

Santa Clara Valley Health & Hospital System Santa Clara County Mental Health Department



APA OMNA Conference

April 2, 2011



The Context

The safety net is threatened

- 10 years of budget reductions
- Countywide impact
- Community's need increasing
- MHD \$22 Million reduction target



The Plan

Objectives

- Fulfill MHD budget reduction target without eliminating service capacity for 1600 adult consumers;
- Maintain critical bilingual psychiatry and licensed clinical social workers. Staff speaks Bosnian, Cambodian, Hindi, Mandarin, Russian, Spanish, Tagalog, & Vietnamese.
- Take advantage of four new primary care facilities in four regions of the county: San Jose, Sunnyvale, & Milpitas, & Gilroy.



The Plan

Objectives

- Align medical home models being developed in Primary Care and Mental Health systems;
- Improve access to primary care by SMI mental health clients; and access to mental health by non-SMI primary care clients



The Context

A Landscape of Diversity

- Population of 1,857,621
- 62% Non-White population
- 26% Hispanic, 31% Asian, 3% Black, 3% Other
- 37% are foreign born
- Close to 2/3 of the population are “Immigrant Stock” (first generation American born) or approximately 1.2 million individuals
- More than 100 languages and dialects are spoken



The Context

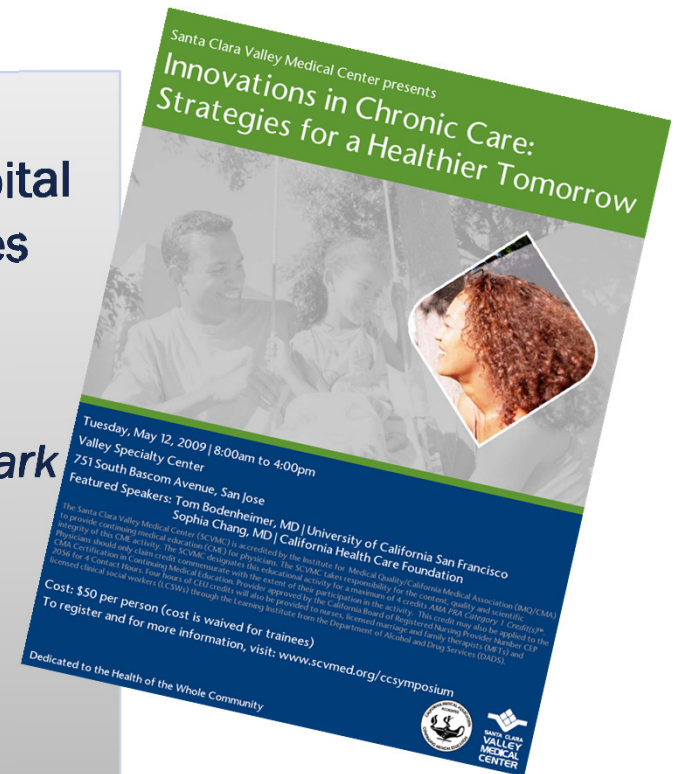


The Context

Primary Care System Changes

Santa Clara Valley Medical Center Hospital and Ambulatory Clinics system advances over the past decade include:

- *medical home model in several clinics;*
- *“embedded psychiatrist” model at Moorpark clinic*
- *integrated homeless service team*
- *integrated FQHC methadone clinic*
- *integrated developmental assessments*



Implementation

Critical Elements

- Leadership Commitment and Connections
- Opportunities: Crisis, Resources
- A visit under the FQCH model can generate potentially twice the revenue under the Short Doyle model
- Two-Year Approach
- Co-Management



Implementation

Shared Mental Health Department & Primary Care

vision: to achieve individual and population health and wellness by providing seamless health care services for the whole person (physical, mental, & substance use health care).

Clear MOU: to outline the collaboration between Mental Health Department (MHD) and Primary Care.

*Adopted from the Integration Policy Initiative sponsored by the California Institute of Mental Health



Implementation

Two Year Implementation:

Year 1: To achieve administrative and financial integration

Year 2: To design and implement clinical integration

Target Population:

- Persons (current MHD clients and new) who have persistent mental illnesses that do not require intensive case management referred through the MHD Call Center.
- Persons (current ACHS and new) who need behavioral health services referred through ACHS primary care providers



Implementation

Program Concept:

- Four FQHCs expanded to include behavioral health services provided by 8 FTE Psychiatrists & 19.5 FTE Licensed Clinical Social Workers, transferred from MHD.
- Service model was originally based on 1.0 Psychiatrist and 2.5 LCSW's and caseload of 200 clients in active treatment; and 20-30% of Psychiatrist time available for Primary Care consults for patients not requiring ongoing care.



Implementation

Tiered Approach: Four levels or categories of care to be provided

- Telephone/Email/Curbside consultation
- Face to face psychiatric consultation
- Ongoing psychiatric treatment
- Time limited behavioral health services, up to 10 visits



Implementation

MHD Roles and Responsibilities:

- **Oversight:** MHD provides oversight of mental health services and collaborates with ACHS regarding integration of these services with primary care.
- **Clinic Operations:** MHD is responsible for day to day management of co-located mental health clinic operations.
- **Staff Supervision:** MHD is responsible for day to day supervision of mental health staff.
- **Documentation and Billing:** MHD is responsible to assure mental health staff comply with ACHS policies and procedures related to budgeting, accounting, reporting, documentation, coding, and billing.

Implementation

Primary Care's Roles and Responsibilities:

- **Oversight:** Primary Care Administration collaborates with MHD to oversee integration of primary care with behavioral health services;
- **Billing and Documentation:** Primary Care Administration is responsible to provide policies and procedures for mental health staff related to documentation, coding, and billing.



Implementation

Registration:

- Same registration system: Invision. Similar charge tickets. Same medical record numbers

Medical Records:

- Medical records in the same integrated paper chart used by both ACHS and MHD. Progress notes are typed. MHD has two separate tabs to file notes.
- Milpitas clinic: chartless. Primary care doctors document directly in electronic health record. Mental Health staff uses Chartview to view the primary care records. Mental Health staff types notes & have them scanned into the electronic health record.

Pharmacy and Labs:

- Conveniently located on the same site.
- Results are available electronically to both primary care and psychiatry
- Psychiatric technicians assist with obtaining vital signs, injectible medications, and medication refill authorizations under physician supervision

Visits and Revenue Issues

- MD visits:
 - Annual expectation: 15,680 visits
 - Annual projection: 13,335 visits
 - Percent variance: 15% short
- LCSW visits:
 - Annual expectations: 31,200 visits
 - Annual projection: 12,677 visits
 - Percent variance: 59% short

Budgetary Issues

- Revenue:
 - Budgeted: \$11,000
 - Annual projection: \$5,900,000
 - Short fall: \$5,1000
- Expense:
 - Budgeted: \$5,700,000
 - Annual projection: \$4,000
 - Surplus: \$800,000
- Total Shortfall:
 - \$4,300,000

Improved Access for All Populations

- Absolute number of clients increased from 1412 in October 2009 to 2402 in January 2011, a 42% increase
- Racial ethnic minority clients: increased from 576 to 1075, a 46% increase
- African Americans: increased from 93 to 144, from 6.6% to 6%
- Asian Americans & Pacific Islanders: increased from 146 to 232, from 10.3% to 9.7%
- Latino/Hispanics: increased from 355 to 695, from 23.7% to 28.9%
- Native Americans: increased from 2 to 4
- Caucasians: increased from 674 to 1071, from 47.7% to 44.6 %

Others: from 162 to 256, from 11.5% to 10.7%

The Lessons

Positives

- Top leadership support was critical;
- Buy-in from both MHD and Primary Care Admin essential;
- Joint planning and oversight;
- Ongoing joint meetings and tracking;
- Two-Year approach gave time to address issues;
- Financial model tracked carefully on a weekly basis
- Early implementation of primary care referrals;
- “Medical Home” synergy
- Continued SD/MC case mgmt.& peer support component
- New facilities with labs, pharmacies, and co-located “clinics”

The Lessons

Challenges

- Leadership distracted by other more pressing issues;
- Over-ambitious financial goals of generating \$11 M;
- Clinic managers tasked with “double” duty and need to learn to work with the new model;
- LCSWs need to learn to work in the new model;
- Biweekly meetings hard to sustain;
- Staff training is critical to work in the integrated model, including screening and warm hand offs

The Lessons

Budgeting:

- Need to allow for more start up time. Our financial goal of generating \$11 M was overly ambitious;
- Need to have plan for regularly tracking productivity, including true no shows, cancellations, & reschedule;
- Need to take into account the no show rate and budget for about 20% of no shows;
- Need to factor in the high rate of uninsured patients;
- Need to factor in Medicare co-pay rates for LCSWs which are higher than that for psychiatrists
- Need to realize and plan for the impact of “same day” prohibition. Patients choose to see the doctors only.

The Lessons

Clinical Care:

- LCSWs have to move from the case management model with substantial phone work to 9 face to face visits per day for our revenue model. Currently, they are at only 50% of their capacity;
- Provided important opportunity to reflect on what clients want in direct service;
- Better understanding of role of case management in SMI populations;
- Dovetail with Adult System Redesign from recovery perspective (using Milestones of Recovery tool)

The Lessons

Clinical Care:

- Increased opportunities to coordinate primary care treatment for clients;
- Increased opportunities to address the needs across broader spectrum of primary care populations including the needs for pediatric and adolescent services and the needs of rehab patients;
- Opportunities to expand clinical practice competencies should be planned for in advance;
- Enriched opportunities for MDs to collaborate and co-treat across specialties = improved job satisfaction = better care!

The Lessons

Partnership with Primary Care:

- Opportunities to better serve clients of both systems;
- Though we know there is pent up demand and higher level of needs, effective referral process was challenging in the beginning;
- Simultaneous “Medical Home” and integration demands added planning time to already stretched teams;
- Our collaboration was both a financial response to budget cuts and also a strong desire to coordinate/integrate care. Need more time for advanced planning and testing.

The Lessons

From Patient-Centered Medical Homes to Person-Centered Healthcare Homes*

PCMH Principles

- Ongoing Relationship with a PCP
- Care Team who collectively take responsibility for ongoing care
- Provides all healthcare or makes Appropriate Referrals
- Care is Coordinated and/or Integrated
- Quality and Safety are hallmarks
- Enhanced Access to care is available
- Payment appropriately recognizes the added value

Person-Centered Healthcare Home

- Not a clear articulation in the PCMH model of the role of MH/SU
- Change to Person Centered Healthcare Home signals that MH/SU is a central part of healthcare and that healthcare includes a focus on supporting goals for improved self management
- Use a bi-directional approach to address the integration of primary care services in MH/SU settings as well as the need for MH/SU services in primary care settings
- Build in the care manager/ behavioral health consultant and consulting prescriber functions that have proven effective in the IMPACT model and mirror this model to bring planned primary care into MH/SU settings

*The National Council on Behavioral Healthcare

Additional Implementations

- Placed a half time psychiatrist in the Valley Homeless Healthcare clinic and at a homeless shelter
- Added a part time psychiatrist to the methadone clinic
- Designated a bilingual Spanish speaking LCSW to work with the Healthy Living clinic with 2 adolescent medicine doctors
- Expanded services to Asian American clients in Milpitas, with a population of 60% Asian Americans
- Work on providing substance abuse trainings for LCSWs to also provide addiction counseling
- Plan for training on the Impact model

Next Steps

- ❑ Continue to transition more psychiatrists into the FQHC clinics. Add 7 more psychiatrists to the 4 clinics with plans to expand to 2 more clinics: Tully & Moorpark
- ❑ Recruit more psychiatric technicians to support the needs of patients and the work of psychiatry
- ❑ Expand psychological groups: smoking cessation, weight management, depression, stress
- ❑ Expand psychological and neuropsychological testing
- ❑ Continue to support and expand the work of peer and family specialists

Your Voice Matters!

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