Santa Clara County Behavioral Health Integration
Implementation Progress Summary
May 30, 2013

Work Group And Co-Chairs	Progress Made	Actions or Milestones to be Completed by August	Gone Well or Smoothly	Not Gone Well; Barriers Encountered	Waiting for Additional Input to Move Forward
Access and Referral ▪ Noel Panlilio ▪ Sandra Hernandez	▪ Access and Referral Integration Workgroup continues to meet and have discussed the consolidated call center future workflow which includes Suicide and Crisis Services (SACS) ▪ The workgroup has also discussed the different registration questionnaires (demographic Screening questions). This includes DADS Referral for Service Client Demographic Questions, MHD OD Screening Scripts, and the AC-OK-COD Adolescent Screen. ▪ Co-location has also been discussed.	▪ DADS SHSR and MHD Decision Support staff will review in detail the demographic questions, determine the order of each question and look into the possibility of adding/revising/deleting questions in the Unicare System until such time that Cocentrix will be utilized ▪ Development of a consolidated Demographic Screening/Registration questionnaire. ▪ Feasibility of Co-location of Behavioral Health Services staff ▪ Telephone system that will be utilized (Cisco vs. NEC)	▪ Workgroup with adequate representation continues to meet and discuss. The workgroup is made up of line staff, managers, and includes labor representation. ▪ Staff on both call centers are constantly being updated during staff meetings	▪ Co-location has to be decided by management (move with Valley Connections?)	▪ Since DADS Gateway Staff will be moving with Valley Connection, the idea came up if MHD Staff can also move for co-location purposes until such time that BHS has its own location at Clove Drive. ▪ Telephone capability for Cisco since it has been decided that Cisco is the preferred system.
Quality Circle ▪ Deane Wiley, Co-Chair ▪ Michael Hutchinson, Co-Chair ▪ Kakoli Banerjee, Co-Chair	▪ Developed a staffing plan for the Data Management division. This was a group that did not exist formally prior to the integration but is seen as critical to the successful business needs of the integrated department both during the integration and into the future. It was integrated with the resources required for the CoCentrix EHR project. ▪ The Quality Improvement Division has been	▪ Discussions with HHS IS are now on the table to work out a Service Level Agreement with IS to cover the MIS business needs for the Behavioral Health Department. That work is on-going and is the prelude to the actual staffing/creation (go-live) of the Data	▪ The two QI staffs interact directly and fearlessly with each other based on their respective commitments and values to maintaining quality in their current departments There is much more to be discussed and resolved.		▪ Need approval of staffing plan ▪ Combined space is a goal but the group has agreed that they do not want to make multiple moves and that they are strongly supportive and excited about the Quality Circle model and do not want to move without their data

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QI, Continued	meeting regularly to learn about the integration model. Kakoli has been providing those trainings. Additionally we have met to share/familiarize each other with how each department actually "does" QI. The two QI departments operate very differently in significant ways. We have been discussing how those "nuts and bolts" are going to come together in an integrated department. These discussions are at the level of the QICs: what and how and why an integrated Behavioral Health QI department will operate ▪ The Decision Support division of the Quality Circle has not received much work/attention since we last presented. Its functions are essentially similar between the two departments and the staffing will remain the same so it is largely complete. ▪ Research and Evaluation unit. There is no counterpart on the MH side to this unit, so the key issue is staffing. Unit currently has only contract staff, who may leave after the grants run out.	Management group. ▪ We have decided that our integration will begin by looking more separate than integrated so that we keep our current respective missions and responsibilities covered (there are a number of regulatory, QA tasks that cannot slip through the cracks) and that we will pick specific projects to begin to share and cross-train on and start operating as an integrated department. ▪ This approach was deemed the most rational, sane, and practical by all QICs. It will likely look like Michael Hutchinson moving back and forth between the two departments. That is our model and we are planning to start this mobile integration July 1st.			counter-parts.
Administration ▪ Pat Garcia, Co-Chair ▪ Laura Luna Co-Chair ▪ Martha Paine, Co-Chair (Finance)	▪ Preliminary plans have been developed with the two administrative operations to integrate by FY15. In preparation, for this integration the departments will be developing uniform administrative policies and procedures, consolidated human resources (HR) functions and proceeding with development of a unified contract renewal system that would be utilized in the integrated Request for Proposals (RFP) process scheduled for the Family & Children	▪ The only item for Admin integration is the common contract boilerplate and RFP process that we need to develop by Jan 2015. ▪ Also, as requested by CEMA/SEIU and accepted by Executive Management, there will be a separate and additional meeting to review	▪ Nothing at this point; it has all been very challenging.	▪ The Administration unit may be more impacted by being asked to perform work for both Departments without a clear understanding of the final shape of the organization than other units. ▪ In addition, we have	▪ Need input from Executive Management about plans for administration integration. This meeting has not occurred yet. ▪ We also need his feedback about how to reconstitute the committees so that they incorporate DADS managers on a more equal basis with

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Administration, Continued	system in October 2014 and the Adult system in January 2015.	the challenges for Administration, both to integrate and overcome the Countywide issues with recruitment and systems for tracking/position control. This meeting is yet to be scheduled but should be happening soon. ▪ Finance staff are working closely together on several projects related to year end closing.		been requested by our bargaining units to not make any significant changes in Administration without providing notice to them and providing them the opportunity to meet and confer.	MH managers and so that there will be a DADS co-chair identified.
Children & Families ▪ Sue Nelson ▪ SherriTerao Children and Family Services,	Juvenile Hall Integration: ▪ Joint team meetings have been implemented ▪ Space planning is being finalized which will integrate both Juvenile Hall Teams by end of June 2014 ▪ Joint team will report to Interim Juvenile Hall Manager, Lauren Gavin AC-OK Screening Tool ▪ Pilot testing of AC-OK screening tool was completed last winter in Sunnyvale and Juvenile Hall DADS screening unit ▪ Youth surveyed indicated that they liked the screening tool and did not have any concerns with completing this ▪ Clinicians reported the tool was helpful in identifying concerns related to mental health, substance use, and trauma ▪ Work group is continuing to refine the AC-OK tool to meet the needs of Santa Clara County	▪ Pilot testing of AC-OK with Call Center ▪ Developing draft integrated assessment ▪ Development of co-occurring training tracks and certification process	▪ Partnership with 521 SEIU on the Juvenile Hall integration was a positive process. We met regularly and union stewards and 521 representatives were helpful and supportive of the integration process. ▪ Team work and work groups focused on screening, assessment, and training have made significant progress. These work groups model partnership and collaboration in their approach and through development of work products. We greatly appreciate their help in moving the work forward!	▪ Some time lags here and there, but overall we have continued to make positive progress.	▪ No, we are proceeding with our integration planning components and continuing to promote and support integration where possible.

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Continued	clients and developing a script for administration of the device including instructions on client scoring and exceptions to confidentiality to be provided to the youth and their caregiver at the time of administration. ▪ Call Center piloting of AC-OK is pending Joint Assessment Work Group ▪ Work group has been meeting regularly that includes a MHD manager, DADS Clinical Lead and QI team members. ▪ Goals include: 1) To develop an assessment which will be comprehensive and inclusive of MH and substance abuse/dependence problem areas while also being user friendly so that there is a natural flow from one section to the next. 2) To prevent an increase in clinician time to complete the assessment process (brevity) and to develop an algorithm process which allows the clinician to explore further details of the client's concerns once the broader picture is complete.				
Primary Care-Based Services ▪ Mark Stanford, PhD, Chair ▪ Tiffany Ho, MD, Co-Chair ▪ Sandra Hernandez Primary care-Based Services (continued)	▪ Primary care based behavioral health teams provide ongoing psychiatric services, time limited therapy using Problem Solving Therapy (PST), and SBIRT (screening, brief intervention and referral to treatment) to patients at several ambulatory clinics, including the Valley Homeless Healthcare Program and Heart Failure program. ▪ The psychiatry department has held several grand rounds regarding substance use disorders training. The psychiatrists have also provided consultation to primary care providers regarding treatment of common	▪ Since January 2014, psychology services have also been provided at the Cancer Center to patients with significant medical issues. Currently, a Psychiatric Nurse Practitioner is being recruited for the Tully Clinic to expand behavioral health services.	▪ Several screening tools including the PHQ-9, GAD 7, and CAGE-AID are built into HealthLink for ease of use. ▪ LCSW staff mtg.'s have recently included Ambulatory Care Leadership. ▪ BH clinics are now referred to as Primary Care Behavioral Health vs. FQHC's. A PCBH	▪ Barrier: LCSW's in Ambulatory Care continue to be supervised by MH manager staff.	▪ LCSW's in Ambulatory Care continue to be supervised by MH manager staff. Leadership is in both MH and PCBH.

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	behavioral health conditions.		brochure has been approved and is now being used at Primary Care clinics by PCP's for internal use only when referring to PCBH. ▪ The psychiatry department has held several grand rounds regarding substance use disorders training. The psychiatrists have also provided consultation to primary care providers regarding treatment of common behavioral health conditions.		
Communication ▪ Deane Wiley ▪ Sue Nelson ▪ Carolyn Verheyen ▪ Joyce Abrams	▪ An e-newsletter was designed and three e-newsletters have gone out to all staff ▪ A draft communications outline was developed ▪ An FAQ was created and posted to the website	▪ A more formal communications plan will be drafted with messages, reach methods and phasing for implementation ▪ A series of e-newsletters will be sent out regularly over the next several months reporting on progress as identified in this matrix.	▪ The e-news masthead was created efficiently and quickly.	▪ There were a few technical glitches caused by sending the e-news out from off-site ▪ Difficult to find progress to report ▪ Difficult to find answers to some questions due to lack of info or decisions made	
Adults & Older Adults ▪ Gabby Olivarez ▪ Cheryl Berman	▪ Discussed staff training needs associated with the approved Integration Plan ▪ Discussed billing Drug MediCal and need for CAADAC credentials for staff	▪ Identify which clinics would have integrated treatment specialist who may or may not be part of a treatment team, but have the qualifications and training to tackle both issues	▪ Discussion regarding the most appropriate programs to pilot for integration. ▪ DADS agreed to work with MHD to develop a Mobile	▪ Discussions under way regarding the differences between Drug MediCal & Short Doyle MediCal & how to bridge & integrate both	▪ Training/pilot programs will need to be determined at a later date as discussion regarding implementing ITS Models etc. is still premature ▪ MRT Training is underway for

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		▪ Discuss how to cross train and work together with physicians ▪ Identify one or two clinics that will be ready to go and properly staffed (there would need to be an ITS on site)	Treatment Van which will work with Criminal Justice & Homeless Populations to provide integrated mobile treatment services. ▪	types. ▪ DADS & MH are so large and complex that discussions are to beginning pertaining to different staffs' roles, responsibilities, certifications, as well as trainings required for staff to reach a level of competency in order to deliver services effectively and efficiently. ▪ MD will need to be certified to prescribe certain medications for detoxification services, and sobriety maintenance.	staff involved with criminal justice presently. Although this model can be used with CalWORKs and SMI population, particularly those in inpatient. Has been tested for 25 years with very good outcomes. Focuses on co-occurring substance abuse and mental health.