

ACA: Opportunities for Improved Health Outcomes

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Opportunities for Improved Health Outcomes under the ACA

- ▶ Integration of primary care and behavioral health
 - ▶ Healthcare Quality Control
 - ▶ Chronic disease self management
 - ▶ Fewer uninsured
 - ▶ Integration of public health with healthcare
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Drivers for Integration of Primary Care and Behavioral Health

- ▶ Provision of comprehensive healthcare to clients
 - Behavioral health and physical health intertwined
 - Care of “whole person”
- ▶ Overlap of patients
 - Majority of mental health clients & substance abuse clients also have physical health issues
 - Mental health issues frequently accompany physical health issues (esp. with chronic disease)
- ▶ Mental Health Parity and ACA

Solano County Clinics

- ▶ Common Electronic Medical Record: NextGen
- ▶ Are Federally Qualified Health Centers:
 - Primary Care and Pediatrics – 19,366 clients in 2013, all County clients
 - Dental Health – 15,069 visits in 2013, 64% for County clients
 - ICC (Adult Mental Health) – 13,659 visits in 2013, 52% for County clients
 - Total unduplicated clients receiving services in County FQHC clinics in 2013 = 25,890
 - ICCs no longer in FQHC (per DHCS)

Behavioral Health Services

- ▶ Electronic Medical Record: Avatar/Netsmart
- ▶ Mental Health services:
 - Child Psychiatry
 - Access Program – Triage and referral services
 - Managed care for Mildly & Moderately Mentally Ill
 - Case management & ICCs for Severely Mentally Ill
 - Crisis Stabilization Unit (<24 hour hold)
 - Inpatient care (via contractors)
- ▶ Substance Abuse services:
 - County screens clients
 - All treatment via contractors

Integration of Mental Health & Substance Abuse into Primary Care

- ▶ LCSWs located in each Primary Care Clinic
- ▶ Interface directly with Primary Care Providers
- ▶ Pediatrics Clinic interfaces with Children's Mental Health Clinic (same building)
- ▶ Screening of clients for SA & MH risk by Providers
 - SBIRT, Beacon tool
 - -> LCSW referral -> triage for MH & SA services
- ▶ PC Providers trained on MH meds
- ▶ PC sees mildly and moderately mentally ill

Integration of Primary Care into ICCs (Adult Mental Health)

- ▶ Built treatment rooms in ICCs
- ▶ Mid-Level Primary Care Providers (RNP or PA) in ICCs
 - ~ 0.5 FTE per ICC, will grow as needed
 - Interface directly with Psychiatrists and LCSWs
 - Same Providers as for Mobile Primary Care Van
- ▶ Document in common EMR (NextGen)
 - Common EMR also makes dental care easier
- ▶ Engage in client-centered case conferences with ICC team

Integration, cont.

- ▶ Introduced Medical Assistants into ICC model
- ▶ Mid-Level Primary Care Providers see:
 - ICC clients with acute physical health issues, regardless of assigned primary care provider
 - ICC clients assigned to Solano County for primary care by appointment for primary care
 - MH and PC visit can now be same-day
- ▶ To date (since late 2013), have provided over 1000 primary care encounters to over 400 ICC clients

Integration, cont.

- ▶ PC and MH MDs coordinate on meds for client
 - Can result in fewer side effects and medication interactions
 - Can result in lower doses, esp. for narcotics
- ▶ Major health conditions seen by PC in ICC clients:
 - Diabetes, hypertension, cardiovascular disease, COPD, chronic pain, etc.
 - Often poorly controlled or uncontrolled initially
- ▶ On occasion, can impact patient's diagnosis
- ▶ Allows stable ICC clients (SMI) to be shifted to PC clinics

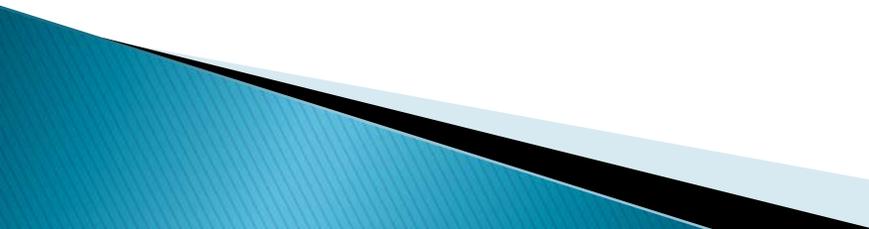
Integration, cont.

- ▶ LCSWs from PC clinics and ICCs working together
- ▶ Using Healthcare for the Homeless Program mid-levels for ICC primary care because of client overlap
- ▶ Supplement with satellite homeless shelter care (for PC and behavioral health)
- ▶ Issues:
 - Duplicate data entry (NextGen & Avatar); need HIE
 - Keeping costs and funding streams clean (FQHC vs. Short-Doyle)

Healthcare Quality Control

- ▶ Managed Care Plan quality measures
 - Provide financial incentives to providers
 - ▶ Have added pediatric and adult immunization measures
 - ▶ Considering additional public health measures
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Chronic Disease Self-Management

- ▶ Training of clients and volunteers to conduct chronic disease self-management classes
 - ▶ Self-management classes provided to clinic clients
 - Diabetes
 - Hypertension
 - Others planned
 - ▶ Supplements medical care and case management services
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Fewer Uninsured

- ▶ Increase in Medi-Cal clients at County clinics, for primary care, dental health and mental health (due to Medicaid expansion)
 - ▶ Covered California clients accessing multiple providers for healthcare
 - ▶ Still have residual uninsured
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Public Health Integration with Healthcare

- ▶ Sharing data and picture of “community health”
- ▶ Overlapping case management services
 - “frequent users” of emergency rooms
 - Public health nursing services
- ▶ Upstream interventions with quick ROI
 - Prevention of falls in the elderly
 - Evidence-based home visiting programs for fragile families (e.g. NFP)