Glenn County
Health & Human Services Agency
Behavioral Health Division

"Building Healthy Futures"

November 6, 2013

Presentation Objectives

- Early Implementation of Health Care Reform
- Integration Impacts on 2011 Realignment
- Opportunities for New Billing Sources
- Thinking Differently about Staff
- Getting More Out of Existing Resources
- Old Problems and New Benefits
- Aiming for the Savings

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This endeavor is not about making county government larger or smaller; this endeavor is about making county government **smarter and better**.

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~ WELCOME TO GLENN COUNTY! ~

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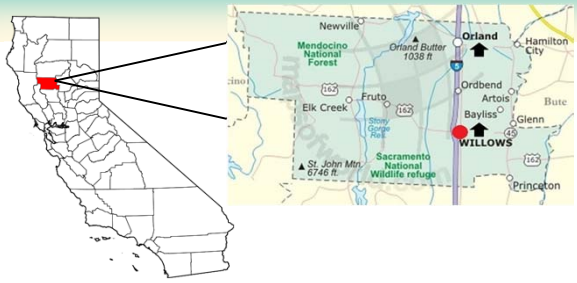

Glenn County Population Data

County of Glenn: 28,122

City of Willows: 6,166

City of Orland: 7,293

2010 U.S. Census

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Glenn County Facts

- Land Area, Square Miles: 1,314
- Persons per Square Mile (Glenn County): 21.4
- Persons per Square Mile (Statewide): 239.1

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Our Mission

The mission of Glenn County Health Services Agency is to enable individuals in our community who are affected by mental illness and serious emotional disturbances to achieve the highest quality of life.

To accomplish this goal, services must be delivered in the least restrictive, most accessible environment within a coordinated system of care that is respectful of a person's family, language, heritage, and culture.

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The Bridge to Health Care Reform: Primary Care and Behavioral Health Integration Initiative

The Glenn County
Health Care Collaborative (HCC)

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A Foot in Two Worlds: The Splits Hurt

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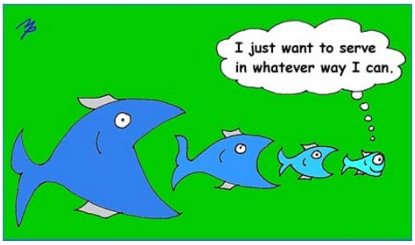
A Small County Trying to Survive in an Expanding Pond



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Integrating Behavioral Health and Primary Care Services

Glenn County obtained a Primary Care Primary and Behavioral Health Care Integration (PBHCI) grant with funding from SAMHSA and HRSA.

- Improved access to primary care services;
- Improved prevention, early identification, and intervention to reduce the incidence of serious physical illnesses, including chronic disease;
- Increased availability of integrated, holistic care for physical and behavioral disorders; and
- Better overall health status of clients.

We have served 130 adult clients to date.

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Bi-Directional Care Integration Model

Glenn County Health Services Agency and Ampla Health, a Federally Qualified Health Center (FQHC), have created a strong, bi-directional program by developing integrated services across the continuum of care.

- The purpose of the partnership is to provide primary care services to public mental health clients without a medical home.
- The continuum of care includes primary care, mental health, and substance abuse services.

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Bi-Directional Care Integration Model

Glenn County has experienced 3 phases of the life cycle of the project in its effort to implement an integrated model .

It is now in a fourth phase of sustaining services after the end of the grant, while expanding funding opportunities.

The fourth phase is to use the licensure to bill for either provider across all Medi-Cal revenue centers in order to achieve a higher level of benefit from a fully integrated health care system.

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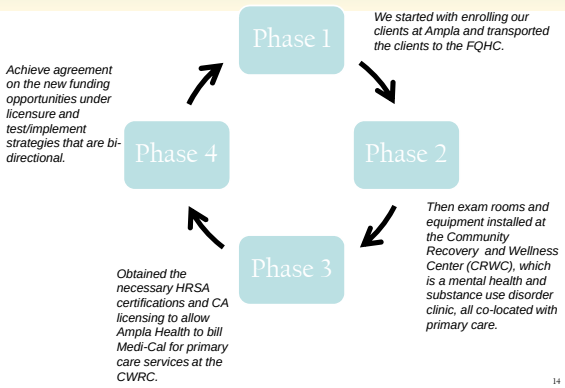
Integration Life Cycle



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Integrated Services Improve Outcomes

- This integrated health program, in collaboration with our local Federally Qualified Health Center (FQHC), Ampla Health, has improved the health outcomes for our clients by co-locating Primary Care services at the Behavioral Health clinic and linking clients to wellness activities.
- The partnership benefits Ampla by improving their capacity to deliver behavioral health services.
- Both parties experience and learn the barriers to health care reform before it arrives and identify new ways to recover service costs.

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Integrated Services Improve Outcomes

Wellness Activities

Many Wellness Groups are available through our local adult drop-in center (Harmony House) and our Transition Age Youth (TAY) Center.

These centers create a welcoming environment where clients and family members are able to develop positive relationships, connect socially, and engage in wellness activities.

These activities improve the health of the patients and their success in managing illness using MHSA revenue that creates savings capacity in health care, thereby improving the position of our system in the allocation of future savings.

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Integrated Services Improve Outcomes

Wellness Activities ***(examples)***

- Wellness 101 (an introduction to healthy living)
- Stress management group
- Smoking cessation group (Kickin' Butts)
- Cooking group
- Yoga group
- Walking group
- Substance recovery group

Many of these activities are not reimbursable by Medi-Cal – but create optimal outcomes for clients! They are a great example of how MHSA can have a direct impact on health that results in savings that we may have access to as a new revenue source.

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Integrated Services Accomplishments

Primary Care Services: The Right Person for the Project

1. Successfully recruited a Physician Assistant who is also an MFT.
2. At the end of each day, the PA meets with our staff so the HCC Team can discuss clients, plan treatment, and coordinate care.
3. The PA has also learned to write "Wellness Prescriptions" to encourage clients to participate in wellness activities.

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Integrated Services Accomplishments

Wellness in All Locations:
The Transformative Power of Integration

The initiative has transformed our programs to include a wellness focus.

Many wellness groups are available through our local adult drop-in center (Harmony House) and our Transition Age Youth (TAY) Center.

These centers create a welcoming environment where clients and family members are able to develop positive relationships, connect socially, and engage in wellness activities.

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Integrated Services Accomplishments

Group Activities:
Wellness 101 (an introduction to healthy living); stress management; smoking cessation; cooking; yoga; walking; healthy living; hiking; book club; outdoors group; embroidery and beading; and a substance recovery group.

We also offer Wellness Wednesdays, a wellness orientation with individualized wellness groups.

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Integrated Services Accomplishments

Collaboration Across the Entire Health Care Continuum
In addition to meeting with the Physician Assistant to coordinate treatment, we also hold a weekly meeting to support multi-agency collaboration.

Staff members from Ampla Health and Glenn County (including the Project Director, Registered Nurse, Case Managers, Clinicians, Peer Mentors, Evaluator, Physician Assistant, and Office Manager) meet weekly to address health care integration system-level issues and successes.

These meetings have been effective in improving the communication and collaboration between agencies to create an integrated health care team. All staff members have expressed that these meetings have been invaluable to this project.

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Integrated Services Accomplishments

Transforming Primary Care Through MHSA Principles: The Use of Peers
Youth Peer Mentors, Consumer Coaches, persons with lived experience, and those in recovery are an integral component to our service delivery system.

Our team includes two (2) Peer Mentors, who have been successful in promoting positive, person-centered services and lead our various wellness activities and groups.

Our Peer Mentors and Consumer Coaches are part-time, paid positions (20 hours per week).

Alcohol and drug treatment counselors have lived experiences.

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Integrated Services: Challenges

Care and Feeding of the Continuum
From time to time, the directors of Ampla and HHSA meet to reconcile differences that cannot be settled by the HCC Team.

Records
Ampla has not implemented an EHR so records exchange is tedious, with constant HIPAA issues since Ampla faxes records and must log their whereabouts.

When all parties have an EHR, it is expected that most of the issues will cease.

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Integrated Services: More Challenges

Licensing
Behavioral Health Clinics are exempt from primary care licensing, but a license is necessary to bill Medi-Cal for primary care. HRSA requires extensive facilities analysis, such as Title 24 (energy) compliance, with significant work and attention by all parties.

Without the license, primary care services are paid for with local revenue.

Sustainability
Licensing allows billing Medi-Cal for primary care services to and increases opportunities for funding integration services.

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The Future is About Outcomes

Tools for Clients and Staff to take Control of their Health

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Individual Wellness Reports

We have developed Individual Wellness Reports to give to each client enrolled in our program. These Wellness Reports show his/her score on a number of different health indicators, including Breath CO, Body Mass Index, Cholesterol, A1c (Blood Sugar/Diabetes), and Days in Recovery (for those with substance use disorders).

This tool has been extremely effective in helping clients to understand their health factors and showing their progress (e.g., level of improvement from baseline) on these health indicators, every six months. It has also been effective in helping Behavioral Health staff to better understand these health indicators, and develop programs to support clients to improve their health over time.

Tools lime this improve outcomes, document efforts by staff and consumers to improve outcomes, and measures the success providing a platform for achieving compliance under future payment scenarios.

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Glenn County Health Care Collaborative
INDIVIDUAL WELLNESS REPORT

Name: Bea Well
Clinician: John Smith
Case Manager: Jane Doe

Normal
Caution
At Risk

Progress on Key Health Indicators

Category	Indicator (Goal)	Baseline *August 2011*	6-Month Reassessment *February 2012*	12-Month Reassessment *July 2012*
Lungs	Breath CO (0-6)	25	8	5
Weight	BMI (18.5-24.9)	25.8	28.1	25.3
	Weight	162.0	176.0	158.0
	Waist Circumference	35.5	38.5	32.2
Blood Pressure	Systolic BP (90-140)	133	135	114
	Diastolic BP(60-90)	80	75	80
Blood Sugar	Fasting Glucose (70-99)	115	-	115
	Hemoglobin A1C (4.0-5.6)	5.4	-	5.4
Heart Health	Total Cholesterol (125-200)	197	-	189
	LDL Cholesterol (20-129)	111	-	103
	HDL Cholesterol (40+)	76	-	73
	Triglycerides (30-149)	52	-	64

Client Wellness Goal(s):

Bea Well will lose 5 pounds within 6 months.

Bea Well will maintain her successful progress in reducing/stopping her tobacco use.

Client Mental Health Goal(s):

Bea Well will sleep at least 7 hours each night to decrease symptoms of depression.

Action Step(s):

Bea Well will walk for 20 minutes five days per week.

Bea Well will eat at least 3 servings of vegetables every day.

Bea Well will go to bed by 10 pm at least 5 nights per week.

Client Signature: Bea Well *Staff Signature:* John Smith *Date:* 9/15/2012

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System-Level Outcome Data: Risk Factors

Our Project Evaluator developed system-level outcome data on our clients' alcohol use and carbon monoxide level. These graphs illustrate clients' improvement, or regression, on their substance use over time (at baseline, every six months, and/or at discharge).

The following graphs provide an example of the outcome data used for management decisions. The data displayed shows clients with risk factors at baseline.

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System-Level Outcome Data: Risk Factors

The following graphs show data for each client at baseline (black bar), six months (blue bar), 12 months (orange bar), 18 months (purple bar), and at discharge (red bar).

By showing several clients on one page, staff can quickly determine who is successful, and who needs additional support in managing their risk factors.

This approach also establishes a platform for outcome measurement at the macro level, which will be necessary to comply with future tracking requirements by the state, as well as providing support for generating new revenue within a reformed payment structure.

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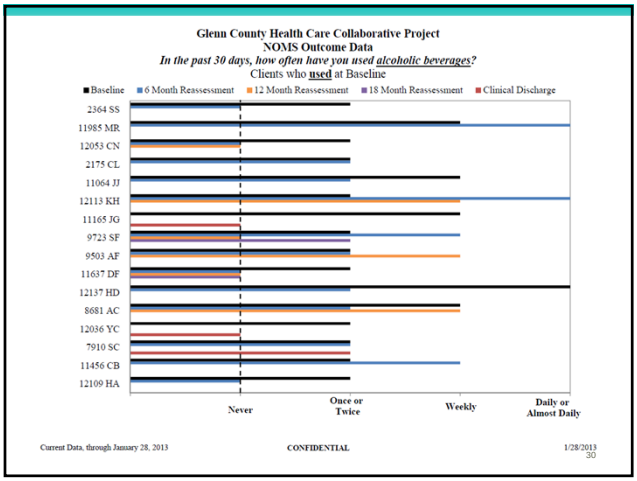

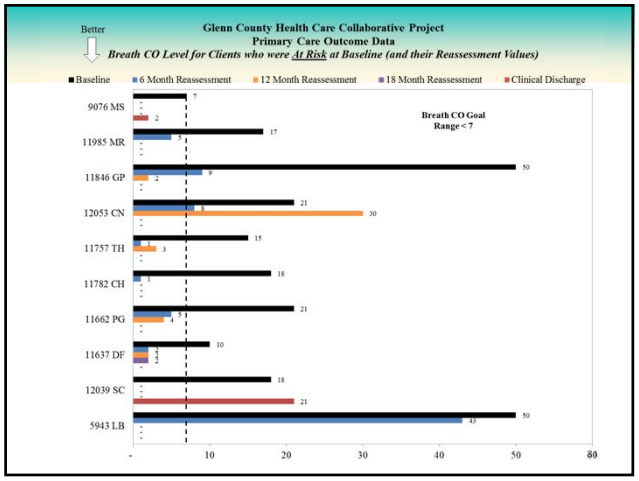

Access, Quality, and Outcomes

- Timely Access to Services
- Clinical Mental Health Assessment
- Linkage to Integrated Health Care
- Access Team assign and authorize Services
- Anasazi Electronic Health Record
- Range of Mental Health and Wellness Activities

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New Sources of Billing Revenue

- Partnership with FQHC provides opportunity to access physical health billing at higher rate and 100% cost recovery patch.
- Improve FQHC performance with behavioral health by coordinating/integrating services.
- Expand access to physical care.
- Be at the table for the savings allocation discussion.

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Think of How to Fund Staff Differently

- Rent your staff to the FQHC or Primary Care Provider so they can bill physical health;
- Improve FQHC or Primary Care services by providing the Behavioral Health programs as a contractor – think of yourself as a business in the private market that can sell your services because you do well what the primary care and physical health industry does not do well. Why do they need to spend the money reinventing the wheel?
- We have a new generation of employees emerging with a different approach to work that we need to be prepared to keep our systems effective.

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Generations X, Y, and Z: The New Workers That Are Different

- Gen X = Born 1966 – 1976: The "me" crowd, not wedded to long term employment with the same organization.
- Gen Y = Born 1977-1994: Sophisticated and diverse due to rapid exposure to television and heavy credit debt carriers.
- Gen Z = 1995 – 2012: Rapidly mobile and extremely media savvy; flexible and want to work at all hours, but break often, breaks must include other stimulating activities and not rest.

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Generations X, Y, and Z: How Does It Effect Revenue and Payment Reform?

- These generations of workers are not an 8:00AM to 5:00PM crowd so, as a result, they do not perform well or maintain high productivity in traditional settings and payment structures. The flip side is that their willingness to work odd times provides opportunities for work coverage outside of the normal workday and on weekends, which is an increasing demand, as well as making our agencies competitive with the private sector.
- Access anything anywhere anytime (labor model problems) – Think HIPAA, think overtime, think about a whole generation of workers that do not see catching up on work via a smart device or home computer as an overtime activity, yet our rules around work hours and systems access actually limit the very flexibility that make these workers very productive.
- Totally different expectations and behaviors – these generations do not always see the need or value in helping others, although younger generations see the value in social issues being addressed; however, their work ethic is far from traditional and thinking just about breaks they require game rooms and stimuli, not quiet or isolated break rooms and take breaks whenever needed, which directly improves productivity.

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Whole Health = Whole Systems

Integrating Across the Health & Human Services Spectrum for Greater Outcomes

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The Silos are Greater than just Us

Health Services | Housing | Employment and Income | Food Security | Family Support | Building Communities

Greater and lasting outcomes can be achieved with coordination, collaboration, and integration across all programs! All services play a role in achieving savings in health care and move local systems to a sustainable model. The entire spectrum of county services is a selling point to the private market and key to the savings discussion!

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Agency Consolidation and Integrated Services: The Glenn County Example

- 2006 - Scott Gruendl appointed Director of Health Services Agency
- 2010 - Scott Gruendl appointed Interim Director of Human Resource Agency
- January 2013 – Board of Supervisors officially consolidated Human Resource Agency and Health Services Agency creating the Health & Human Services Agency

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Pre-Integration Picture

Behavioral Health | Public Health | Social Services (Eligibility, Child Welfare, Adult Protection) | Community Action | Employment Services | Economic Development

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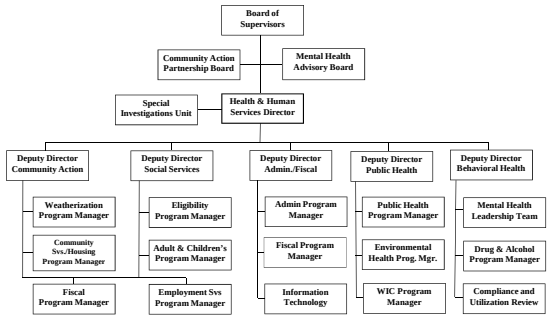
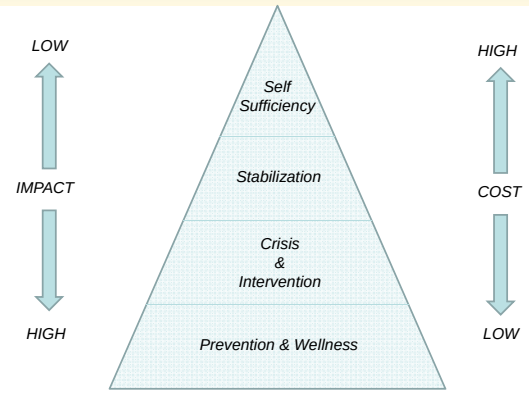
Glenn County Health & Human Services Agency



Post-Integration Picture



Agency Consolidation and Integrated Services: Co-Location/Cooperation Examples

- **CalWORKs** – Co-Locating Mental Health, Drug and Alcohol, and Social Services to improve employment
- **Katie A.** – Integrating Child Welfare and Mental Health Services to improve outcomes for children and youth with a serious emotional disorder who are at risk for out-of-home placement
- **CHAT** – Co-locating a Mental Health clinician to conduct mental health assessments and early intervention to children at risk for child abuse and/or trauma

Agency Consolidation and Integrated Services: Countywide Collaboration Example

- Collaboration Approach Across Many County Departments: The AB 109 Example:
  - **Glenn County CREW** - County Re-Entry Work Program (CREW)
  - **CSAC awarded CREW as the Most Innovative Program in 2012:**
    - Free Housing
    - Classroom Training on Employment Skills
    - County Work Crew Experience
    - Placed into Private Employment (90% Employed)
    - Zero Recidivism!

Getting More Out of Existing Resources: AB109 Realignment Example

- Most counties have successfully funded treatment programs utilizing AB109 realignment revenue.
- California's health care reform efforts result in new and enhanced behavioral health services for the expansion and existing Med-Cal population.
- Glenn County is integrating their AB109 Programs (CREW and STAIRS) in the CRWC providing primary care, mental health, and substance abuse treatment services in one location.]
- The CRWC is certified for Drug Medi-Cal and under expansion, most of the AB109 population will be eligible.
- Reimburse for the first 3 years is 100%, which frees up AB109 realignment revenue for piloting new practices and improving outcomes.

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Old Problems and New Benefits

- New Benefits under Health Care Reform for both the existing and expansion populations provide a new level of treatment to populations not previously covered.
- New Behavior Health Coverage for existing and new beneficiaries includes significant enhancements to Drug Medi-Cal services that have been previously very limited. Additionally, in recent years, programs such as Prop 36 and Drug Court have had either reduced or no funding.
- Reimbursement rates for Drug Medi-Cal are 100% in the first three years and 90% thereafter.
- Pay attention to ongoing State General Fund that provides match to the enhances benefits for existing populations and the potential for Prop 30 impacts.

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Health Care Savings

- Reduced Hospitalizations and Re-Hospitalizations
- Reduced Use of Emergency Department
- Reduced Physical Health Care Costs Through Improved Primary Care Services
- Reduced Use of Substance-Related Costs

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Summary

- Consolidation and integration of services are key to improving outcomes for clients.
- We utilize data to make decisions, involve clients in all aspects of planning, treatment, and outcomes.
- We use Individual Wellness Reports to engage and involve clients to understand their health indicators and be active participants in achieving healthy outcomes.

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Summary

- We are developing innovative strategies to prepare for Health Care Reform.
- Many of these integration and consolidation activities are outside of the Medi-Cal program because we can be more flexible with our services.
- We hope that CMS will move payment towards improving outcomes, health, and wellness.

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Thank you!


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