Contra Costa Mental Health System of Care Needs Assessment

Mental Health Services Act (MHSA)

Three Year Program and Expenditure Plan
Fiscal Year 2017-20

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Needs Assessment

- Data driven quantitative analysis to supplement the MHSA Community Program Planning Process for FY 2017-20
- Addresses three areas of inquiry - is Contra Costa Behavioral Health Services (CCBHS):
  - Serving the people it should?
  - appropriately allocating its resources to provide a full spectrum of care?
  - experiencing any significant workforce shortfalls?

1. Serving Target Population?

Method

- Compare the estimated number of Contra Costa County individuals who are poor and experience serious mental health issues with the number served by CCBHS (prevalence rate)
- Compare the proportion of actual total Medi-Cal eligible clients who access CCBHS services by County regions (West, Central, East) as well as by race/ethnicity, age group and gender, and compare to statewide averages for the same population (penetration rate)

Prevalence

- 1,126,745 = total Contra Costa County population in 2015
- 19,878 or 8.13% = estimated prevalence of individuals at or below 200% of the federal poverty level with serious mental health issues
- 19,733 = total Medi-Cal eligible clients served by CCBHS in 2015, or 99.3% estimated prevalence
- 99.3% represents an increase from 77% in 2013.

Penetration Rate

- 19,343 = total Medi-Cal eligible population served by CCBHS in 2014
- 254,658 = total Medi-Cal eligible population countywide in 2014
- 7.6% penetration rate for Contra Costa
- 5.2% statewide penetration rate

Penetration Rates

Contra Costa compared to statewide average:

- Race/Ethnicity – Contra Costa's penetration rates exceed the statewide average in every category except those self-identifying as "Other" (1.7% to 6.1%)
- Age Group – Contra Costa exceeds the statewide average for every age group except ages 0-5 (1.7% to 2.5%)
- Gender Identity – Contra Costa exceeds the statewide average for every self-identified gender.

Penetration Rates within County Regions (2014)

	West	Central	East	County	Statewide
Total	7.6	9.1	7.9	7.6	5.2
By Race/Ethnicity:					
African American	12.1	25.9	11.8	12.1	9.1
Asian/Pacific Islander	2.7	3.0	2.6	2.7	2.9
Caucasian	15.3	16.7	15.9	15.3	8.5
Latino	5.2	5.2	4.8	4.8	3.6
Native American	22.2	23.8	28.4	22.2	8.1
By Age Group:					
0-5	2.4	1.6	1.7	1.7	2.1
6-12	6.6	6.6	6.8	6.6	6.5
13-17	11.8	13.7	11.8	11.6	N/A
18-21	6.1	10.5	7.3	7.0	6.2
22-59	9.7	12.2	10.5	9.9	N/A
60+	5.5	5.7	5.5	5.4	3.1

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Discussion

- Data analysis supports that the number of clients served by CCBHS approximates the estimated number of individuals requiring services
- Contra Costa serves Medi-Cal eligible clients at a rate higher than the majority of counties in California.
- Regions and sub-populations within the County are generally appropriately represented
- Persons who identify as Asian/Pacific Islanders, Latina/os, children under the age of five, and adults over 60 appear to be somewhat underrepresented in each region.

2. Allocating Resources Appropriately?

Method

- Grouped CCBHS FY 2015-16 expenditures by LOCUS/CALOCUS levels of care definitions and compared to funding allocation benchmarks established by “A Model for California Community Mental Health Programs”, published by the Mental Health Association of California.
- Levels of care include locked facilities, 24 hour community care, outpatient services for the seriously mentally ill, therapy, outreach and engagement and training/staff development.

Results

Level of Care	Expenditures	Percentage	Recommended Percentage
Locked Facilities	$38.9m	22	17
24 hour Community Care	43.8	24	33
Outpatient Services for SMI	42.3	24	22
Therapy	45.7	25	22
Outreach and Engagement	8.0	4	5
Training/Staff Development	.6	.3	1
	Total: $179.2m	100	100

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Discussion

- The full spectrum of mental health services is made available, as significant resources are allocated at every level of care
- Expenditures indicate that more funding is provided at the most acute level of in-patient care (locked facilities) than is ideally recommended, while
- High intensity community based services, to include 24 hour residential care, appear to be below the recommended benchmark
- Workforce development, to include recruiting, training and retention efforts appear to be underfunded

3. Significant Workforce Shortfalls?

Method

- Staff vacancies reviewed to determine focus of analysis of staff position shortages - revealed a significant lack of available psychiatry time
  - Analysis of authorized versus filled positions
  - Comparison of psychiatrist pay with neighboring county mental health programs
- Staff demographics compared to county demographics to determine any significant variances
- Bi-lingual pay differential and interpretation services reviewed for staff capacity

Psychiatry Time/Pay

Psychiatrist Full-Time Equivalent Positions (FTEs)

County:	authorized = 18.925	filled = 8.175	% filled = 43
Contract:	authorized = 25.035	filled = 21.35	% filled = 85
	Total: 43.96	29.525	67

Annual Psychiatrist Mid-Range Salary

Alameda:	$194,191
Marin:	170,348
San Francisco:	208,087
Solano:	210,051
Average:	$195,669

Contra Costa: $155,498

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Demographics/Bi-Lingual Capacity

Race/Ethnicity	County Population	Consumers	County Staff
White	49%	36%	46%
Hispanic	24	18	11
African American	9	30	19
Asian/Pacific Islander	14	6	7
Native American	.4	.6	.4
Other	4	9	16

- Staff receiving bi-lingual pay in 2010 = 74; in 2015 = 90
- 75% of requests for language interpretation now provided by telephone or video Healthcare Interpreter Network

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Discussion

- Significant shortage of psychiatrists contribute to compromising mental health care
- Contra Costa pays psychiatrists significantly less than neighboring counties
- County staff identifying as Latina/o and Asian Pacific Islander are underrepresented when compared to all county staff
- County staff receiving differential pay for bi-lingual capacity are increasing.
- Interpretation services appear to be available to meet the needs of clients when bi-lingual staff are unavailable

Summary

- CCBHS is reaching the target population it is mandated to serve; penetration rates are greater than the statewide average, and are consistent across county regions
- Sub-populations of Latina/os, Asian Pacific Islanders, children up to age five, and adults over the age of 60 have slightly lower penetration rates than other sub-populations
- CCBHS is apportioning its funding to provide a full spectrum of services, while spending more than the recommended benchmark for locked facilities, and less on intensive community based services
- There is a significant shortage of psychiatry time that appears to be due in part to lack of pay parity with neighboring counties

Recommendations

Suggest CCBHS:

- strengthen outreach and engagement strategies for the underserved populations of Asian Pacific Islanders, Latina/os, children ages 0 to 5, and adults over 60.
- Improve capacity to assist consumers move from higher levels of care, such as locked facilities, to lower levels of care in the community
- Explore strategies for increasing psychiatry time, such as increasing county psychiatry pay and contract rates, and establishing workforce incentives, such as loan forgiveness programs

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Study Limitations

- This assessment of need does not assess the quality of care provided to consumers
- Prevalence benchmarks are approximate calculations, not exact figures
- Numbers of clients served may have included some who may not have met medical necessity
- Client and service data are based on billing records, not mental health records, as CCBHS does not have an electronic health record system
- Individuals served by most contract Prevention and Early Intervention programs are not included in the penetration rate data, as these programs do not enter client data in the PSP/INSYST billing system
- The expenditure benchmarks recommended by the Mental Health Association of California were established in 1981, and may not accurately reflect the impact of the movement to decrease institutional services and increase community-based outpatient services
- Some programs listed for one level of care may actually be providing services to clients representing more than one level of care
- Levels of care 4 and 5 was combined, as was levels 1 and 2 due to many programs providing both levels of care and making it difficult to attribute expenditures to a single level of care.
- Staffing demographic data was taken directly from FY 2010-13, and may not accurately reflect today's demographics