**THE BOARD OF SUPERVISORS OF THE COUNTY OF STANISLAUS**
**ACTION AGENDA SUMMARY**

**DEPT:** Health Services Agency **BOARD AGENDA #** B-8

**Urgent** ☐ **Routine** ☒ **AGENDA DATE** May 5, 2009

**CEO Concurs with Recommendation YES** ☒ **NO** ☐ **4/5 Vote Required YES** ☒ **NO** ☐
**(Information Attached)**

SUBJECT:

Approval of the Integrated Behavioral Healthcare Program expansion in the Federally Qualified Health Center Look-Alike Primary Care Clinic System of the Health Services Agency and Adjust the Budget

STAFF RECOMMENDATIONS:

1. Approve the Integrated Behavioral Healthcare Program expansion in the Federally Qualified Health Center Look-Alike primary care clinic system of the Health Services Agency.

2. Authorize the Managing Director of the Health Services Agency to take those reasonable actions necessary to implement the above recommendation, including execution of an agreement for Psychiatric services not to exceed $185,000 through June 30, 2010.

3. Direct the Auditor-Controller to increase the appropriations and estimated revenue as detailed in the Budget Journal.

FISCAL IMPACT:

The current Fiscal Year 2008-2009 budget for the Clinic and Ancillary division of the Health Services Agency is $49,282,147. The estimated impact of the recommended program change is $109,225 in appropriations and estimated revenue for the remaining two months of Fiscal Year 2008-2009. The attached Budget Journal details these impacts. The ongoing annual expense for this program is estimated at $649,200 offset by estimated revenue of $662,000 from patient fees for service.

(Continued on Page 2)

BOARD ACTION AS FOLLOWS:

No. 2009-301

**On motion of Supervisor** Chiesa **, Seconded by Supervisor** Grover
**and approved by the following vote,**
**Ayes: Supervisors:** O'Brien, Chiesa, Grover, Monteith, and Chairman DeMartini
**Noes: Supervisors:** None
**Excused or Absent: Supervisors:** None
**Abstaining: Supervisor:** None

**1)** X **Approved as recommended**
**2)** _____ **Denied**
**3)** _____ **Approved as amended**
**4)** _____ **Other:**
**MOTION:**

Christine Ferraro

**ATTEST:** **CHRISTINE FERRARO TALLMAN, Clerk** **File No.**

**FISCAL IMPACT (Continued):**

The proposed Integrated Behavioral Healthcare program is estimated to result in a nominal improvement in annual net revenue of $12,800. If approved, the 2009-2010 adjustments will be included in the Health Services Agency Clinic and Ancillary Services 2009-2010 Final Budget submission.

**DISCUSSION:**

In order to more fully meet the needs of Health Services Agency patients, the Agency is proposing to substantially expand access to Licensed Clinical Social Workers in the primary care clinics and to implement an integrated behavioral health model. Integrated Behavioral Health programs have been increasing across the country as a best practice to more effectively coordinate physical and mental health care in the patient's "medical home." This practice means more than simply adding Licensed Clinical Social Workers to the staffing of a clinic. Rather it includes an integrated model whereby the primary care physicians work closely with the mid-level mental health clinicians to coordinate a seamless continuum of care, which more fully addresses the spectrum of problems that patients bring to the primary care exam room. This model allows a more effective approach to meeting patient needs, while also supporting a more efficient flow of patient volumes to the appropriate level of care. Integrated behavioral health programs are intended for the mild to moderate mental health conditions, however can be an adjunct to further psychiatric consultation, further supporting the primary care physician's effectiveness.

In order to provide a practical perspective to the Integrated Behavioral Health model, the following examples are provided.

a) Patient A is in the exam room with Dr. Smith for a persistent cough. Dr. Smith examines the patient for the presenting symptom (cough) and explains his suggested treatment. As he begins to tell her goodbye she breaks down crying in despair over her husband's recent death and her feelings of isolation. Dr. Smith has patients waiting. After talking for several more minutes, the doctor determines that Patient A would be well-served with more time and discussion. The doctor arranges for the patient to be assessed and counseled by the Licensed Clinical Social Worker a few exam rooms away. This session can occur immediately after the doctor visit or on another day. Moving the patient on to a more appropriate level of care is not only an effective means of providing service to Patient A, but also allows the physician to move on to see Patient B. Patient A may also be more likely to return to the primary care office for this service than going to a mental health clinic due to the perceived stigma.

b) Patient B is in the exam room and demonstrates symptoms of a severe mental illness. Dr. Smith addresses the physical health issues as

appropriate during that visit, but is unsure about the best course of action and/or most appropriate medications for the patient. Dr. Smith determines that a Psychiatric consult is necessary to appropriately and effectively manage Patient B's needs. Depending on the stability of the patient at the time, Dr. Smith may literally walk Patient B down the hall to a Licensed Clinical Social Worker to complete an assessment and arrange for a subsequent Psychiatric consultation. Such consultation will provide feedback and advice for on-going care by the primary care provider and continuity of care for the patient (treating the "whole person").

c) Patient C is in the exam room and the physician reads in the chart that this patient continues to smoke cigarettes. In addition to addressing the patient's reason for making the appointment, Dr. Smith raises the need for the patient to quit smoking. Through the interaction, Dr. Smith determines the patient is finally willing to try a smoking cessation program. The physician having read studies indicating a patient's chance for success is doubled if the program includes motivational counseling and re-enforcement, arranges for the patient to come back to the clinic to see his colleague, a Licensed Clinical Social Worker.

Over the last 30 years studies have found high rates of physical health problems and death among individuals with serious mental illness. In addition, studies also reveal that less than 50% of those with mental illnesses actually seek help for their mental health condition while 80% of those same individuals had a primary care visit within the previous six months. This underscores the importance of primary care providers as the first line of defense for identification and treatment of mental illness. Twenty-five percent of those referred by a primary care physician never make it to their first appointment with a mental health clinician, supporting the importance of the "warm-handoff" to that practitioner on the same day, while the patient is already in the clinic facility.

Supporting the position that Integrated Behavioral Healthcare in the primary care setting is the trend for the future, the U.S. Department of Health and Human Services' Bureau of Primary Health Care which oversees Federally Qualified Health Centers (FQHCs), is now looking to FQHCs to develop plans to increase mental health services in a manner that will create a more seamless system of comprehensive care.

From a financial perspective, there are several important issues. First, in an FQHC setting, the federal government dictates which provider types are eligible for reimbursement. While there are additional mental health clinician designations, the only services which are eligible for reimbursement are those provided by a Licensed Clinical Social Worker, a Clinical Psychologist, or a Psychiatrist. In the proposed model, the services of multiple Licensed Clinical Social Workers working full-time within the Agency's clinic system would be made available and supported by a part-time contracted Psychiatrist for consultation. The second notable financial issue is relative to

a State of California reimbursement rule. Although the federal government does not require this limitation, the State will only honor for reimbursement, one visit on the same day in the same office for the same patient. From a healthcare effectiveness standpoint, there are times when the best care for the patient is to provide the "warm-handoff" on the same day. In acknowledgement, Assemblyman Chesbro recently introduced AB1445 which would allow for a maximum of two healthcare visits on the same day in the same office within FQHCs. While our system would financially benefit if that legislation passes, because similar legislation has been vetoed in the past and recognizing the dismal condition of the State budget, the Agency in its financial projections, assumed the current one visit rule would continue to apply.

Finally, from a financial perspective, the Agency prepared a projection of volumes, expenses and reimbursements to determine whether the Integrated Behavioral Healthcare model would be financially feasible for the clinics. The financial projections started with a survey completed by each of our primary care physicians using actual experience during a set duration of clinic visits. The number of patients who would benefit from access to mental health services, was measured. Multiple detailed statistics (age, gender, categorical problem, etc.) were collected to support the development of an appropriately modeled program. The result indicated the need for an additional four Licensed Clinical Social Workers. Expenses were identified and using experience information shared with Agency staff by Golden Valley Health Centers, revenue projections were determined. The projections discounted revenue to account for the portion of non-reimbursable same day visits. The projections also included an estimate for contracted professional fees for Psychiatric consultations. Annually, total expenses were estimated at $649,200, revenue at $662,000, and a net income of $12,800.

Implementation of this Integrated Behavioral Healthcare Program would modify the pilot program launched in September of 2008 for the Medically Indigent Adult program enrollees. That pilot was approved by the Board of Supervisors on May 13, 2008 as a two year pilot and involved collaboration between Behavioral Health and Recovery Services (BHRS), the Community Services Agency (CSA) and the Health Services Agency. The component coordinated by BHRS with a mental health clinician and contracted Psychiatrist would be replaced by the new access within the primary care setting under the Integrated Behavioral Healthcare program. The sharing of net expenses with BHRS would be eliminated and would become wholly the Health Services Agency's responsibility. The advocacy efforts to obtain Medi-Cal coverage for patients and the federal claiming component through CSA would remain in place.

Although this program is significantly different from and not a substitute for the mental health treatment services traditionally offered by the County's Behavioral Health and Recovery Services, it is considered to potentially lessen the impact on the primary care providers and patients, from the impending BHRS reductions. As such, the Agency is committed to implementation as quickly as possible should this proposal be approved.

The Agency estimates implementation would be on or about the beginning of the new fiscal year.

*Note: Reference in this document to FQHCs applies to both FQHCs and FQHC Look-Alikes. The primary care clinics of the Health Services Agency were designated as FQHC Look-Alikes effective September 20, 2007.*

This recommendation was presented to the Health Executive Committee of the Board of Supervisors on April 14, 2009. The Health Executive Committee members are Supervisor Grover and Supervisor O'Brien.

**POLICY ISSUE:**

Approval of this item supports the Board of Supervisors' priorities of *A healthy community* and *Efficient delivery of public services*, by expanding mental health access in an integrated model within the primary care setting.

**STAFFING IMPACT:**

There is currently one Licensed Clinical Social Worker working within the primary care system at the Health Services Agency. Implementation of this program is projected to require the service capacity of four additional Licensed Clinical Social Workers and up to one case manager. Due to the budget reductions impacting the County's Behavioral Health and Recovery Services (BHRS) department, the Health Services Agency is proposing to contract with and utilize existing BHRS staff to build this service capacity within the Health Services Agency.

# County of Stanislaus: Auditor-Controller
## Legal Budget Journal

Database: FMS11IDB.CO.STANISLAUS.CA.US.PROD
Set of Books: County of Stanislaus

| | | |
|---|---|---|
| Balance Type | | Budget |
| Category | * List - Text | Budget - Upload |
| Source | * List - Text | |
| Currency | * List - Text | USD |
| Budget Name | List - Text | LEGAL BUDGET |
| Batch Name | Text | |
| Journal Name | Text | |
| Journal Description | Text | FY09 INTEGRATED BEHAVIORAL HEALTH PROGRAM ADJUSTMENT |
| Journal Reference | Text | |
| Organization | List - Text | Stanislaus Budget Org |

| Upl | Fund | Org | Acc't | GL Proj | Loc | Misc | Other | Debit (incr appropriations / decr est revenue) | Credit (decr appropriations / incr est revenue) | Period (Upper case MMM-YY) | Line Description |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 4 | 7 | 5 | 7 | 6 | 6 | 5 | (format > number > general) | | List - Text | Text |
| P | 4051 | 1010001 | 50000 | 0000000 | 000000 | 000000 | 00000 | 70,500.00 | | Apr-09 | Increase Salaries and Benefits |
| P | 4051 | 1010001 | 62861 | 0000000 | 000000 | 000000 | 00000 | 2,625.00 | | Apr-09 | Increase equipment less than $1,000 |
| P | 4051 | 1010001 | 65780 | 0000000 | 000000 | 000000 | 00000 | 6,400.00 | | Apr-09 | Increase training |
| P | 4051 | 1010001 | 63000 | 0000000 | 000000 | 000000 | 00000 | 29,700.00 | | Apr-09 | Increase Prof/Consulting Services |
| P | 4051 | 1010001 | 34930 | 0000000 | 000000 | 000000 | 00000 | | 109,225.00 | Apr-09 | Increase In Patient Revenue |
| Totals: | | | | | | | | 109,225.00 | 109,225.00 | | |

Explanation: FY09 INTEGRATED BEHAVIORAL HEALTH PROGRAM ADJUSTMENT.

| Requesting Department | CEO | Data Entry | Auditors Office Only | |
|---|---|---|---|---|
| Signature | Signature | Keyed by | Prepared By | Approved By |
| 04/27/09 | 4/27/09 | | | 4-27-09 |
| Date | Date | Date | Date | Date |

PowerPoint Presentation for B-8

# Health Services Agency
# Clinic and Ancillary Division
# May 5, 2009

## Integrated Behavioral Health Program Expansion

# Primary Care Clinics

Six Federally Qualified Health Center Look-Alike clinics

- Staffing varies at each clinic.
- Can include:
  - Physicians: Family Medicine, ObGyn Pediatrics, Internal Medicine
  - Mid-Level Providers: Nurse Practitioners and Physician Assistants
  - Licensed Clinical Social Worker (only 1)

# Internal and Environmental Factors

- Demand for behavioral health access strong
- Input from Community Health Center Board
- Access to behavioral health limited
- Federal emphasis on FQHCs to expand integrated access to mental health care related services
- Best Practices – national trend toward Integrated Behavioral Health in primary care setting

# Integrated Behavioral Health Model

- Integrating a Licensed Clinical Social Worker (LCSW) into the staffing of each clinic
- LCSW works with the primary care physicians and mid-level providers; sees patients by referral
- Become part of the medical team to case manage and care for clinic's patient population (all payor sources)
- Psychiatrist available part-time for consultation

# Integrated Behavioral Health Model cont…

- Not intense counseling/treatment, but rather approximately 15 minute intervention encounters
- Services are primarily for mild to moderate conditions such as depression and anxiety
- Improved outcomes when primary care doctor care is combined with short-term cognitive behavior therapy

# Integrated Behavioral Health Model cont…

- Status of chronic physical illnesses improve with short-term intervention
- One part-time contracted Psychiatrist available for consultation which could include the more seriously mental ill (SMI) conditions
- SMI conditions more effectively managed in primary care setting with help from Psychiatrist

# Warm-Handoff Concept

- Physician makes introduction
- Not a mental health clinic – avoids stigma which may currently prevent some from seeking needed care
- Frees-up Physician to move on to next patient = more effective and efficient
- Encounter with LCSW may be same day or another

# Process to Establish Proposed Model

- Collaborative discussions with Golden Valley Health Centers and Behavioral Health & Recovery Services
- Review of Best Practice Models
- Survey of HSA Clinics' Primary Care Physicians to measure expected volumes
- Applied utilization and collection rates from Golden Valley Health Centers
- Determined staffing need
- Established financial forecast

# Financial Projections

| | |
|---|---|
| Projected Annual Revenue | $662,000 |
| Projected Annual Expense | 649,200 |
| Net Impact | $12,800 |

Appropriation requested for the current 0809 fiscal year = $109,225

Capturing in the FQHC base year

# Replaces the Two-Year Pilot Program

- Brings in-house (within HSA) the services provided by BHRS under the two-year pilot for MIA patients
- Pilot was implemented in September 2008, but data too limited to objectively report achievements.
- Federal/State Claiming through CSA would continue

# Implementation Plan

- Contract with County Behavioral Health and Recovery Services for staffing
- Identify available licensed staff
- Launch training program
- Launch internal communication plan to develop referrals
- Begin to see patients by first week of June 2009

# Staff Recommendations

- Approve the Integrated Behavioral Healthcare Program expansion
- Authorize the HSA Managing Director to take reasonable actions to implement, including executing an agreement for Psychiatric services not to exceed $185,000.
- Director the Auditor-Controller to increase the appropriations and estimated revenue