans must be approved by the coordinator; special provisions apply to plans for case management and the management of medications. Moreover, Targeted Case Management requires that the client meets the target population criteria and needs case management (DMH, 1992). Periodic documentation is required for ongoing services, and a quality management system will establish a review process for providers in order to improve their performance (DMH, 1993b).

The San Francisco reorganization established four Integrated Service Centers (ISCs) operated by San Francisco public mental health as the single points of entry for eligible clients. Services for ethnic or cultural communities such as Latinos, Asians, gays and lesbians, and the homeless are located in ISCs near neighborhoods with a greater concentration of these groups. Clients may freely choose to use any of the ISCs, reducing language and cultural barriers to care and access (City and County of San Francisco, Division of Mental Health and Substance Abuse Services [DMS], 1993b).

The expected outcomes for the reorganization are an integrated care system for the severely mentally ill, a culturally appropriate system that is culturally sensitive, consumer guidance and outcome measures that help ensure accountability, and less reliance on institutional care. The core services provided by ISCs include urgent care, outreach, assessment, medication monitoring, individual and group care, dual diagnosis (substance abuse and mental illness) treatment, case management, self-help and family support. Specialty services provided by either private contractors or the Division ISC staff include 24 hour care and vocational services (DMH, 1993b).

The ISCs are centrally managed by the Division so admission and discharge criteria are standardized, as are target population definitions. A primary responsibility of the publicly operated ISCs is to serve as gatekeepers, determining which individuals seeking services meet the admission and treatment criteria. The staff in the four ISCs now assume responsibility for clients from their geographic area who are admitted to acute care facilities, in order to link these individuals to community services upon discharge (DMS, 1993c). San Francisco adopted the Coordinated Services model established by the state, with each client assigned a coordinator to plan and authorize services throughout the course of illness, following the client through inpatient and community-based care (DMH, 1993a).

Under the San Francisco reorganization, the geriatic programs serving about 3,000 seniors (DMS, 1990) became a geriatric ISC. The main functional difference after reorganization involved centralizing quality management across all programs; unlike adult services, which are largely provided by private contractors, most non-acute, non-residential geriatric services are provided by the Division. The geriatric program operates much like the adult ISCs, with four teams providing all services except for contracted programs, and serving as gatekeepers to the system (DMS Officials, personal interviews, 1993–94).

OBSTACLES TO REORGANIZATION

When asked about the major obstacles in reorganizing mental health services and moving toward a managed care model, a Division official identified cultural changes required of both consumers and providers, budgetary issues, and the multiple missions of various mental health policy initiatives. One of the cultural changes concerns the implementation of target criteria for access to public mental health care, which was (and continues to be) painful and difficult, as universal access had long been a highly valued principle within the Division. A point system now identifies adult clients eligible for admission or continued treatment based on psychiatric symptoms, medication requirements, threat or danger to self or others, functional disability, and length of time since discharge from an acute care facility (DMS, 1993a). However, the Division recognizes that there is still some ambiguity and disagreement in interpreting and applying these criteria (DMS, Target Population Work Group, 1993). For example, advocates for ethnic and cultural groups are concerned that some minority populations, such as Asian refugees with high rates of severe psychological trauma, may not receive adequate access to services (DMS Officials, personal interviews, 1993–94).

Another cultural change involves the breaking up of the old system of largely independent providers and programs, which was replaced by a system structured around single points of entry providing gatekeeping and formal authorization of approved services. This change requires that providers, both public and private, operate differently than in the past. What traditionally was a system driven by providers or treatment ideologies will now be "cost and outcomes and performance and consumer driven" (DMS Officials, personal interviews, 1993–94). Both the public and private sectors are now expected to manage their programs based on performance and outcomes data, a marked shift from the clinical management model under which programs operated before (DMS Officials, personal interviews, 1993–94). As one project director asserts, mental health officials must move from "department thinking" (a focus on one's own department) to community partnership (Administrator, personal interview, February 14, 1994). Another official explains:

> We will have to ask questions, for example, 'Is day treatment for three years effective and providing the desired outcome?' Managed care forced me to ask those kinds of questions, but right now I'm talking to myself—people must shift gears in their thinking before they can start asking these questions. (DMS Officials, personal interviews, 1993–94)

There is a tremendous need for education of Division staff and providers regarding managed care; training needs include quality assurance, care coordination, and tracking and managing the costs and utilization of services.

The move to managed care changes the roles and responsibilities of public and private providers. Public providers must shift from serving as therapists to being brokers; in the words of one official, "we will be more like an insurance company" (DMS Officials, personal interviews, 1993–94). In addition, as coordinators are expected to follow clients throughout the entire course of their illness, outreach and hospital liaison activities are a new responsibility for some Division staff (DMS Officials, personal interviews, 1993–94). Private contractors face increasing pressures to meet guidelines for accountability, productivity, and client referrals. In some cases, providers are expected to serve more (and more severely ill) clients, with a more restricted length of stay than in the past, so care is more difficult and intense. In other cases, gatekeeping provisions may substantially reduce the number of clients referred to private contractors (DMS Officials, personal interviews, 1993–94).

A second obstacle, the budgetary process in which reorganization took place, was described by one official as "tumultuous and horrendous." Consequences of this difficult budgetary situation include heightened staff anxiety about job security. Budgetary decisions also reduced the number of ISC sites, originally proposed as six, to only four. The local budget crisis is an outgrowth of state shortfalls and cutbacks. For over 30 years, state general funding for mental health has faced continued budgetary reductions; although the amount of state funding increased from about $80 million to $140 million from 1959 to 1989, over the same time period the mental health services budget declined from about 4.2% to 2.0% of the state general fund (Elpers, 1989). Throughout the 1990s, California has endured a severe economic recession and both the state and San Francisco suffer budget deficits, with cutbacks to health, mental health, and social services. Continued shortfalls in tax revenues and increased rates for state hospital and other residential beds result in continued budget shortfalls for counties, compromising the financial flexibility intended by realignment (California Mental Health Directors Association, 1992). Another problem related to financial resources and control is the local infrastructure for cost reports and reimbursement. Managed care requires that clients, services and costs are closely tracked to allow the authorizing agency to monitor utilization, quality of care, and outcomes. However, the design of the San Francisco computerized billing system makes it difficult to use as a management information system; program reports must often be specially programmed or calculated manually (DMS Officials, personal interviews, 1993–

94). The cumbersome bureaucratic approval process for reimbursement also creates problems. Under publicly funded managed care it is important to reimburse providers as quickly as possible; otherwise, it is difficult to retain high quality providers, and equally difficult to exert enough leverage to motivate providers to improve quality (Administrator, personal interview, February 14, 1994).

The third obstacle to the San Francisco reorganization involves the multiple initiatives aimed at system reform and managed care. State policies had been pushing counties toward local control of mental health financing and services since 1958, when the Short-Doyle Act provided state funds to cover 50% of the costs of mental health programs established by local governments and organized state administration for local services (Elpers, 1989). "We've been operating under managed care in some form since realignment," one official observes, "the target population and provider responsibilities have been spelled out for some time" (DMS Officials, personal interviews, 1993–94). However, unlike capitation contracts in successful managed care plans, a stable source of funding has not materialized.

Another mission of federal, state, and local initiatives is system reform resulting in a more coordinated, integrated, and client-centered approach to mental health care. Although this community-based approach is important in shifting care away from the institution, the multiple constituencies who participate in decision-making lead to multiple missions, and sometimes to controversy and conflict. For example, when the four Integrated Service Centers were originally proposed, each with their own ethnic or cultural specialty areas, the San Francisco Health Commission turned down the recommendation based on fears of "separatism" (DMS Officials, personal interviews, 1993–94). Consumer participation in program planning and service delivery, reinforced by the establishment of an Office of Self-Help in the Division, resulted in some resistance from mental health professionals who find it difficult to "let go" of clients (DMS Officials, personal interviews, 1993–94).

A related issue is the state's requirement under the Coordinated Services program to focus on client desires as well as needs in care planning. Although focus on the individual's "desires" has the advantage of establishing a client-centered approach, one provider points out that an emphasis on desires may keep clients from focusing on what they can realistically obtain from the mental health system (Service Provider, personal interview, January 6, 1994).

Multiple missions are also introduced as the state adopts new Medi-Cal guidelines for the Coordinated Services Program Rehabilitation Option and Targeted Case Management. Although the goals of these policies complement the shift to managed care, implementing various elements of managed care in this piecemeal fashion results in frequent changes in policies, practice guidelines and documentation requirements, adding to the frustration of consumers and staff who already experienced dramatic changes in the service system over

the last year. The high turnover of state mental health officials worsens this situation; in the words of one local provider, "we have a new person in Sacramento [the state capital] every week" (Administrator, personal interview, February 14, 1994).

STATE MANDATES FOR MANAGED CARE

Another driving force behind San Francisco's system reorganization is the anticipated state mandate for capitated managed care. The California Department of Health is requiring managed care for all of its Medi-Cal eligible recipients, and has separated or "carved out" mental health from the physical health care system. Unlike the Medi-Cal managed care system being developed for physical health care, which will offer the choice between two health plans, most counties will provide only one mental health plan, offered through the county mental health department. The intent of capitated managed care is to integrate Medi-Cal mental health and county mental health department services. County mental health departments will have the choice (specified as the first right of refusal) to serve as the Local Managed Mental Health Care Plan (LMMHCP). If the county does not participate, the California Department of Mental Health will select one or more private sector LMMHCPs using a "competitive process" (DMH, 1993a, p. 8).

When fully implemented, LMMHCPs will establish "a full risk, capitated system" (California Department of Health Services, 1993, p. 33). Key financial elements are:

1. Consolidation: state general funds used as matching funds for fee-for-service mental health will be allocated to the LMMHCP as an initial step in making the transition to managed care;
2. Capitation: the LMMHCP will be paid a pre-determined capitation rate for each Medi-Cal eligible person per month regardless of service utilization; and
3. Cost neutrality: state general fund expenditures will not increase when managed mental health care is implemented.

All Medi-Cal eligible persons requesting mental health services will be screened for the need for services; if these persons meet "statewide criteria for mental health services they will receive appropriate services" (DMH, 1993a, p. 9).

California recently issued a timetable for phasing in managed care for public mental health. Consolidation of state funding for Short-Doyle Medi-Cal programs (the California Medicaid reimbursement system for hospitals, clinics and case management services administered by county mental health depart-

ments) and fee-for-service Medi-Cal begins July 1, 1994. (This date has been changed to October 1, 1994; projected timelines may be subject to further changes.) Capitation of inpatient psychiatric care is scheduled for July 1996, with all remaining mental health services included by July 1997 (DMH, 1993a). However, the design of the managed care system to be implemented by the counties is still in the planning stage; the California Department of Mental Health does not expect to finalize its managed care guidelines until March 1994. This situation only adds to the uncertainty that exists in communities such as San Francisco about how to put managed care in place.

FUTURE ISSUES BEYOND MANAGED CARE

In thinking beyond the implementation of capitated managed care, local decision makers have some ideas about future issues and concerns, and to some extent are developing and sharing a vision of how the system will take shape. One likely development is that there will be less emphasis on categorical programs and financing. The pooling of funds to increase financial flexibility is largely in place; counties already administer most of the public mental health dollars in California (DMH, 1993a). What is predicted to change in the future is the categorical organization of services; in most local systems children, adults and seniors are served in separate programs by specialized providers. San Francisco officials believe that the focus of care will shift from the individual to the family, so that clients of all ages can obtain services at the same place or from the same provider pool, and so children, parents, and grandparents can be treated (and their care funded) as a family unit (Administrator, personal interview, February 14, 1994; DMS Officials, personal interviews, 1993–94). A nearby county is seeking Robert Wood Johnson Foundation funding for a pilot demonstration of a Family Maintenance Organization (FMO) to coordinate and consolidate services and funding across a broad range of health care, mental health, substance abuse, housing, social services, education and criminal justice agencies and programs (Contra Costa County Health Services Department, Office for Service Integration, 1993). If successful, this FMO may provide another model for local reform.

Another view of the future is that there will be more interagency and public-private cooperation and collaboration. There will also be more attention given to cultural and community needs, and greater involvement by consumers in the planning and delivery of mental health services (Administrator, personal interview, February 14, 1994; DMS Officials, personal interviews, 1993–94). As a result, the managed care model for public mental health services is likely to take a somewhat different shape than in other health care settings, although key elements such as capitation, gatekeeping, and single points of entry will probably be preserved. It is also likely that managed care models for public

mental health services will vary somewhat from county to county, depending on the cultural mix and consumer concerns.

After fully implementing managed care, one official points out that national health care reform is next. California managed care services are currently limited to the Medi-Cal eligible population. Health care reform measures providing universal access could have a profound effect on services financing and delivery in a community such as San Francisco, where substantial numbers of undocumented persons lack health benefits (DMS Officials, personal interviews, 1993–94). Before national health care reform legislation is enacted, San Francisco providers will have had some time to put a capitated managed care model in place, which any health care reform package is expected to resemble.

CONCLUSIONS

The San Francisco reorganization of mental health services is occurring in the context of a number of state and local initiatives that are restructuring and redirecting financial and service delivery elements toward an overall system of managed care. These initiatives have been gaining momentum over recent years; as the state reaches its deadlines for fully capitated mental health services the momentum is expected to increase. Although changes occurred for a number of reasons, including federal and state mandates as well as local advocacy and strategic planning efforts, each of these developments shared the goal of providing coordinated, cost-effective care to the severely mentally ill.

It is important to remember that most of the implementation of system reforms in San Francisco took place over fiscal year 1993–1994, and that this local system heretofore consisted of a network of highly independent providers offering relatively uncontrolled access. San Francisco has therefore made tremendous strides toward making the transition to managed care, despite facing some difficult obstacles. Providers and consumers are resolving their concerns, and continue to participate together in planning and reviewing programs, policies and procedures. Provider training and community meetings helped clarify new policies and procedures and reduce resistance. An interagency retreat opened lines of communication and addressed "department thinking" vs. community partnership issues. Consumers are finding the single point of entry system easier to navigate than the former, fragmented model, and though some staff chose to leave their jobs rather than adapt to new roles, those who remain are strongly committed to their work (DMS Officials, personal interviews, 1993–94). Although the adult and geriatric services are not yet capitated, mechanisms for pooling financial resources, identifying target populations, ensuring accountability and operating in partnership with consumers and private providers have been established.

In recent years, capitation financing and managed care approaches have moved from the private to the public health and mental health sectors, by 1988, over half of the states were participating in some form of Medicaid managed care programs. This rapid diffusion may, however, lead to considerable confusion among local officials charged with implementing these policies (Hurley, Freund, & Paul, 1993); as one mental health program director observes, "everybody has their own definition of managed care" (Administrator, personal interview, February 14, 1994). Regardless of the nature or results of the health care reform debate at the federal level, managed care is mandated for implementation throughout California by July 1997. It is expected that communities in this state and across the U.S. will be learning from each other's experience in implementing managed care approaches in the public mental health sector; a review of the obstacles and achievements experienced in the evolving San Francisco system may therefore be both timely and useful.

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