INTEGRATION PLAN FOR A NEW
DEPARTMENT OF BEHAVIORAL HEALTH SERVICES

FINAL DRAFT PRESENTED TO THE BOARD OF SUPERVISORS
JANUARY 28, 2014
INTEGRATION PLAN FOR A NEW SANTA CLARA COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH SERVICES
# PLANNING PARTICIPANTS

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization/Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dolores Alvarado</td>
<td>CHP</td>
</tr>
<tr>
<td>Gabrielle Antolovich</td>
<td>BHCA</td>
</tr>
<tr>
<td>Karen Anton</td>
<td>BHCA</td>
</tr>
<tr>
<td>Denise Boland</td>
<td>SSA</td>
</tr>
<tr>
<td>Karen Bolding</td>
<td>HHS</td>
</tr>
<tr>
<td>Carolyn Brown</td>
<td>VMC</td>
</tr>
<tr>
<td>Amy Carta</td>
<td>HHS</td>
</tr>
<tr>
<td>Brian Cheung</td>
<td>ECCAC</td>
</tr>
<tr>
<td>Bruce Coley</td>
<td>DADS*</td>
</tr>
<tr>
<td>Sonia Field</td>
<td>HHS</td>
</tr>
<tr>
<td>Kathy Forward</td>
<td>NAMI</td>
</tr>
<tr>
<td>Mary Kaye Gersky</td>
<td>BHCA</td>
</tr>
<tr>
<td>David Guerrero</td>
<td>CEMA-MHD</td>
</tr>
<tr>
<td>Patricia Gutierrez</td>
<td>MHB</td>
</tr>
<tr>
<td>Melody Hames</td>
<td>ECCAC</td>
</tr>
<tr>
<td>Patricia Hernandez</td>
<td>UAPD</td>
</tr>
<tr>
<td>Andrea Hightower</td>
<td>SEIU</td>
</tr>
<tr>
<td>Tiffany Ho</td>
<td>MHD**</td>
</tr>
<tr>
<td>Carla Holtzclaw</td>
<td>MHB</td>
</tr>
</tbody>
</table>

*Leadership Team Member  
**Workgroup and Leadership Team Member  
***Workgroup Member

---

# STEERING COMMITTEE MEMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization/Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>James Horrigan</td>
<td>SEIU-DADS</td>
</tr>
<tr>
<td>Laura Jones</td>
<td>BOS</td>
</tr>
<tr>
<td>Elisa Koff-Ginsborg</td>
<td>BHCA</td>
</tr>
<tr>
<td>Margaret Ledesma</td>
<td>SEIU-MHD</td>
</tr>
<tr>
<td>Robert Li</td>
<td>SEIU</td>
</tr>
<tr>
<td>Judge Stephen Manley</td>
<td>Courts</td>
</tr>
<tr>
<td>Patricia McClure</td>
<td>HHS</td>
</tr>
<tr>
<td>Michael Meade</td>
<td>MHD*</td>
</tr>
<tr>
<td>Leticia Medina</td>
<td>ECCAC</td>
</tr>
<tr>
<td>Nancy Pena</td>
<td>MHD**</td>
</tr>
<tr>
<td>Elaine Saulter</td>
<td>SEIU-DADS</td>
</tr>
<tr>
<td>Susan Sidel</td>
<td>SEIU-MHD</td>
</tr>
<tr>
<td>Prudence Slaathaug</td>
<td>CEMA</td>
</tr>
<tr>
<td>David Speicher</td>
<td>MHB</td>
</tr>
<tr>
<td>Joe Tansek</td>
<td>SEIU-MHD***</td>
</tr>
<tr>
<td>Paul Taylor</td>
<td>BHCA</td>
</tr>
<tr>
<td>Jan Weber</td>
<td>UAPD-MHD</td>
</tr>
<tr>
<td>Gerald Witters</td>
<td>DADS-SEIU***</td>
</tr>
<tr>
<td>Emily Wong</td>
<td>UAPD-Custody MH</td>
</tr>
</tbody>
</table>

---

# LEADERSHIP TEAM MEMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization/Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bruce Copley</td>
<td>Co Chair</td>
</tr>
<tr>
<td>Nancy Pena</td>
<td>Co Chair</td>
</tr>
<tr>
<td>Carolyn Verheyen (MIG)</td>
<td>Facilitator</td>
</tr>
<tr>
<td>Kakoli Banerjee</td>
<td>DADS</td>
</tr>
<tr>
<td>Cheryl Berman</td>
<td>DADS</td>
</tr>
<tr>
<td>Karen Bolding</td>
<td>IS</td>
</tr>
<tr>
<td>Sue Clements</td>
<td>IS</td>
</tr>
<tr>
<td>Terry Edmonson</td>
<td>MHD</td>
</tr>
<tr>
<td>Pat Garcia</td>
<td>MHD</td>
</tr>
<tr>
<td>Sandra Hernandez</td>
<td>MHD</td>
</tr>
<tr>
<td>Tiffany Ho</td>
<td>MHD</td>
</tr>
<tr>
<td>Michael Hutchinson</td>
<td>DADS</td>
</tr>
<tr>
<td>Ky Le</td>
<td>MHD</td>
</tr>
<tr>
<td>Dan Lloyd</td>
<td>DADS</td>
</tr>
<tr>
<td>Laura Luna</td>
<td>MHD</td>
</tr>
<tr>
<td>Michael Meade</td>
<td>MHD</td>
</tr>
<tr>
<td>Sue Nelson</td>
<td>DADS</td>
</tr>
<tr>
<td>Gabby Olivarez</td>
<td>MHD</td>
</tr>
<tr>
<td>Martha Paine</td>
<td>HHS</td>
</tr>
<tr>
<td>Noel Panililio</td>
<td>DADS</td>
</tr>
<tr>
<td>Mark Stanford</td>
<td>DADS</td>
</tr>
<tr>
<td>Sherri Terao</td>
<td>MHD</td>
</tr>
<tr>
<td>Mel Whitlow</td>
<td>DADS</td>
</tr>
<tr>
<td>Deane Wiley</td>
<td>MHD</td>
</tr>
</tbody>
</table>

---

INTEGRATION PLAN FOR A NEW SANTA CLARA COUNTY  
DEPARTMENT OF BEHAVIORAL HEALTH SERVICES
WORK GROUP MEMBERS

Model Discovery

Co-Chair, Kakoli Banerjee - DADS
Co-Chair, Sue Nelson - DADS
Steve Monte - MHD
Tiana Nelson - DADS
Will Norman - DADS
Margaret Obilor - MHD
Jeremy Orcutt - Family & Children’s Services
Pam Stephens - Bill Wilson Center
Gerald Witters - DADS
Arlene Spring - Gardner Family Care
Dan Dustin - MHD
Christine Trounge - DADS
Sally Lawrence - DADS
Lydia Bueno - Gardner Family Care

Quality

Co-Chair, Kakoli Banerjee - DADS
Co-Chair, Michael Hutchinson - DADS
Co-Chair, Deane Wiley - MHD
Pauline Casper - DADS
Mary Harnish - MHD
Hung Nguyen - MHD
Lek Taylor - DADS
Nubia Torres - DADS
Carolyn Yip - Information Services
MHD & DADS Q.I. Staff

Budget/Financial Support, Contracts and Administration

Co-Chair, Pat Garcia - MHD
Co-Chair, Laura Luna - MHD
Co-Chair, Martha Paine - HHS Finance
Co-Chair, Mel Whitlow - DADS
Elia Bonner - MHD
Don Casillas - MHD
Hedy Farrales - DADS
Melinda Golden - Momentum
David Guerrero - MHD
Howard LaGoze - Family & Children’s Services
Landee Lopez - Office of Budget Analysis
Martha Martinez - DADS
Jeanne Moral - MHD
Tuan Nguyen - MHD
Phu Trang - MHD
Leilani Villanueva - DADS
David Guerrero - MHD

Family & Children’s & Transition Age Youth Services*

Co-Chair, Sue Nelson - DADS
Co-Chair, Sherri Terao - MHD
Peter Antons - MHD
Lauren Gavin - MHD
Monique Grijalva - DADS
Louise Hill - MHD
Teresa Kim - DADS
Sally Lawrence - DADS
Dan Lloyd - DADS
Steve Lownsberry - DADS
Steve Monte - MHD
Brian Salada - MHD
Joe Tansek - MHD
Mark Miller - Advent
Marilyn Cornier - MHD
Zelia Faria-Costa - MHD
Tianna Nelson - DADS
Jan Weber - MHD
Jorge Wong - AACI
Michael Duran - Indian Health Center
Karen Avila - Juvenile Hall
Boliavone Kegarice - Juvenile Hall
Lilian Alfaro - MHD
Robson Nkomo - Youth Voice
We would like to express our sincere appreciation for the time and tremendous input dedicated to this plan by all those listed here and to countless others who you represent.

Thank you for your ideas, your constructive guidance, your wisdom, and your dedication to building the best system for those we serve.

It is through you – clients, families, staff, providers, community partners - we will achieve Better Health for All.

Bruce Copley
Nancy Peña
**TABLE OF CONTENTS**

I. **EXECUTIVE SUMMARY** ........................................................................................................ 1

II. **INTRODUCTION** .................................................................................................................. 3

III. **WHY INTEGRATE NOW?** .................................................................................................... 4

IV. **OVERVIEW OF THE CURRENT DEPARTMENTS** .............................................................. 9

V. **APPROACH TO INTEGRATION PLANNING** ......................................................................... 18

VI. **PROPOSED DEPARTMENT OF BEHAVIORAL HEALTH SERVICES** ....................... 22

VII. **IMPLEMENTATION** ........................................................................................................... 53
I. EXECUTIVE SUMMARY

The following Draft Plan outlines a proposed structure for a new Department of Behavioral Health Services (DBHS) within the Santa Clara Valley Health and Hospital System (SCVHHS). It is the result of a process that began more than one year ago at the direction of the Board of Supervisors and the County Executive and is sponsored by the Deputy County Executive for the SCVHHS. The planning has involved consultations with a range of internal and external stakeholders through a coordinated process of work group efforts guided by a Steering Committee. It has been supported by an Executive and Division Directors Group comprised of senior leaders from the Department of Mental Health (MHD) and the Department of Alcohol and Drug Services (DADS).

The plan is built on research that shows that when patients of healthcare systems have access to a continuum of primary care-based behavioral health services, in addition to an array of specialty recovery-oriented services and supports, health outcomes are improved, mental health/substance abuse disorder (MH/SUD) recovery is enhanced, clients are more engaged in and satisfied with care, and costs are lower. When this continuum of supports is further anchored in a health care system that offers public health strategies which promote healthy communities, healthy lifestyles, and access to robust preventative care across the lifespan, the promise of “Better Health for All” is more likely to be realized.

Ultimately, the Return on the Investment (ROI) of the new DBHS will be its contribution to the improved health of County residents as a result of:

- Improved access to integrated behavioral health services at the appropriate level of care;
- Seamless access and referral to diagnostic assessments and coordinated treatment;
- Improved treatment outcomes in behavioral health, which include improved psychosocial functioning, reduced use of expensive services, and increased capacity for a stable life in the community;
- Increased engagement in peer support and self-care that maintain treatment gains;
- Cost-effective service as indicated by reduced need for intensive services;
- Reduced stigma and discrimination related to behavioral health; and
- Reduced disparities in service access and engagement.
The integration of critical specialty MH and SUD treatment services and related infrastructure functions and services will offer a full continuum of quality, culturally competent and community-based specialty behavioral health services that will provide SCVHHS clients a range of developmentally appropriate integrated services and supports. The new consolidated specialty system, in concert with the development of robust primary care-based behavioral health services, will maximize and leverage the competencies and capacities of the SCVHHS departments (Valley Medical Center Ambulatory Care and Hospital, MHD, DADS and Public Health).

The Plan adopts a hybrid model of integration based on elements of two behavioral health integration frameworks: the CCISC (Comprehensive Continuous Integrated System of Care) and the EBT (Evidence-Based Treatment) Kit, developed by SAMHSA (Substance Abuse Mental Health Services Administration). The primary approach of both frameworks emphasizes the need to incorporate best practices and evidence-based practices. The CCISC has been implemented in a number of states and its overarching philosophy is endorsed by SAMHSA. The values underlying the CCISC model represent the key principles of integrated treatment.

- Co-occurring conditions and issues are an expectation, not an exception;
- Clients must receive treatment that emphasizes empathy, hope, integration, and a strength-based approach;
- Treatment for co-occurring disorders must be tailored to the needs of the population;
- Treatment of both mental illness and substance use disorders should be concurrent;
- Recovery involves moving through stages of change;
- Progress occurs in an environment in which a client is adequately supported and rewarded for skill-based learning for each condition; and
- Recovery plans and interventions must be individualized.

The Plan outlines a structure to be implemented over 18 months that combines the functions of the two departments and consolidates services into two aged-based delivery systems, the Child, Family and Transition Aged Youth System of Care and the Adult and Older Adult System of Care. Both will have MH, SUD, and co-occurring treatment and support services throughout all levels of care. The new DBHS will interface closely with Valley Medical Center (VMC) Acute Psychiatric Services and inpatient medical services, and the Primary and Specialty outpatient care systems, in addition to the broader healthcare delivery system and the Medi-Cal, Medi-Cal/Medicare, and Exchange Health Plans serving Santa Clara County residents.
II. INTRODUCTION

This plan outlines the philosophy and design for a new Santa Clara Valley Health and Hospital System (SCVHHS) Department of Behavioral Health Services (DBHS). The planning process to complete the DBHS Plan was initiated at the direction of the Board of Supervisors and the County Executive. The Directors of the SCVHHS Mental Health Department (MHD) and the Department of Drug and Alcohol Services (DADS) have initiated a process to integrate the two departments into an integrated Department of Behavioral Health Services (DBHS). The expectation is that implementation will begin in January 2014 following approval of the Board of Supervisors and that implementation will be phased in over the remainder of FY14 and through FY15.

The approved plan will evolve over time for two important reasons: 1) an organizational change of this magnitude will require continuous monitoring, which will likely result in changes to the integration phasing and approach; and 2) the new DBHS must be flexible and responsive to the changing needs of existing and new clients and the changing characteristics of client populations over time.

The integration of critical specialty MH and SUD treatment services and related infrastructure functions and services will offer a full continuum of quality, culturally competent and community-based specialty behavioral health services that will provide SCVHHS clients with a range of developmentally appropriate, integrated services and supports. The new consolidated specialty system, in concert with the development of robust primary care-based behavioral health services, will maximize and leverage the competencies and capacities of the SCVHHS departments (Valley Medical Center Ambulatory Care and Hospital, MHD, DADS and Public Health), their County-operated programs, and their partner contract providers and will position the County to offer a unified health care service delivery system that offers health plans and their beneficiaries a continuum of high quality, integrated behavioral health and health services.

To that end, over the past year, the leadership of MHD and DADS has facilitated a process to design a plan for full integration of all services and functions into a single new Department of Behavioral Health Services. The resulting DBHS Integration Plan outlines the rationale, structure, and actions to be taken to create an integrated DBHS for Santa Clara County. The effort has engaged internal as well as external stakeholders, examined best practices from relevant research sources and other similar agencies, and assessed organizational readiness in order to maximize the success of integration.
III. WHY INTEGRATE NOW?

A. Relationship to HHS Strategic Priorities

For the past two years, SCVHHS leaders have focused on the strategic priorities and related activities that will position the County’s health system to be prepared for Health Care Reform. To that end, the Executive Leadership Team has developed a high level roadmap with a vision of an integrated health system aligned to the County’s mission to:

- **Plan** for the needs of a dynamic community,

- **Provide** quality services, and

- **Promote** a healthy, safe and prosperous community for all.

The SCVHHS selected *Better Health for All* as its vision and has developed a multi-year roadmap that outlines strategic outcomes, objectives, and system-level priorities and activities expected to position SCVHHS to address the emerging challenges post-national health reform. The vision is for all residents in Santa Clara County to be healthier and live in healthier communities, supported to a great extent by the significant services and resources available through the SCVHHS services and its Health Department, Mental Health Department, Department of Alcohol and Drug Services, and Valley Medical Center hospital and clinics.

The SCVHHHC strives to position the system to achieve the following critical outcomes:

- **Become a high-performing and integrated health system;**
- **Be more accountable and transparent;**
- **Deliver timely, efficient, effective, and equitable care;**
- **Advance innovation, evidence-based practices, and learning;**
- **Provide access to safe and quality patient/person-centered care at reasonable costs;**
- **Provide excellent patient, customer, and community service; and**
- **Promote healthy living and behaviors in safe environments.**

The behavioral health integration planning process is one effort that supports the SCVHHS strategic roadmap. Through the implementation of a unified delivery system of substance use and mental health promotion, prevention, early intervention and treatment services, SCVHHS
will offer a seamless array for service to persons of all ages who are at risk of, or are experiencing the impact of substance abuse and mental illness.

**WHY Integrate: Better System Performance**

By Aiming for the ACA Triple Aim:

- **Improved Experience:** “no wrong door”, person-centered, integrated screening/referral
- **Improved Outcomes:** through “holistic care”, culturally and dually competent staff
- **Reduced Costs:** through integrated interventions, improved transitions, prevention

---

**B. Response to Parity and Health Care Reform Legislation**

With the enactment of the Patient Protection and Affordable Care Act, the federal health care reform law and the federal Mental Health Parity and Addiction Equity Act, California public and private health plans and current delivery systems will be significantly impacted as more people obtain health coverage that includes defined benefits for MH/SUD treatment. Counties can expect to see a significant increase in Medi-Cal eligible individuals; and many more currently uninsured residents will now have health coverage. In Santa Clara County, it is estimated there will be more than 90,000 additional Medi-Cal enrollees, with up to 6,800 needing mental health services and 3,527 needing substance use services over the next six years.\(^1\) It also is clear that the current Medi-Cal specialty mental health system will continue to be offered through a “carved out” managed care benefit provided through counties for at least five years; and substance use services will continue to be offered through a “fee-for-service” system in the Health Benefits Exchange – A Series of Five Policy Papers on the California Health Benefit Exchange; D. Jarvis and J. Freeman, Dale Jarvis and Associates, LLC; June 2012

---

\(^1\) Health Benefits Exchange – A Series of Five Policy Papers on the California Health Benefit Exchange; D. Jarvis and J. Freeman, Dale Jarvis and Associates, LLC; June 2012
near term. However, planning is occurring at the state level that may result in DHCS seeking a waiver from CMS to implement an integrated and expanded SUD delivery structure that is similar to the current Mental Health Managed Care program.

Further, plans are being finalized that outline how California Medi-Cal Health Plans will implement new behavioral health benefits for those with “mild and moderate” mental health needs. It has been determined that these new outpatient treatment services for both MH/SUD will be the responsibility of health plans, while the uninsured will continue to rely on the public “safety net” delivery system for care. The current county MHD and DADS delivery systems are poised to offer the most robust and well-organized system of mental health and substance use treatment, with the addition of appropriate infrastructure and resources, for Medi-Cal beneficiaries and other newly insured individuals in Santa Clara County. However, the current capacity of both mental health and substance abuse treatment systems will need to be expanded to accommodate those who will seek treatment as a result of having new MH/SUD benefits and who will present with a wide range of symptom severity from low to moderate to high levels.

C. California Moves toward Integration at State and Local Levels

A majority of the California Counties have implemented some form of integrated Behavioral Health services over the last decade. There are now only nine remaining California Counties that have separate MH and SUD departments. In the last year, the California Mental Health Directors Association (CMHDA) and California Alcohol and Drug Program Administrator Association of California (CADPACC) voted to begin merger of the two organizations over the next several years.

The State of California has integrated the mental health and alcohol and drug departments into the Department of Health Care Services under one Deputy Director of Behavioral Health. The path forward is clear that within the near future integrated specialty behavioral health care for those with complex and concurrent needs, as well as primary care-based behavioral health service for those with episodic outpatient needs, will be the standard throughout the State of California.

In preparation for the implementation of integration, the two departments studied various integrated county departments across the state. That review revealed that integration models span a range of options, representing different degrees to which services have been merged under a single administration. Some counties have consolidated to one Executive Director but continue with two distinct operations. In these counties, operations remain separate with clients needing to seek either or both services, MH or SUD treatment, which they or the system
protocols determine addresses their symptoms and issues. In these systems there is no common “door” for access nor is there an integrated care framework. Other counties have established an integrated dual-diagnosis care delivery system for the crossover population while individuals with either MH or SUD issues are directed to independent, disconnected delivery systems. These models do not embody the integrated behavioral health system of care as envisioned by the Santa Clara County Integration Steering Committee. In Santa Clara County, we propose to implement an integrated system of care that will eventually provide a seamless treatment experience for consumers and clients who will enter through a common portal and receive treatment without barriers within a merged Behavioral Health system.

D. In Line with Triple Aim: Improved Outcomes, Customer Experience, and Reduced Costs

The goal in Santa Clara County is to integrate care into one Behavioral Health specialty system in which clients do not have to choose between MH and SUD services. The aim of this integrated delivery system is:

“The management and delivery of primary care-based and specialty Behavioral Health services is combined in a way that clients (consumers) receive a continuum of preventive and rehabilitation services according to their needs over time and across different levels of the health care system.”

This aim reflects conclusions drawn from a number of national studies that have evaluated issues that clients bring to treatment, local prevalence data, and the objectives of the Affordable Care Act. These sources have identified the important role BH will have in overall national health improvement. For example, the Substance Abuse and Mental Health Service Administration (SAMSHA) has conducted a number of research studies over the last decade on the efficacy of integrated BH care that repeatedly have shown integrated services produce better outcomes for individuals with co-occurring MH and SUD disorders. These findings align with preliminary data from the AB 109 returning population, where an integrated assessment team is in place and over 60% of the population has either a serious mental illness or SUD. Of this population, 47% present with both MH and SUD issues.

Further, research is increasingly demonstrating the role of Behavioral Health interventions in assisting in the management and control of chronic health conditions such as diabetes and heart disease. Research has indicated how depression and substance abuse can be a complicating factor in the treatment of other diseases, exacerbating or causing those conditions to worsen. Moreover, there is a strong linkage to recovery from a chronic health condition when Behavioral Health support is provided the patient. Yet, within Santa Clara County,
between 20% and 40% of patients with serious MH and SUD disorders are estimated to be seen exclusively by their primary health physician and are rarely referred or treated for the Behavioral Health condition, presumably because access to Behavioral Health resources has been inaccessible. Likewise, research indicates that those with severe and persistent MH and SUD problems die much earlier than their non-MH/SUD-affected counterparts due to preventable and/or untreated conditions. Again, it is thought this is due in large part to their apparent lack of access to primary care.

The body of research clearly indicates that when patients/clients have access to a continuum of primary care-based Behavioral Health services as well as an array of specialty recovery-oriented services and supports, health outcomes are improved, MH/SUD recovery is enhanced, clients are more engaged in and satisfied with care, and costs are lower. When this continuum of supports is further anchored in a health care system that offers public health strategies that promote healthy communities, healthy lifestyles, and access to robust preventative care across the lifespan, the promise of “Better Health for All” is much more likely to be realized. Ultimately, the Return on the Investment (ROI) of the new Department of Behavioral Health Services will be its contribution to the improved health of County residents as a result of:

- **Residents having access to integrated BH services at the appropriate level of care;**
- **Efficiencies in the integrated system of care due to mergers between disparate systems of access and referral, diagnostic assessments, coordinated treatment, contract administration, quality assurance, decision support, and training;**
- **Improved treatment outcomes in BH, which include improved psychosocial functioning, reduced use of expensive health care services such as emergency room and inpatient services, reduced criminal justice involvement, and increased capacity for a stable life in the community;**
- **Increased client engagement and self-care resulting in reduced emergency and hospital admissions;**
- **Cost effective service as indicated by reduced need for intensive services;**
- **Reduced stigma and discrimination related to behavioral health; and**
- **Reduced disparities in service access and engagement.**

The development of an integrated system through both the specialty system integration and a strengthened partnership with primary care/medical homes will provide clients with a comprehensive approach to their BH issues. Ultimately, if successful, this integrated system
through effective and efficient coordinated care will provide prevention, intervention and treatment to a greater share of the community, offering “Better Health for All.”

### WHAT is Integrated or Restructured

- Philosophical approach
- Developmentally and clinically anchored
- Unified screening and referral
- Defined levels of care
- Seamless primary care-based and specialty coordination
- Unified quality focused and data and outcomes driven system
- Common/compatible electronic health record and billing systems
- Unified contracts administration and process
- Consolidated finance team
- Robust workforce development to develop specialized SU, MH and co-occurring capable staff

### IV. OVERVIEW OF THE CURRENT DEPARTMENTS

This section provides an overview of the existing features of two distinct departments that will be combined to form the new BHSD.

#### A. Department of Alcohol and Drug Services (DADS)

**Budget Unit:** 417  
**FY14 Approved Budget:** $46,951,754  
**FY14 Approved FTEs:** 165.5

**Public Purpose:** Reduce the impact of alcohol and other drugs on individuals and the community. DADS serves a diverse client population with special programs for pregnant and parenting women, parolees and other criminal justice-referred clients, homeless, opiate addicted clients, students, and criminal justice-involved youth. In FY 2012, there were 7,700 admissions to DADS treatment services—detoxification, outpatient, residential, and addiction medication services. DADS operates its System of Care under Managed Care principles, which
refers to a planned, comprehensive approach to providing health services where administrative and clinical services operate in an integrated, coordinated manner to provide clients timely, cost-effective and high quality care.

**DADS Structure:** A standardized assessment is used to place clients in the appropriate level (intensity) of treatment, based on their treatment need. Substance abuse treatment is provided through a DADS network of more than 20 County and community-based treatment providers. Community-based providers offer detoxification, residential and outpatient treatment and transitional housing services to DADS clients. Transitional housing provides a vital component for recovery by offering clients recovery-oriented housing support during outpatient treatment.

The treatment system is organized into two distinctive though related systems—the Adult System of Care (ASOC) and the Youth System of Care (YSOC). Adult clients enter substance abuse treatment voluntarily or by referral from criminal justice agencies, social services, mental health and the larger health care system. Most referrals are coordinated through the main portal into the Adult System of Care-Gateway, which screens and refers clients to appropriate treatment providers for comprehensive assessment and treatment. Specialized entry services are operated for certain criminal justice populations, such as those entering services under the rubric of AB 109 and related legislation.

The DADS Youth System of Care provides outpatient substance use treatment for adolescents and Transition Age Youth (TAY) throughout the County at clinics, schools, Juvenile Hall, and James Ranch as well as residential treatment. In addition, the Prevention Strategic Plan focuses on reducing underage drinking, marijuana and ecstasy use in Santa Clara County by working with local communities, educating parents and youth and providing groups in schools for at-risk youth.

**DADS Funding**

Funding for the department is primarily provided from County General Funds (46%). The second highest funding source (26%) is federal block grant for Substance Abuse and Prevention Treatment (SAPT) services. The third is criminal justice funding (18%) from Public Safety Realignment and AB 109 for treatment services to defendants from the Superior Court, Probation, Pre-Trail Services and Department of Corrections. Finally, 12% is provided through small grants, patient fees and Trust Fund Accounts.
The chart shown above summarizes the capacity and monthly screenings conducted at Gateway and post-authorization sites during FY 2013. (Note: This refers only to the Adult System of Care). Gateway and post-authorization sites (such as the MAP center) screened a total of 9135 persons during FY 2013. The monthly distribution of calls from July 2012 to June 2013 is shown in the above chart (red bars).

The total static capacity of the adult system combined across all modalities—detoxification services, residential, outpatient and addiction medicine—was 2685 in FY 2013. The dynamic capacity was estimated at 10,869 annually and 905 slots/beds monthly across all modalities except transitional housing units. Dynamic capacity is based on the estimated turnover in slots and beds in the adult system of care.
There are seasonal fluctuations with respect to the number of calls fielded in any given month. Calls decline in the holiday months (November and December), rise in January, and reach their peak during the 4th quarter of the fiscal year (April to June).

The total capacity of the youth system of care is considerably smaller. It has a total of 522 slots, mainly in outpatient treatment. The estimated dynamic capacity is about 2200 clients annually, based on the average turnover per slot.

The following charts provide an overview of the current DADS structure in addition to an overview of the programs provided within DADS.
B. Mental Health Department (MHD)

Budget Unit: 412  
FY14 Approved Budget: $326,013,620  
FY14 Approved FTEs: 399

MHD Public Purpose: Support individual well-being and achievement of personal goals and support a healthy and safe community.

The Mental Health Department (MHD) currently serves an estimated 30,000 residents per year through a network of County-operated and contracted services located throughout the County. Those eligible for services include:

- Child and adult Santa Clara County Medi-Cal beneficiaries in need of specialty MH services;
- Child and adult county residents who are provided involuntary psychiatric treatment through the County-operated Emergency Psychiatric Services (EPS), and inpatient psychiatric services;
- Adults and children in County-operated custody settings; and
- Low-income county residents without mental health insurance who experience serious psychiatric conditions.

MHD Structure: Services are organized by four major divisions: Family and Children’s Services, Adult and Older Adult Services, Integrated Behavioral Health, and Acute Psychiatric Services. Each division provides an array of services for specific populations. In FY 2012, the MHD served approximately 25,000 clients. The number of clients seen in community-based services continues to increase as a result of changes in capacity related to the implementation of MHSA-funded programs.

MHD Funding: The MHD is funded through several sources of federal, state and local funds. As the managed care plan administrator for Medi-Cal mental health services, a significant proportion of funding comes from federal Medicaid reimbursement for services provided to Medi-Cal beneficiaries, which is reimbursed at approximately 50% of costs. The second major source of funding generates from State Realignment funds, which are tax revenues distributed to counties by the State specifically for public mental health services. A third source of funding is tax revenues from the Mental Health Services Act (MHSA, formerly known as Proposition 63), which was passed in November 2004. The last major source of funding is County discretionary general funds approved by the Board of Supervisors.

The chart below summarizes the number of referrals and consumers served monthly by the Specialty Mental Health System. The Call Center processes and refers an average of 745 individuals a month into Family and Children and Adult/Older Adult specialty mental health
services. The specialty system serves an average 10,000 individuals a month. In addition, the Federally Qualified Health Care (FQHC) clinics serve another 5000 individuals annually.

**Monthly Referrals and Served in the Specialty Mental Health System for FY 2013**

Outpatient services comprised of specialty, unsponsored, and full service partnership programs make up the majority of the department’s service delivery. Services supplied in the FQHC settings are growing quickly as primary care physicians have begun to become more accustomed to making referrals to the clinics.

**MHD Adult/Older Adult Served by Modality FY13 (N=23,110)**

The Family and Children’s System of Care provides a variety of services with varying service intensities. The majority of individuals are seen in the outpatient system (60%), however, more
intensive wraparound services also are available. School-Linked Services are provided and a number of culturally specific services are supplied to meet the needs of special populations or populations requiring additional support.

The following two charts provide an overview of the MHD in addition to an overview of the services and support functions of the MHD.

MENTAL HEALTH DEPARTMENT
Santa Clara Valley Health and Hospital System
FY13 Executive and Division Director Team

Deputy County Executive

Mental Health Director

Deputy Director

Administration Division Director
Adult/Older Adult Division Director
Family & Children Services Division Director
Integrated Services Division Director
Learning Partnership Division

Compliance Manager

Medical Director
Community Medical Director
Mental Health Finance Director
Mental Health IT Director
Acute Psychiatry Nursing Director
Homeless Systems Director
INTEGRATION PLAN FOR A NEW SANTA CLARA COUNTY DEPARTMENT OF BEHAVIORAL HEALTH SERVICES
V.  APPROACH TO INTEGRATION PLANNING

The process of integrating two departments, with a combined 564.5 FTEs and $373,306,017 annual budget, is complex and sensitive. The planning process began with several meetings with external and internal stakeholders and continued with a multi-group planning effort involving top leaders in both departments, an external stakeholder Steering Committee, and numerous Work Groups to develop approaches and plans for integration. The implementation will begin in 2014 and continue through 2015 until all functions and services are combined and delivered in a truly integrated way. The process includes the following steps and involves several groups in planning.

A. Input from Staff, Contractors, Clients and Advocates

Starting in 2012, the MHD and DADS Directors gave multiple presentations on the importance of behavioral health in the new era of Health Care Reform. Presentations were given to various stakeholders—community, staff, managers, and contract providers. They also shared that the Board of Supervisors requested that DADS and MHD develop a plan for the integration of the two departments into a single behavioral health system.

Prior to initiating planning for integration, the departments sought feedback from key stakeholders. Staff, contractors and members of the community were invited to a forum to discuss three specific aspects of integration: opportunities, challenges and questions. There were both commonalities and differences in responses across the groups with respect to these three things.

For both County staff and contract providers, integration was viewed as an opportunity to redesign the treatment system. Both groups ranked treatment-related improvements as the number one opportunity. These groups mentioned that treatment could be improved by: improving the workforce through training, introducing new services or improving existing services, providing integrated treatment, greater client orientation, improving access for clients, and having better outcomes. By comparison, members of the community identified integration as an opportunity to create administrative efficiencies by combining common functions across the two departments.

There was greater divergence among the three groups with respect to challenges associated with integration. County staff identified integration-related issues as the most important challenge. Included in this category were issues related to the selection of framework or model to guide integration, confidentiality, infrastructure, specific plans for services, the timeline for the process, and lack of funding and resources. For contract providers, treatment-related
concerns emerged as the paramount issue. They identified challenges associated with integrating treatment assessment and treatment plans, treatment capacity, dealing with dual diagnosis clients, determining the primary provider, potential loss of treatment modalities, and coordinating case management across the system. For community members, merging operations emerged as the paramount challenge, and included issues such as reconciling different cultures, billing, getting private payers to buy public sector services, working out operational details, the time required to integrate and the potential creation of addition levels of bureaucracy.

All three groups had questions about the integration process itself—how various issues related to integration would be solved. A sample of questions from the three groups suggest that there were questions about why a merger was needed at this time, how the organizational cultures would be reconciled, how the integrated system could be made competitive in the marketplace, whether system staff would be trained to serve complex clients, how contractors would participate in this process, and what would the integrated system actually look like.

B. Steering Committee

A Steering Committee, comprised of key system stakeholders, was convened and chaired by Bruce Copley and Nancy Peña. The Steering Committee was charged with guiding the integration planning and implementation process. Specifically, they were tasked with reviewing and recommending a plan to fully integrate the County’s behavioral health vision, values, approach, infrastructure, systems, processes, services and supports to:

- **Support the County’s Vision, the HHS Vision and Strategic Priorities, and the visions and missions of partner organizations;**
- **Recognize that individuals may have multiple conditions affecting their health, not only a mental health challenge or substance use disorder;**
- **Better meet the needs and expectations of current and future clients and their families;**
- **Focus on prevention and early intervention;**
- **Be prepared for Affordable Care Act implementation and full collaboration across the span of health care;**
- **Improve visibility, access and service in communities to reduce disparities; and**
- **Merge the perspectives into a broader model of integrated care and apply best practices, cultural competency, and the highest quality of our work for those we serve.**
The Steering Committee had the following objectives:

- *Review and respond to the drafts prepared by the functional area teams to develop recommendations for effective and timely consolidation of two departments into one integrated department;*

- *Work together to discuss and agree on a cohesive set of recommendations to optimize the success of the integration; and*

- *Prepare recommendations regarding consolidation to advance to the County Executive and Board of Supervisors and make refinements according to their input and recommendations.*

**C. Executive and Division Directors Group**

The primary group that will lead integration implementation consists of the Division Directors from both departments and is chaired by Bruce Copley and Nancy Peña, with assistance from Carolyn Verheyen of MIG, Inc. This group, called the Executive and Division Directors Group (or Joint EDDG) was tasked with developing and recommending a plan to fully integrate the County’s behavioral health vision, values, approach, infrastructure, systems, processes, services and supports with aims identical to those shown above for the Steering Committee.

The Executive and Division Directors Group had the following objectives:

- *Work in functional area teams to develop recommendations for effective and timely consolidation of two departments into one integrated department by December 2013.*

- *Work together to discuss and agree on a cohesive set of recommendations to optimize the process and success of the integration by December 2013.*

- *Present recommendations to the Steering Committee and make refinements according to their input and recommendations by January 2014.*

- *Proceed to implement the plan once fully approved, with continuous monitoring and adjustments as needed, with integration complete by June 2015.*

**D. Work Groups**

A series of work groups was formed to address topical issues related to service delivery and administrative functions. Work Groups addressed the following areas:

- *Integration Approach*
• Quality
• Administrative Services
• Budget/Financial Support and Contracts Administration
• Compliance and Privacy
• Access and Referral
• Family and Children’s Services and Transition Age Youth Services
• Adult Services and Senior Services
• Primary Care-Based Services
• Supportive Housing
• Workforce Development and Training
• Consumer and Family Affairs

Each Work Group developed an overall Charter, including Aim statements, objectives and milestones. They met at least twice a month, and all work was reviewed by the EDDG prior to presentation to the Steering Committee for refinement and/or endorsement. These recommendations appear in the next section.
VI. PROPOSED DEPARTMENT OF BEHAVIORAL HEALTH SERVICES

This section presents the proposed approach to creating a Department of Behavioral Health Services. It includes the overarching framework consisting of the Vision and Guiding Principles, the Philosophy and Approach based on a review of best practices and relevant literature, and a clear focus on Client-Centered Care.

The section below provides an overview of the proposed DBHS system and functional structure and a summary of the planned integrated Behavioral Health Services delivery system and support functions.

“Ultimately, we agree we will know we are successful when we have:

- **Satisfied, healthy clients who are achieving their personal goals;**

- **Satisfied, competent staff and managers, motivated to change practice, and empowered to meet client needs;**

- **A thriving system with a focus on optimal outcomes in prevention, wellness, and health.”**
A. Best Practice Models of Integration and Selected Approach

In June 2013, the Integration Models Work Group recommended, and the Steering Committee adopted, a hybrid model of integration based on elements of two behavioral health integration frameworks. These were the CCISC (Comprehensive Continuous Integrated System of Care) and the EBT (Evidence Based Treatment) Kit, developed by SAMHSA (Substance Abuse Mental Health Services Administration). The Integration Models Work Group concluded that no single model had the scope to cover the range of issues presented by clients in Santa Clara County.

Given this situation, the most efficient approach was to combine components from both models. A hybrid approach also offered other Work Groups ample latitude to design programs that were tailored to the needs of different groups of clients. The hybrid or blended approach also is recommended because of the overlap in proposed solutions in each of the major areas addressed below: access and referral, adult and child systems of care, treatment approach, integration approach, financial considerations, management issues, cultural competency, outcomes and implementation barriers/challenges.

The primary philosophical approach of both frameworks/models was similar and both emphasized the need to incorporate best practices and evidence-based practices. The CCISC has been implemented in a number of states and its overarching philosophy is endorsed by SAMHSA. The values underlying the CCISC model represent the key principles of integrated treatment.

- Co-occurring conditions and issues are an expectation, not an exception.
- Clients must receive treatment that emphasizes empathy, hope, integration, and a strengths-based approach.
- Treatment for co-occurring disorders must be tailored to the needs of the population.
- Treatment of both mental illness and substance use disorders should be concurrent.
- Recovery involves moving though stages of change.
- Progress occurs in an environment in which a client is adequately supported, rewarded for skill-based learning for each condition.
- Recovery plans and interventions must be individualized.
B. Patient-Centered Care

Patient-centered care supports active involvement of patients and their families in the design of new care models and in decisions about individual options for treatment. The IOM (Institute of Medicine) defines patient-centered care as: “Providing care that is respectful of and responsive to individual patient preferences, needs, values, and ensuring that patient values guide all clinical decisions.” Patient-centered care also is one of the overarching goals of health advocacy in addition to safe medical systems and greater patient involvement in healthcare delivery and design. Care that is truly patient-centered cannot be achieved without active patient engagement at every level of care design and implementation. There are four attributes of patient-centered care:

- “Whole-person” care,
- Coordination and communication,
- Patient support and empowerment, and
- Ready access.

Patient-centered care is about much more than simply educating patients about a diagnosis, potential treatment, or healthy behavior. It means considering patients’ cultural traditions, personal preferences and values, family situations, social circumstances and lifestyles, as used by the Institute of Medicine and Institute for Healthcare Improvement. Patient-centered care leads to higher levels of patient engagement. The five constituent dimensions of patient engagement include: 1) communication, 2) provider effectiveness, 3) alignment of objective, 4) information and encouragement, and 5) patient incentive. The core belief is that engaged patients have better health outcomes with a greater ability to manage the health condition within the community setting.

C. Cultural and Linguistic Competency

Santa Clara County is one of the most diverse counties in the nation. With 63% of the 1.85 million population being non-white, 37% being foreign born, and over 100 languages spoken, our commitment to cultural and linguistic competency must be front and center if we are to achieve our vision of Better Health for All. Thus, a particular focus of the new DBHS will be to insure that those served by the system have access to services that consider and are attuned to their linguistic and cultural needs. Emphasis will be placed on assuring underserved communities, i.e., those populations where utilization of the service is not commensurate with their proportion of SCC Medi-Cal and uninsured recipients, in order to achieve our vision of Better Health for All. Particular efforts will continue to respond to the linguistic needs of individuals speaking any of the county’s five threshold languages (Spanish, Vietnamese,
Mandarin, Tagalog, and English).

In addition, extensive work with additional ethnic and cultural communities currently conducted through the MHD’s Ethnic and Cultural Community Advisory Committees (ECCAC’s) will be extended to all behavioral health clients. ECCAC staff is multicultural and multilingual, representing seven targeted cultural communities and speaking more than a dozen languages.

The ECCAC’s represent and serve African Heritage, African Immigrant (primarily Eritrean, Ethiopian, and Somali), Chinese, Filipino, Latino, Native American and Vietnamese communities. In addition, current planning is underway to add LGBTQ and Veterans community groups. Each ECCAC team is comprised of family members and consumers and has a community-specific service plan based on identified needs of their particular community.

Further, work to insure that staffing competencies include sufficient linguistic capability among both County and contract providers will be an important focus of the new DBHHS. That will be accomplished through tracking bilingual staff throughout the new system and by collecting and reviewing client data regarding ethnicity and language preference to ensure clients have access to bilingual resources commensurate with clients’ need.
Finally, training and continued focus on evidenced-based practice as well as the implementation of new community-informed effective models of care will be an important aspect of the new DBHS’ commitment to continuous quality improvement.

D. The Four Quadrant Model

The “four quadrant” model builds on the 1998 consensus document for mental health and substance abuse/addiction service integration as initially conceived by state mental health and substance abuse directors and further articulated by Dr. Kenneth Minkoff. This model for a comprehensive, continuous, and integrated system of care (CCISC) describes differing levels of MH and SUD integration and clinician competencies based on the four-quadrant model, divided by severity of each disorder.

The model was developed as a heuristic tool to link location of treatment and different levels of co-occurrence of substance abuse and mental health disorders. The purpose of the four quadrant model was to provide guidance as to the recommended location of treatment of different combinations of MH and SUD disorders. For example, the recommended location of treatment for Level 1 is the primary health care setting, as Level 1 represents low levels of severity for both substance abuse and low mental disorders. Some research suggests that the largest categories are Levels 1 (low severity of both mental health and substance use disorders) and Level 4 (high severity of both mental health and substance use disorders). The four quadrant model was originally designed for planning purposes rather than as a tool for patient placement.

- Quadrant I: Low MH-Low SA, served in primary care
- Quadrant II: High MH-Low SA, served in the MH system by staff who have SU competency
- Quadrant III: Low MH-high SA, served in SA system by staff who have MH competency
- Quadrant VI: High MH-High SA, served by a fully integrated MH/SA program

(Source: The co-occurring matrix for mental and addiction disorders, Richard Ries, University of Washington.)

E. DBHS System Overview

The proposed system is one that is organized primarily around developmentally aligned continuums of services. This is consistent with most public institutions, education, welfare, justice, and social services. At the same time, there are key system components that are
physically located in VMC hospital (Emergency Psychiatric Services and Barbara Arons Pavilion adult inpatient psychiatric unit). These key services are administered through VMC. Further, there are services that are provided through VMC ambulatory clinics (psychiatric care and non-psychiatric clinical care) and are currently managed by MHD and DADS managers. These organizational structures have been utilized to maximize SCVHHC departmental resources on behalf of our clients and the services they need.

**Proposed System Functional Overview**

The graphic above is intended to represent the grouping of functions of the new system. While there are leadership roles within each functional area, those are not defined here. The determination of specific executive, management and line staff functions within each of the functional areas will be determined through an analysis of current positions. This process will be a major task of the implementation plan to be launched upon approval of the Board of
Supervisors to proceed with implementing the proposed new organization. A special Task Force is proposed to be convened, consisting of labor, management, physician, registered nurse, Employee Services Agency, and Executive Management stakeholders to address staffing-related changes that will be required with implementation of the Plan; and to insure that appropriate contractual obligations are fulfilled.

The following sections present the proposed organization of each of the functional areas shown in the graphic on the previous page, including the process and rationale for the proposed structure. These sections, resulting from the Work Group planning process, have been endorsed by the Steering Committee. In most cases, the Steering Committee received more detailed documents showing the Work Group recommendations.

F. Access and Referral

The MHD and DADS will integrate access and referral services under the new DBHS with the goals of: 1) improving and increasing services, 2) centralizing the access point for clients, and 3) improving efficiencies and reducing redundancies. The chart below outlines a framework for the new integrated Access and Referral that includes identification of five functional areas in the integration process. These areas are: Call Center, Urgency Care, Bridge Outpatient, Suicide Prevention and Crisis Response Services. Under these functional areas are different key activities carried out within the function. The Work Group also identified three phases of implementation: First Phase includes tasks that could be integrated within the first six months; the Second Phase, are tasks that will be integrated within twelve months; and the Third Phase, tasks that will be integrated after Phase One and Two.
The Access and Referral Work Group will continue to meet to develop a common screening and assessment tool and referral procedures, including who will be administering each element, so that clients will be referred anywhere in the Behavioral Health system where their needs will be best addressed.
G. Family and Children’s and Transition Age Youth Services

It is proposed that the integrated Family and Children’s and Transition Age Youth Services system organize services as presented in the chart below. The organizational concept was influenced by several factors. The integrated division will be responsible for serving prenatal through young adults and, therefore, the system must consider the child and youth developmental trajectory. An integrated system also considers the populations served and, because of that, attention was paid to service integration with partners including education, Probation and child welfare. In addition, service acuity and intensity were considered in order to ensure that a comprehensive system of care ranging from promotion/prevention through intensive services are available to clients and that all sectors of the system include integrated behavioral health services.

The integrated youth system, which includes Transition Age Youth (TAY), will provide targeted services to youth in all four quadrants of the Quadrant Model, the cornerstone of the hybrid integrated system framework. The integrated system will include mental health specialty services, substance use services, and co-occurring services for youth and TAY who have both mental health and substance use diagnoses. Youth will be referred to the appropriate County site or contractor who will best meet their needs. All staff will be Co-Occurring Disorder Capable (COD-C), i.e., trained to assess for both mental health and substance use. Integrated Treatment Specialists (ITS) will treat those youth who have both mental health and substance use diagnoses. Integrated Treatment Specialists will be trained to be Co-Occurring Disorder Enhanced (COD-E) and will have specialized training to treat both conditions.
Planning Process and Rationale

The Family and Children’s/Transition Age Youth Services Work Group worked on several deliverables including: 1) a service inventory and geographic mapping of available services for children, youth and transition age youth, 2) identification and piloting of an evidence-based screening tool, 3) a comprehensive assessment protocol, 4) a training plan, and 5) organizational concept.

The service inventory reflected an array of mental health and substance abuse treatment services across the county. However, a review of contracts indicated few agencies provided both services. Most notable was the limited availability of both mental health and substance abuse services in South County. Both departments have piloted an evidence-based screening tool that will screen for substance use, mental health symptoms, and trauma resulting in an improved customer experience for youth and their families. Families will contact a single call center rather than two in order to access services and youth will be treated by a single provider.
for both their mental health and substance use issues. The departments also are developing one comprehensive assessment tool so that youth only have to tell their story once to one provider, an Integrated Treatment Specialist. Early in 2014, as a pilot site for integrated services, youth in Juvenile Hall will receive a single, integrated mental health and substance use assessment from an integrated treatment specialist therapist rather than two therapists, which will result in a better client experience. Based on client experiences during the pilot activities, DADS and Mental Health propose to move forward toward an integrated youth system of care by July 1, 2014, that will result in improved client care and client experience.

H. Adult, Older Adult, Criminal Justice Treatment and Support Services

The proposed organization of the Adult and Older Adult specialty system is organized around continuums of care for four large populations of adult clients. These continuums will be continuous both laterally and horizontally, according to the needs of the adult populations served by the new integrated system.

**Adult and Older Adult System**
Planning Process and Rationale

The Adult and Older Adult Services Work Group (A/OA Work Group) members consisted of Program Managers, line staff, SEIU members, community-based organization service providers, and a client that has received services from both the MHD and DADS. The Work Group accomplished the following tasks:

A. An inventory of Adult and Older Adult Services available to MHD and DADS;
B. A resource guide for DADS and MH staff;
C. Geo-mapping to assist in determining appropriate locations of integrated service centers;
D. An integrated screening tool to be piloted at the AB 109 Re-Entry Center; and
E. A Behavioral Health integrated services matrix.

As with the Family and Children/TAY Work Group, the A/OA Work Group incorporated the “four-quadrant” model as a basis for the development of service tracks, however, the proposed structure was influenced by several additional factors:

1. Since the integrated division will be responsible for serving Adults and Older Adults, the system must consider the Adult and Older Adult lifespan.
2. An integrated system must consider the system partners that have contact and service relations with the populations. This included Probation, Social Services and primary care services.
3. In addition, client acuity and service intensity were considered in order to ensure that a comprehensive system of care ranging from state hospital, long-term locked hospitalization (i.e., Institutions for Mental Disease), to unlocked residential (crisis, transitional and detoxification facilities) are available to clients.
4. While all programs of the system provide access to integrated behavioral health services, the integrated Adult and Older Adult system will provide targeted services to clients in all four quadrants of the Quadrant Model, the cornerstone of the hybrid integrated system framework.

The integrated Adult and Older Adult Behavioral Health Department will include mental health specialty services, substance use services, and co-occurring services for Adult and Older Adult clients who have both mental health and substance use diagnoses. Clients will be referred to the appropriate County site or contractor who will best meet their needs. MHD and DADS Programs providing similar types of services will be grouped together in one of four service
areas; 1) Behavioral Health Adult Services, 2) Behavioral Health Older Adult Services, 3) Behavioral Health Intensive Services, 4) Criminal Justice Services.

The final consideration is the development of a “Seamless System of Care.” This care system is based on the concept of “no wrong door.” It allows for a client to receive all necessary treatment with a consistent care team and to receive higher and lower levels of care in an integrated fashion. The following describes the four “divisions” identified in the above chart:

**Behavioral Health Adult Services** will include the current specialty care populations that the two departments traditionally serve. These populations are the seriously mentally ill and the chronically addicted population. Many of these clients exhibit both mental illness and substance abuse. The prevalence of co-occurring disorders in this population is between 30% and 50% of the served clients.

**Behavioral Health Older Adult Services** will serve individuals age sixty and older with integrated behavioral health services. This is a growing and currently underserved population within the current departments. The services will be integrated with the primary care health system and the outreach and support services currently provided by the Social Services Agency in the Adult Protective Services Department. Elder services will emphasize case management and social support development that will address elders who have lost contact with friends, family and community activities.

**Behavioral Health Intensive Services** will include the residential services that are provided to clients that need 24-hour care to address their chronic MH and SUD symptoms. These services will provide wraparound services with the goal of stabilizing MH/SA symptoms in as short a time as possible and returning clients to community support services. The population has a high prevalence of co-occurring disorders that require a full assessment and determination of which presenting issues need to be addressed in the residential setting and which can be initiated once the clients return to community care.

**Criminal Justice System of Care Services** will include all of the current activities associated with the services provided to the Superior Court’s criminal and dependency treatment court clients. This population has the highest prevalence of co-occurring disorders among the population served in the departments. The development of the AB 109 services has accelerated the integration of the two departments. With the multi-service Reentry Resource Center, the departments integrated the clinical assessment staff under one manager. It is a collaborative effort of multiple departments that includes Probation, Parole, Social Services, housing, medical, MH and SUD services. It is the first example of an integrated mental health, primary health and substance abuse treatment component.
Work Force Development will be an important aspect of the new integrated Adult/Older Adult system and will include development of Integrated Treatment Specialists (ITS) with dual competencies necessary to work with the co-occurring client population with both MH and SA problems. These staff will receive specialized training in both mental health and substance use treatment in order to become Co-Occurring Disordered Enhanced (COD-E) qualified, thus allowing staff to treat clients who have both mental health and substance use diagnoses. This competency will support the aim of providing “person-centered” recovery services. Trainings will focus on evidenced-based practices for working with this population.

I. VMC Acute Emergency and Inpatient Psychiatric Services

Acute Psychiatric Services provides three clinical missions for the MHD through Valley Medical Center:

**Emergency Psychiatric Services (EPS):** This service offers the only 24/7 locked psychiatric emergency room/5150-designated receiving center in Santa Clara County and serves approximately 10,000 clients annually. EPS provides emergency interventions for those in psychiatric crisis, most of whom are at EPS on an involuntary psychiatric detention. EPS also provides emergent and urgent detoxification from alcohol and other drugs. EPS provides services to all those in the county who are in psychiatric crisis, including those with private insurance. For those patients who need further psychiatric inpatient care, EPS works with private health plans and/or MHD providers to facilitate transfer to an inpatient hospital. For those who following evaluation and treatment at EPS are not in need of hospital care, approximately 60%, EPS staff facilitates arrangements for community-based follow-up geared to meet individual treatment needs.

**Barbara Arons Pavilion Inpatient Psychiatric Service:** Following an EPS evaluation, a smaller number (approximately 40%) of patients are admitted to a psychiatric hospital for further treatment and stabilization. Barbara Arons Pavilion (BAP) is a locked 48-bed inpatient unit, which provides psychiatric treatment and stabilization. Following stabilization at BAP, patients are transitioned to appropriate aftercare placements. In addition to BAP, the MHD contracts with a range of psychiatric inpatient programs within the county and the broader Bay Area. BAP and contract hospitals care for an average of 88 patients a day who are the responsibility of the MHD.

**VMC Psychiatric Consultation Service:** The Valley Medical Center psychiatric consultation and liaison (C&L) service provides emergent, urgent, and routine psychiatric evaluation and care to patients hospitalized on the medical, surgical, and pediatric floors of Valley Medical Center. While no changes are anticipated in this service as a result of the integration of the two specialty departments, there are plans underway to develop expanded crisis-related services.
These new services—mobile crisis and triage, crisis stabilization, and crisis residential—will significantly improve and expand the way in which crisis and emergency psychiatric services are provided in Santa Clara County.

J. VMC Primary Care-Based Behavioral Health Services Work Group

A critical component of the planning for the new DBHS, which will serve as the specialty services system in the broader HHS system, is the continued development of primary care clinic and hospital-based MH and SUD services. While these services, per se, are functions provided through Valley Medical Center hospital and clinics, they are essential to providing a continuum of specialized behavioral health within the context of primary medical settings. Thus, a specific work group focused on this and the expansion of addiction medicine specialists and psychiatric medicine and other behavioral health specialists within the context of SCVHHS and partner community-based medical environments. The following chart outlines the proposed functions of Primary Care-Based Behavioral Health Services.

**Primary Care-Based Services**
Process and Rationale

The AIM of the Behavioral Health-PC Work Group is

The integration of physical health, mental health, substance use services, with a whole person orientation, in order to achieve improved client satisfaction, care quality and lower cost.

Members of the Work Group consisted of leaders from the MHD, DADS, primary care, clients and labor unions. The Behavioral Health-PC work group identified five goals to support its Aim statement:

- Provide fully integrated behavioral health services in all primary care clinics;
- Provide routine universal screening for behavioral health conditions;
- Provide cross training in addiction, mental health and co-occurring disorders;
- Provide training in brief motivational interviewing to medical staff; and
- Develop data-driven outcomes and performance evaluations.

As a result of implementing integrated Behavioral Health-PC services, it is expected that outcomes will demonstrate increased patient satisfaction with coordination of services, increased quality of care through compliance with physical care plans, and reduced costs of health care associated with lower utilization.

**SCVMC Addiction Medicine and Therapy Program (AMT)**

The purpose of the AMT primary integrated care services is to identify the substance use disorders within primary care through simple screening methods and then to provide brief intervention and/or refer to treatment in specialty care services. Research shows that between 25 and 30% of patients seen by primary care physicians have significant co-occurring substance use disorders that these patients are much more likely to develop medical problems than the general population, and they present more frequently for medical conditions caused by or

---

2 The link between behavioral health and physical health has been well established (JAMA 2001;286:1715-1723, American Family Physician 2003;67:1529-32, 1535-6, Institute of Medicine, 2010, National Association of Public Hospitals and Health Systems, 2011, National Hospital Inpatient Quality Measures. The Joint Commission, 2012, JAMA 2013; Volume 310, Number 16). Therefore, no integrated care effort would be complete without also including the integration of behavioral health and primary care services.
exacerbated by continued alcohol and/or drug abuse. Medical conditions related to substance use include hypertension, coronary artery disease, chronic liver disease, and hepatitis C.

According to the American Society of Addiction Medicine (ASAM), substance use disorders occur along a continuum of severity with misuse at one end and addiction at the other end, of which there are several subtypes requiring different treatment approaches. The prevalence rate is widespread. Columbia University and the Substance Abuse and Mental Health Administration (SAMHSA) estimate that 40 million Americans ages 12 and over (12%) meet the diagnostic criteria for addiction involving nicotine, alcohol or other drugs—a disease affecting more Americans than heart conditions, diabetes or cancer. Another 80 million people (26%) are risky substance users and drinkers, using drugs and drinking alcohol in ways that threaten health and safety. Applying these percentages to Santa Clara County, there would be about 220,560 (12%) people ages 12 and over who meet the diagnostic criteria for addiction and another 477,880 (26%) people who are risky substance users, using drugs and drinking alcohol in ways that threaten health and safety.

The physician can be a powerful influence for getting the substance abusing patient to accept treatment. According to the National Quality Forum (NQF), Standards for the Treatment of Substance Use Condition, evidence-based practices and pharmacotherapy should be recommended and available to all adult patients diagnosed with opioid, alcohol and nicotine dependence and without medical contraindications. Pharmacotherapy should be provided in addition to and directly linked with psychosocial treatment/support.

In 2010, DADS began using the evidence-based and cost-contained approach called, Screening, Brief Intervention and Referral to Treatment (SBIRT). SBIRT was developed by primary care staff for busy medical settings and integrates addiction treatment with primary care medicine.

The SCVMC Addiction Medicine and Therapy Program (AMT) is a state and federally regulated, fully accredited program that includes medication-assisted treatment using methadone, buprenorphine and naltrexone for opioid addicted adults, the HIV intervention program, primary care integration services, and the Addiction Medicine Consultation service for primary care medicine. For patients of the medication-assisted treatment program, 53% have demonstrated sustained functionality for one year or more, compared to a national average of 30%. Additionally, 99% of AMT patients indicate an “Always Satisfied” in the Annual Patient Experience of Care Surveys.

The HIV Intervention Program provides hepatitis and HIV education and testing for patients in residential substance abuse treatment programs. The HIV Intervention Program also provides
TB testing, triage advice nursing for the Gateway program, and flu vaccines to the program’s patients on an annual basis.

AMT provides the following primary/specialty care integration services:

- **The SCVMC Heart Failure Program (HFP).** Through early identification of substance abuse by using SBIRT, patients of the HFP in post-discharge phase will be referred to on-site addiction specialty care. This cohort of HFP patients is at a high risk for post-discharge complications, non-compliance with their care plans, and is at elevated risk for hospital readmissions. This coordinated and integrated care effort can improve patient compliance, reduce post-discharge complications, reduce readmissions and, therefore, reduce preventable costs associated with utilization.

- **SBIRT and VMC Trauma Center.** Between 80 and 90% of repeat visits to the Trauma Center are for alcohol and drug-related accidents (vehicle, assaults, fall accidents, domestic violence, etc.). The SBIRT approach has demonstrated its importance in injury prevention through reductions in substance use and, subsequently, reductions in utilization.

- **Pain Management and Addictions Treatment Program (PMAT).** The relationship between chronic pain and addiction is prevalent and complex. A pilot initiative at the Tully Clinic demonstrated a reduction in narcotics prescriptions, reduced acting out behaviors in the clinic lobby, and improved compliance with medical care plans when chronic non-cancer pain was addressed by a multidisciplinary team of clinicians. There are plans to expand this model in 2014.

- **Medical Resident Training and Stanford Fellowship in Addiction Medicine.** This initiative begins to prepare the new workforce of physicians to more effectively identify, diagnose and provide coordinated care for patients with SUDs. It is part of several innovations that address substance use-related medical conditions and are designed to capture the significant costs savings benefits and improved overall health outcomes.

- **Medical Health Homes.** In September 2010, substance use services were integrated into the Moorpark medical home clinic. Specialty addictions treatment services were offered to provide a more coordinated and integrated model of care in one setting. The SBIRT approach was introduced and a dashboard for outcomes benchmarks, loosely based on Health Plan Employer Data and Information Set (HEDIS) was developed. In 2011, the Tully Clinic and the Medical Respite program were added to expand the use of collaborative primary care using SBIRT in specialty addiction treatment services.

- **Addiction Medicine Consult Service for Primary and Specialty Care Medicine.** A “curb side” consult service for primary care physicians by specialists in Addiction Medicine, the Consult Service Team is comprised of physicians who are Nationally
Board Certified in Addiction Medicine, Internal and Family Medicine, Nursing, Psychology, Clinical Social Work and Pharmacy/Pharmacology.

**WHY Integrate: Better Outcomes for those Served**

Persons with substance use disorders (SUD) have more physical health problems than persons without SUD. These include pulmonary and heart disease, hepatitis, HIV/AIDS, cancer, and mental disorders such as depression, anxiety, bipolar disorder, and schizophrenia.

Persons with SUD have:
* 9 times greater risk of congestive heart failure
* 12 times greater risk of liver disease
* 12 times the risk of developing pneumonia


**Goals of the AMT Primary/Specialty Care Integrative Services:**

- Increased ability of primary care clinics to screen for substance use disorders using evidence-based and time-efficient screening instruments;
- Increased provision of clinical support and addiction medicine training for primary care;
- Improved care coordination between primary care and addiction medicine; and
- Improved capability for primary care and addiction medicine to document outcomes and performance for patients in common to both systems.

**Projected Outcomes from AMT Primary/Specialty Care Integrative Services:**

- Medical and substance use problems both improve when treated in an integrated manner;
- Patient compliance with medical care plans and substance use treatment plans will improve;
- Improved patient experience of care;
- Decreased utilization of primary medical services and readmissions; and
- Realized cost savings through a more efficient use of the health system.
**Ambulatory Psychiatric Medicine**

For several years, VMC primary care physicians and other specialists at VMC have requested increased access to the expertise of psychiatric physicians in the ambulatory care clinics. Initial efforts involved a full-time psychiatric consultant at the Moorpark Clinic, which is the largest VMC primary care clinic and which also hosts the VMC primary care residency training program. Subsequently, a psychiatrist also was embedded in the Valley Homeless Healthcare Program to provide integrated care at the homeless clinic, the shelters and the homeless encampments. The psychiatrists were seen as a valuable resource that significantly improved access to psychiatric treatment by primary care patients and enhanced the primary care doctors’ skills in screening for and treating more common mental health conditions such as depression and anxiety disorders.

Due to the success of these pilots and to support the increasing need for services in the ambulatory care clinics, in 2009 several psychiatrists were assigned to work at both specialty and ambulatory clinics at Valley Health Center Alexian, East Valley, Gilroy, Milpitas, and Sunnyvale Clinics to provide psychiatric treatment and consultation. This collaborative partnership with VMC enabled the MHD to retain critical psychiatric services to over 1600 adult mental health clients who were in jeopardy of losing service due to the budget reduction targets faced by County departments at the time. Over the last 4 years, the service has expanded to accept referrals from primary care physicians as well as the Specialty Mental Health system through (MHD) and has rapidly grown to 6000 patients in the five ambulatory clinics and two satellite MHD sites at Downtown and Narvaez.

The psychiatrists accept patients referred from primary care physicians, the MHD Call Center, as well as transfers of patients from specialty mental health clinics who have recovered sufficiently to require only medication management and brief psychotherapy and case management support. The range of disorders that can be treated include mood and anxiety disorders, psychotic disorders, personality disorders and those with co-occurring substance use disorders.

**Goals of Ambulatory Psychiatric VMC Partnership:**

- Increased ability of primary care clinics to screen for depression, bipolar, substance use and suicide risks;
- Increased capacity of primary care clinics to provide proactive follow up and management of patients identified with depression in primary care;
- Increased provision of psychiatry training and clinical support for primary care to support a more comprehensive, stepped-care model from primary care to ambulatory psychiatric care to specialty psychiatric care;
• Establishment of processes for ongoing communication regarding collaborative care between primary care and psychiatry;
• Establishment of a more seamless mechanism for medical management of patients at risk of metabolic syndrome; and
• Increased capacity of both primary care and psychiatry to document and track care processes and performance.

As a result of the psychiatrists working across several settings at SCVHHS, including VMC ambulatory care clinics and specialty mental health clinics, it is expected that outcomes will demonstrate improved access and matching of services to the needs of the patients, utilizing an appropriate stepped care methodology using the Milestone of Recovery Scale and other screening instruments, increase quality of care through medication reconciliations and reduce costs of healthcare associated with increased coordination of care, as well as care provided at the prevention and early intervention phase, and in settings that are more convenient and less stigmatizing for patients of diverse cultural backgrounds. Our experience thus far has shown more than double the access for patients of all ethnic cultural backgrounds, including those with limited English proficiency.

K. Executive Functions

The integrated DBHS will be more complex than a simple merging of the two entities under one executive management structure. This complexity stems from the development of two new service elements. The first element includes services for those clients who present with both MH and SUDs and require integrated treatment. The second is development of the BH services for the SCVHHS, other health systems and the local health exchanges that will require a full array of integrated BH services as called for in the Mental Health Parity and Substance Equity federal regulations. The integration of the departments will be a competitive advantage that will expand the range of services offered. To realize this opportunity, the department must be properly staffed at the executive and senior management levels. Presently, the scope of responsibility for division director levels and the executive levels will impair the ability to expand into the new health care arena without additional senior management staffing.

The integration of the two departments for effective operation of the DBHS, in light of major changes due to health care reform, will require significant executive and administrative changes. The most pressing changes are outlined below.
**Additional Senior Staff Management Positions**
The service proposals for the Adult, Primary Care-Based BH Service, and Family and Children systems of care as proposed in this plan provide a new level of integrated client care that meets the standards of the Triple Aim as defined by the Institute for Healthcare Improvement (IHI). Operating these newly configured systems of care will necessitate a dedicated and expanded senior management structure that is currently lacking in the two departments.

**Additional Executive Management Staff Positions and Infrastructure Support**
This expanded senior management level will require additional executive management staff in order to establish and manage the treatment system as defined in this proposal. The potential to develop further integrated services with the SCVHHS Ambulatory and Specialty Care system and establish contracts with other health entities to provide BH services represents an entirely new level of executive responsibility and work activity requiring proper executive and senior management staffing. The executive management of the integrated department must have the administrative infrastructure and adequate senior level managers in order to devote the time and attention to achieve the vision.

**Increased Executive Responsibilities**
The responsibilities and activities of executive management will become more complex and demanding in a larger organization striving to provide truly integrated services. The areas impacted include, but are not limited to, Strategic Planning and Priority Development, Quality and Outcomes Management, Compliance, County Partnerships, Cultural Competency, and Operations Oversight.

The Strategic Planning and Priority Development responsibility will include the annual development of a budget that supports the aims and services provided by the integrated department and the increasing element of third-party and/or Medi-Cal funding over the next three to five years. The expansion of the Medi-Cal population will significantly alter the traditional funding from local, state and federal sources. It is anticipated that funding of healthcare services also will move toward blended performance/fee-for-service, partial capitation or full capitation by 2020. The financial changes in healthcare reimbursement will require the full attention of the executive leadership in the integrated department to respond and develop BH services and an organizational structure that can work within evolving reimbursement mechanisms. Quality and Outcomes Measurement will be a key focus in the DBHS executive team and will require improved analytics that can fully detail costs, effectiveness of services, and trends in client BH needs on a real-time basis.

Compliance and accountability is another significant responsibility area of executive management. With the multiple funding sources---and need for appropriate reimbursement
justification for BH service to support the level of care provided—the executive team will require regular reporting, review and initiation of appropriate corrective actions to remain in compliance. In collaboration with the SCVHHS Compliance Officer, and under the direction of the DBHS executive team, the Compliance and Privacy Office of the DBHS will oversee compliance-related activities of the integrated department. This will include coordination of external audits, internal investigations, internal audits and reports, legal consultation, and development of compliance-related policies and procedures.

The DBHS will continue to work with key departments within the County family. These include the courts, Probation, and the Social Service Agency. Over the last decade, there has been significant development of joint projects to improve client care and outcomes across these agencies by both the departments (MH and DADS). With healthcare reform, there is need to work closer with these partners in order to realize the benefits of BH coverage and the new health benefits for clients from these multiple sources.

The DBHS will continue providing culturally appropriate services that reflect the values of clients and their families, which is critical in meeting the vision of “Better Health for All.” The direct linkage with the executive management level will provide immediate awareness and action to address any conditions or barriers in providing these services in the most culturally appropriate, person-centered and family-supportive manner.

This new system of integrated services under the DBHS will need a refined and broader structure to ensure proper operations oversight. This will include oversight of the operations within the various service elements, close monitoring of client revenue and overall budget expenditures. Additionally, there will need to be continued work through the respective state-level Mental Health and Substance Use Disorder associations to push for additional expansion of BH services through the California Department of Health Care Services (DHCS) and to improve the local control of policies and implementation of BH community services. In addition to the responsibility areas highlighted above, the executive managers will need to perform more high level work in relation to health plan development, consumer and family affairs, and workforce development.

L. Supportive Housing

The MHD currently hosts the countywide Office of Housing and Homeless Support Services (OHHSS), which coordinates efforts to end homelessness and develops programs to meet the housing needs of extremely low income individuals and families, including those with special needs. Housing stability is a critical need; it is the foundation for wellness and recovery from mental illness and addiction disorders. The OHHSS currently manages several MHD-specific
housing programs. Through the consolidation, some of DADS’ housing functions (e.g., oversight of Transitional Housing Units) will be overseen by OHHSS. The OHHSS also will be tasked with coordinating with the service division and quality improvement to assess the effectiveness of various housing interventions for the Behavioral Health Division’s various subpopulations. Over time, these actions will lead to more effective supportive housing programs and improved housing stability for individuals with mental illness and/or addiction disorders.

The consolidation of housing functions within the DBHS mirrors a broader Countywide effort. The County Administration, under the leadership of the Chief Operating Officer, is working with the Board of Supervisors to redefine the County’s role in developing and providing housing. The Administration has proposed that the County’s housing mission be to create and preserve housing that is *affordable and available* to extremely low income and special needs households in the region to increase the effectiveness of County health, social and criminal justice services. Through this renewed effort, housing programs will be coordinated with County departments and services. The intent is that the County will be in a position to better address the housing needs of its clients by leveraging County services, by strategically using County housing resources, and by partnering with cities, government agencies, developers, service providers and the business community. To achieve this, the County Executive is recommending that the Office of Affordable Housing (OAH) and the OHHSS be consolidated to form the Office of Supportive Housing (OSH) within the new DBHS. While supported by the DBHS administratively, the OSH would receive general direction from the County’s Chief Operating Officer and will support all County departments and initiatives, including the Office of Reentry Services and the Seniors Agenda. The new OSH would support four goals.

**Goal 1**: Increase the supply of and access to affordable housing units in the region for extremely low income (ELI) households.

**Goal 2**: Increase the supply of supportive housing programs with direct access for special needs populations such as at-risk youth, chronically homeless, victims of domestic violence, homeless, persons with disabling conditions, mentally ill, seniors and those individuals re-entering the community from the criminal justice system.

**Goal 3**: Lead and support regional collaboration and coordination of countywide housing efforts and resources to maximize outcomes.

**Goal 4**: Take a leadership role in the creation of a regional body that will improve housing outcomes and more efficiently utilize limited resources available for this purpose.

Working within the County and externally, the office’s key responsibilities would include:
• Developing, implementing and coordinating supportive housing and homeless and homelessness prevention programs;

• Facilitating the development of housing affordable to extremely low income households;

• Managing and maximizing County-funded affordable housing development and rehabilitation programs, Housing and Community Development (i.e., CDBG and HOME) grant functions, the OAH’s current and future loan portfolio;

• Implementing countywide housing policies and priorities;

• Serving as the primary planning body for coordinating, evaluating and improving homeless services in the County;

• Supporting countywide and regional planning efforts; and

• Recommending policies to the Board that would advance the County’s housing mission.

M. Medical Functions

In addition to the Addiction Medicine and Medical Partnerships described in the section on Primary Care-Based Services, the DBHS Medical Division will coordinate Medical Policy and provide Physician Oversight.

The DBHS medical executive leadership is responsible for providing medical and clinical leadership for all Behavioral Health Department programs and setting the standard for state of the art clinical care for the system. The two Medical Directors report to the Chief Medical Officer of Santa Clara Valley Health and Hospital System and provide direct administrative and clinical supervision of fifty psychiatrists and physician extenders working in primary care-based FQHC clinics, specialty mental health adult and older adults programs, criminal justice programs and family and children services, as well as inpatient, emergency psychiatric services, and mental health urgent care programs.

The Medical Directors chair the monthly Psychiatric Practices committee and the quarterly Medical Directors meetings, which set the medical standard of care for both County-operated programs and contract agency-operated programs. They also chair the Utilization Review Committee, which reviews appropriateness for continued hospital stay at Barbara Arons Pavilion. The Medical Directors represent the Psychiatry Department at Santa Clara Valley Health and Hospital Medical Executive Committee and liaison and coordinate care closely with Valley Medical Center departments, Custody Mental Health Services Department, Public Health Department, and health plans. They have a strong presence at the state level, as the most
recent Co-Chair of CMHDA Medical Services Committee, which influences and helps to set medical and clinical practices statewide.

**N. Quality Functions**

It is proposed that four quality related functional areas in each department be consolidated. Those include Quality Improvement, Decision Support, Data Management, and Research and Evaluation. The following chart provides an overview of the proposed organization of the Quality Functions of the new DBHS.

**Process and Rationale**

These functions will operate inter-dependently as the Behavioral Health Department “Quality Circle” (BHQC). The rationale for the BHQC is based on the pursuit of the triple aim goals within a Behavioral Health Continuum of Care. To deliver the triple aims, the BHQC approach to health care delivery is based on several fundamental principles: direct customer/client feedback is essential to continuous quality improvement, measured fidelity to EBPs, data-informed decision making at all levels of the organization, “no wrong door” access to services, and systemic level coordination of care. By inter-dependently linking data integrity, business intelligence, data-
based program evaluation, and quality improvement efforts, the BHQC outputs will represent a data-driven, system-wide approach to the triple aims.

The BHQC structure will focus on utilization and population-based data to drive multiple Quality Improvement initiatives. Utilization data will drive Care Coordination activities. Direct client assessment of their treatment experience will drive Clinical Quality Improvement initiatives along with the more traditional clinical outcomes data. Population-based data analysis will drive efforts to provide system-wide treatment planning and coordination of all health services for specific groups of clients (e.g., integration with primary care and inpatient providers). Because the BHQC will rely on exploiting the overlaps between the four functional areas rather than rigidly “silo-ing” the four units and their staff, the BHQC will operate on a project management-based organizational structure. Utilizing the PQIC methodology recently developed by the MHD for CQI efforts, the BHQC is structured to monitor the chosen integration framework of the three separate tracks (MH only, SUD only, and Integrated Treatment Services) using specialist QA staff to ensure regulatory compliance with the distinct payor structure that is the present and near future of behavioral health service delivery under the ACA in California. The flexibility of the BHQC will allow for monitoring regulatory and billing compliance while being able to focus more broadly and systemically on utilization-based care management.

The implementation of the CoCentrix CCP (“Coordinated Care Platform”) Electronic Health Record provides the data collection infrastructure that supports this flexible and data-driven approach. The CCP product leverages Microsoft technology to create data sharing across multiple electronic platforms for the purpose of integrating multiple care efforts by different providers on behalf of a single client. This gives the Behavioral Health Department the technological advantage of integrating disparate data on the same client so that systemic-level treatment planning will be sensitive to the client’s needs as well as enabling the system to provide integrated health solutions that are both outcome and cost oriented. In addition, a Business Intelligence/Data Warehouse solution is being integrated into the EHR implementation. This will provide management with varied and timely process outcome reports (dashboards) that support the data-driven objective of the BHQC. The implementation is scheduled to run concurrently with the implementation of the two departments and has been structured to include assessment of the business needs of the future Behavioral Health Department (including coordinated care of co-occurring clients and integration of health care services with primary care providers) so that the EHR will be a seamless support to the business and clinical staff.
O. Consumer and Family Affairs

The Consumer and Family Affairs work group is currently being formed with the intent of strengthening the department’s ability to be a client-focused, family-driven service delivery system. Implementation planning will support the expansion of the office in scope, staff and responsibility. Clients and family members will be infused throughout the system in leadership, managerial, clinical, clerical, advisory and oversight roles. Since it will be critical that there be a strong interface between the Office of Consumer and Family Affairs and senior leadership, we will be seeking to elevate leadership of the office to place them in direct report with the Behavioral Health Department Director.

P. Training and Workforce Development

The Training and Workforce Development Work Group met and determined that a separate division is needed to support the needs of a Department of this size and diversity. It will be important to include clerical, clinical and peer staff in the training plan development to insure that the training needs of all the staff are met. The training plan will need to support the integrated model by insuring that staffs are competent in the delivery of SUD and MH services. By working closely with the Quality Circle, the delivery and impact of the provided trainings should be monitored closely to determine if the desired outcomes are being achieved.

The Training and Workforce Development Division also will focus on strengthening the Department’s ability to be culturally and linguistically competent. This will include developing policies and procedures which support the recruitment of a diverse workforce such as intern programs, community recruitment efforts, and scholarship programs. In addition, the Division will develop morale and communication strategies which will improve the retention of skilled staff at all levels.

Q. Finance and Contracts

The chart below outlines the proposed structure for the integrated Financial Services functions of the new DBHS. Five financial accounting areas are identified: Planning, Revenue Cycle, Contract Medi-Cal Services, 24-Hour Services, and Mental Health Services Act Services.

Process and Rationale

Since April 2013 the Budget Fiscal Support and Contracts Work Group has been meeting to discuss a framework for behavioral health services integration as it affects both DADS and the MHD. These Work Groups, comprised of subject matter experts from both departments,
include staff overseeing grants, financial monitoring, appropriation modifications, financial planning, revenue cycle and reporting functions, DADS contracts, MHSA contracts, SDMC contracts, 24-Hour Care contracts, Fee-for-Service contracts, and contract solicitation processes. The Work Group aims to: (1) Create a seamless and efficient organization that addresses budget/fiscal and contracts support needs of a merged department, (2) Consolidate financial accounting structure and constricting timeframe for payment, and (3) Consolidate contract functions to improve efficiencies and reduce redundancies.

Project management tasks included reviewing goals for a merged finance and contracts support structure, developing a current picture of the budget/fiscal and contracts support functions and operations in each department through an inventory of existing documentation on staffing resources, job functions, and business workflows, and surveying other county Behavioral Health departments. This enabled a process to identify the resource needs of the combined finance and contracts structure and address commonalities as well as differences in the two departments. It included a review of combined structure roles and responsibilities, developing an approach based on identified functional areas of combined Finance and Contracts divisions, reviewing specific tasks pertaining to a phased implementation, and developing an operational
approach for implementation to develop a recommended functional structure which would evolve in phases toward a merged organization. The two functional areas under a merged department would be Behavioral Health Financial Services and Behavioral Health Contracts Management. The Behavioral Health Financial Services division will have additional tasks relating to the recommended financial accounting structure for the entire consolidated behavioral health organization.

R. Administration

Four functional areas are identified that comprise Administrative Services functions: Human Resources/Personnel Management; Administration Support/Operations/Custodian of Records; Contracts Management/RFP Coordination; and the Behavioral Health Advisory Board. The chart below outlines the key components under each of the four functions:

![Administrative Services Diagram]
**Process and Rationale**

Since April 2013, the Administrative Services Work Group has been meeting to discuss a framework for behavioral health services integration as it affects administrative services and contract administration services for both DADS and the MHD. These Work Groups, comprised of subject matter experts from both departments, include staff overseeing Human Resources/Personnel Management, Administrative Support/Operations/Custodian of Records, MHD Advisory Board, and Compliance/Privacy functions.

The Work Group aims are to: (1) create a seamless and efficient organization that addresses administrative support needs of a merged department, consolidating Human Resource functions to promote timely recruitment and filling of positions; (2) coordinate and combine Labor Relations/Equal Employment Opportunity/Workers Compensation/Risk Management functions to ensure appropriate response to workforce members consistent with County policy and procedure, and; (3) coordinate Facilities/Space/Security/Safety and other administrative functions of the combined departments to ensure appropriate response to workforce members consistent with County policies and procedures.

Project management tasks included reviewing goals for a merged administrative structure, developing a current picture of administration services operations in each department through an inventory of existing documentation on staffing resources, job functions, and business workflows. This enabled a process to identify the resource needs of the combined administrative structure and address commonalities as well as differences in the two departments. It included a review of combined structure roles and responsibilities, developing an approach based on identified functional areas of a combined administration division, reviewing specific tasks pertaining to a phased implementation, and developing an operational approach for implementation to develop a recommended functional structure for Administrative Services operations which would evolve in phases toward a merged organization.
VII. IMPLEMENTATION

A. Phased Approach

The Behavioral Health Integration planning is organized in two phases, from planning to implementation. As outlined above, the planning has involved consultations with a range of internal and external stakeholders, a coordinated process of work group efforts guided by a Steering Committee and Executive and Division Directors Group. The planning milestones engaged these groups in articulating specific service delivery objectives as well as finance, quality and administrative responsibilities, structures and protocols. The Integration Implementation Plan will help the new Behavioral Health department provide integrated systems of care using an integrated staffing, treatment and training approach. The implementation milestones focus on creating the leadership structure, establishing key functional operations, initiating the integrated treatment model and conducting performance measurement.

B. Communication Task Force

A Communication Task Force will be convened in the early stages of implementation to plan and implement communications to inform all staff and stakeholders of the approach, timing and responsibilities for all aspects of integration. Since integration will happen over time in phases, it will be critical to communicate how functional operations will change and when.

C. Labor Management Task Force

As described earlier, a Labor Management Task Force will be established to include members of all bargaining units impacted by the integration. This group, along with staff from the Employee Services Agency, will identify aspects of the implementation process that require formal meet and confer processes or other actions and will take appropriate steps to initiate those processes in collaboration with Labor Relations.
How Does Integration Occur

- **Two Planning Phases**
  - Study and Design
  - Implement

|-----------|--------------|--------------|-----------|
- Establish Leadership Team
- Convene Steering Committee
- Establish planning structure
- Establish Workgroups
- Determine key functions
- Agree on aim/vision/goals
- Decide on approach
- Assess key functions
- Draft design integrated functions
- Steering Committee endorsement of key function designs
- Key functions built into draft plan
- SC endorses draft plan design
- Board approval of design plan and initiation of implementation
- Detail implementation plan
- Initiate Labor/Management Task Force
- Initiate Contractor Task Force
- Build Stage 1 into Mid-Year process
- Implement Stage 1
- Build Stages 2 & 3 into FY15 Budget process

Behavioral Health is Essential to Health
Prevention Works
Treatment is Effective
People Recover