Contra Costa
Health Services

CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

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The Mission Statement of the MHSA/Finance Committee: In accordance with our mandated duties of Welfare & Institutions Code 5604, and aligned with the Mental Health Commission's MHSA Guiding Principles, and the intent and purpose of the law, the MHSA/Finance Committee will work in partnership with all stakeholders, all community-based organizations and County providers to review and assess system integration and transformation in a transparent and accountable manner

MHSA/Finance Committee Meeting

Thursday August 17, 2017 ♦ 1:00-3:00 pm

2425 Bisso Lane, Concord

Second floor conference room

AGENDA

I. Call to order/Introductions

II. Public Comment

III. Commissioner Comments

IV. Chair Announcements

V. APPROVE Minutes from July 20, 2017 meeting

VI. REVIEW 2017 Committee goals and DISCUSS the areas of focus in order to obtain the desired goals.

VII. DISCUSS the Contra Costa County Budget for Mental Health and identify the accomplishments for 2016-2017.
***To obtain a copy of the Contra Costa County 2017-2018 budget, please copy and paste the link below-**
file:///S:/Mental%20Health/Admin/EXEC%20ASST%20TO%20MHC/MHSA-FINANCE%20COM/28634_FY%202017-18%20Recommended%20Budget%20-%20Final3%204-18-17.pdf

VIII. DISCUSS recent Grand Jury Reports addressing mental health.

IX. DISCUSS and identify possible areas for improvement for 2018-2019

X. Adjourn

In accordance with the Brown Act, if a member of the public addresses an item not on the agenda, no response, discussion or action on the item may occur. In the interest of time and equal opportunity, speakers are requested to observe a 3-minute time limit.
If special accommodations are required to attend any meeting, due to a disability, please contact the Executive Assistant of the Mental Health Commission, at: (925) 957-5140

MHSA-FINANCE Committee
MONTHLY MEETING MINUTES
JULY 20, 2017 – First Draft

	Agenda Item / Discussion	Action / Follow-Up
I.	**Call to Order / Introductions** Chair, Lauren Rettagliata, called the meeting to order at 1:05 pm. **Commissioners Present**: Chair- Lauren Rettagliata, District II (arrived @1:07 pm) Vice-Chair-Douglas Dunn, District III Diana MaKieve, District II Sam Yoshioka, District IV Duane Chapman, District I **Commissioners Absent**: **NONE** **Other Attendees**: Haley Wilson, CPAW rep and Co-Chair of Systems of Care Committee Margaret Netherby, NAMI (arrived @1:50) Warren Hayes, MHSA Program Manager Adam Down, BHS Admin (arrived @1:58pm) Jill Ray, Field Representative, District II Liza A. Molina-Huntley, MHC Executive Assistant	**Executive Assistant:** • **Transfer recording to computer.** • **Update Committee attendance**
II.	**Public comments**: None	
III.	**Commissioners comments:** • **Sam-** briefed the Chair that there was a discussion (while the Chair of the Committee was not present), regarding the re-focus of the entire Mental Health budget process and the request for a change in scope of the MHSA/Finance Committee. Asked the Chair if the she was aware and involved in the request? • **Chair/Lauren-** answered that she was involved and it was her request, to bring in realignment and further understanding of realignment, along with other areas of funding that require greater attention from the Committee. Would like the Committee to broaden the perspective to the entire Mental Health budget. Specifically to the funds appropriated to "specialty mental health" consumer services. Once the funds for specialty mental health have been spent, from both Mental Health Services Act (MHSA) funds and Realignment funds, further requests for funding will be dependent on the approval of the Board of Supervisors, which	***EA/LIZA- inquire regarding budget/finance training and scheduling for commissioners**

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	must be prioritized due to the limitations of available funding, and allocated accordingly. • **Vice Chair/Doug-** noted that during the Executive Committee, the Chair and Vice Chair will collaborate to create a scope of required changes, address encompassing the entire budget for Mental Health/Behavioral Health Services. • **Sam-** Jill suggested that training should be provided, "Budget 101," for all the Commissioners and parties that are interested in the budget and finance. There are revenues and they are part of the budget. What are the chances of having training regarding the budget? • **Lauren-** That is a good point. The EA/Liza, will inquire more regarding the training and scheduling.	
IV.	**Chair comments:** • **Lauren-** attended the National Alliance for Mental Illness (NAMI) National Convention. Her primary focus is the seriously mental ill to gain more attention to this area. NAMI sent out directives, to no longer use the word "illness, suffering, or disorder" in any form of communication. Although the organization has expanded, the "roots" of the organization is supporting the seriously mentally ill. The Chair is an active member of this organization and supports all its programs. Was able to meet and discuss issues with, Senator Diane Feinstein and Kamala Harris's political analyst. Also went to Mark DeSaulnier's office and discussed different areas. According to Lauren, NAMI's platform did not include three very important issues that will need legislative change and funding, which may or may not be part of this Committee's scope. The first being the removal of the "Health Insurance Portability and Accountability Act" (HIPPA) handcuffs, for family members, opioid crisis and hopefully serious mental illness will be added. The second, that might fall under the purview of this Committee because it does involve funding, is the removal of the Medicaid Institutions for Mental Diseases (IMD) exclusive, which is antiquated term for locked facilities for those who are mentally ill and ordered, by a court of law, to serve their sentence in such institutions. The third issue is the rule of parity, which falls under the purview of the full Commission, but still has ties to finance. If a person is mild/moderately suffering from a mental illness, the consumer does have parody because they do not access under specialty mentally health, they would go to their primary doctor or clinic. We want to assure that there is parity for serious mental illness in the department's funding stream. Hopes to be able to move forward in these areas.	
V.	**Approve minutes from April 20, 2017 meeting** **MOTION to approve minutes made by, Duane, seconded by Doug Dunn.** **VOTE: 5-0-0**	**Executive Assistant** • **Post finalized minutes.** • **No quorum**

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	YAYS: Lauren, Duane, Diana , Sam, Doug **NAYS: none** **ABSTAIN: none** **ABSENT: none**	**was achieved in the months of May and June**
VI.	**DISCUSS the Commission's role, regarding the housing priority that was identified at the Consolidated Planning Advisory Workgroup (CPAW), during the community planning process which was incorporated into the Mental Health Services Act Three Year Program and Expenditure Plan- With MHSA Program Manager- Warren Hayes** • **Warren-** During the July, CPAW meeting, there was an extensive presentation by the Health, Housing and Homeless Services (H3) division staff. The CPAW Steering Committee made the request for the presentation. Housing is a priority and a major issue. The "NO PLACE LIKE HOME" initiative, the program guidelines next phase is the legal challenge process. By winter, 2018, it is hoped that a notification for funding availability will be received. Stakeholder participation is key, around what the services looks like that goes to permanent supportive housing units planned; taking into account what the current inventory is and what is needed, in order to plan for the future. The "Community Housing" meeting is coordinated by H3 and CPAW coordinates the "System of Care Committee," which Haley Wilson Co-Chairs. The System of Care Committee is actively engaged in Family Services Support Network, Loan Repayment Program and the next matter to be addressed is what kind of care is needed in permanent supportive housing. There are Quarterly meetings with "full service partner programs," which do service serious mental illness and will be a part of the planning process and looking forward to it. Currently, the network is being established. Sarah Marsh (with Contra Costa Interfaith Housing), is another CPAW member that is very active with Health, Housing and Homeless (H3) and will be a spoke person for CPAW, at the Community Housing Committee meeting to assure that the Interfaith housing model is included. At the moment, the process is in the organizational phase, to assure that all the means are participating in the planning process and are coordinated. H3 is focused on the "brick and mortar" piece, for example- master leasing, scattered site, individual units, new construction, renovating sites, looking at all possibilities. The H3Division has submitted an application for $150,000 for technical assistance and it is being considered to use some of the money for a quality needs assessment, to assure to get the most out of the resources that are available, that could best fit the needs. • **Lauren-** to summarize, the Commission should make sure to have good representation at the System of Care Committee and Doug is attending the meetings **and can update the Commission.** Personal observation is that people that need housing are currently in county shelters or homeless. The Commission should	***Doug will update the Commission regarding the Systems of Care Committee meetings** ***Lauren will send a copy to Warren of the 2008 planning document**

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be able to visit the three main shelters, annually. In order to ascertain what the needs are more accurately, maybe CPAW members and Commission members can meet at a shelter to obtain feedback from the community receiving services.

- **Duane-** can you send us a copy of the shelter Program Review for the next meeting?
- **Warren-** Yes and because it was done at the beginning of the three year cycle, it will be done early on, during the next program review cycle
- **Lauren-** I did receive a copy, it was one of the first program reviews we received, and I will give Duane a copy. Maybe we can have a meeting at one of the shelters? ANKA shelter has a large area.
- **Duane/Doug-** none of the shelters visited, have available space to hold a full commission meeting. Maybe another program can contribute bus tickets to shelter residents to come to Commission meeting, if it is held at the San Pablo facility that would be the closest to the residents.
- **Sam-** in the agenda "housing priority" is used, what are the components that are being prioritized? What consists of the costs of the priorities or of these components?
- **Warren-** it refers to the annual process to provide input regarding what is at the top of the list and what is not. There are 16 or 18 priorities and they do shift from year to year. Housing continues to be a top priority.
- **Lauren-** looking at "high end utilizers," what the Committee/Commission needs to look at is the funding is invested into housing and services, as a priority, the County will benefit in financial savings, in the long run. It is not just about finding low cost housing, services need to be included as part of the plan, to achieve a better outcome and the budget needs to reflect and address all areas of need.
- **Sam-** It is different from the housing priority that is listed in the agenda. The components have not been identified, nor the costs, which is quite different from what your describing.
- **Lauren-** I do not believe that I am following you-
- **Warren-** I am following and his point is if a certain priority is picked, that stakeholders have identified as a need, and it was stated in the three year plan, there is a financial context for each priority identified. That is a variable, as Sam stated, to make sure that if the MHSA/Finance Committee is working to focus on the money/funding, then it is important to follow the needs identified in the three year plan. Example- if a priority is at #11, but can easily be resolved- monetarily, then the priority may rise up the list, if the funding is available. Housing is #1 priority, and it will always be in this climate due to the socio-economic factors of the area. The factor is too great that it goes beyond Mental Health's

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capabilities, due to the high costs of living in the area. The current economic situation in the area is such that most couples, both working full time, find it difficult to afford rent. A possible perspective can be to view what funding is available, that will make the most impact, (on the list of priorities/goals), that is trying to be accomplished?

- **Lauren-** Housing for specialty mental health is not under H3, the responsibility is under Behavioral Health Services (BHS), correct?
- **Warren-** Correct. Locked facility management and funding and the augmented board and cares remain under Behavioral Health Services Division (BHSD). The larger picture/task, of housing in general, affordable housing and subsidized housing all is under H3.
- **Jill-** further review is being done by H3 and BHS directors, regarding the residents of "super board and cares," to verify which residents may no longer need to be housed in those types of facilities. To assure that the right people are in the right housing in the right time.
- **Warren-** a person at risk of being homeless or homeless does not have to be in a full service partnership. Some enrolled in the full service partner programs have the whole spectrum of housing. How to solve the roof over each person's head can have a different solution. The point of entry for BHS, is identifying within the system of care most notably full service partnerships, those who are most challenged with mental health issues, identify the population that is at risk or currently homeless. BHS is in the process of tracking the data to obtain a count of the current full service partners, which is the target population, to focus on how to obtain permanent supportive housing for the population previously mentioned. We are working on the planning process and identifying how many are in need, what services need to be provided and what the costs will be to assist the individuals to get into the program and going forward, what the costs, along with other factors, will be to maintain the program. Training in basic independent living skills need considered, as part of the care.
- **Lauren-** Shared her planning document and stated that in 2008, when the Mental Health Services Act (MHSA) started, housing was identified as a number one priority. In April 12 of 2010, "Raising the Roof" was a conference that discussed – meeting the housing needs of the mental health consumers and families in Contra Costa County. Kera Douglas, Victor Montoya, Lavonna Martin, Molly Heimeker made the presentation regarding the above. The money that is being spent on the program, is there enough improvement being obtained from the investment to improve the quality of life of the people?
- **Warren-** one of the impediments is to be able to "step up" individuals, to move onward to becoming self-sufficient,

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	independent and find affordable housing, moving out of supportive housing. People can be capable of being independent, if allowed. Some people take a longer period of time than others, but still can achieve it. • **Lauren-** the Crestwood facility is an example of Warren's statement. For some mentally ill, they will need lifelong permanent supportive housing. Some mentally ill can be cyclical and do well, then they experience a life changing event and lose everything and find it difficult to reestablish them until the mental illness is under control again. • **Warren-** these are important issues that need to be accounted for and addressed. Transitional housing has a high cost and due to the current economy, individuals can maintain there for an extended period of time due to the lack of affordable housing. If transitional housing is created, affordable housing should be created simultaneously.	
VII.	**DISCUSS what the Commission's role is in the upcoming triennial MHSA Program and Fiscal reviews? Now that the triennial reviews have been completed, what is the process to incorporate previous results and findings into the upcoming reviews? With MHSA Program Manager- Warren Hayes** • **Warren-** This is the time to start planning the process, over again, establishing the new three year cycle. There are approximately 50 MHSA funded programs, divided over a three year period, leaves approximately two programs to be reviewed, monthly. Currently working on establishing the calendar for the up and coming program review process. The key difference between the first three year cycle and the current one is that there are results for the first three years. Staff is assigned to program reviews in a supportive role, not as auditors, to assist in the contractual part of doing business (County-Community based organization-CBO). If there are any contractual issues, that they be corrected, by contacting the Contract Monitor. How to assist the program improve is by building on what the previous program review. It is a benefit to have the previous program review, to refer back to and check for changes. There is a three month period used to prepare, prior to announcing and starting the program reviews, may start at the end of August. • **Lauren-** The summary of findings is helpful in reviewing the program reviews. What is the process for checking on prior issues? • **Warren-** We are leading the program review but if we are not the contract monitor, we include the contract monitor as part of the team. The contract monitor may not be the authority to fix a problem but we can help to get the issues that need to be address, up to the level they need to be so that they are addresses by the appropriate person or department. There are approximately 7 contract monitors. • **Lauren – would like a list of who the contract monitors are** • **Warren-** the BHS Chief of Operations, is Helen Kerns and she would	***EA- contact Chief of Operations, Helen Kerns, to request a list of the contract monitors to forward to the Committee Chair.** ***MHSA Program Manager- Warren Hayes will provide a list to define programs for the Commission's participation.** ***Duane will discuss with the Executive Committee adding to the duties of the Committee Chairs to sign up and check the notifications from the Grand Jury, Board of Supervisors and Family and Human Services and any others that might be decided on that is of interest to the**

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	be the person to make that request to. • **Lauren-** Will any changes occur to the format of the program reviews? • **Warren-** there may be a few changes. Note to check reviews that refer to "repeat findings," only done if an issue is repeated. • **Lauren-** Is there a way that the Commission can participate in some of these contracts and program reviews, could you define which ones? • **Duane-** brought to the attention, how can the Commission become more aware of contracts? • **Jill-** the Commission, can become better informed by signing up for County notifications, in the areas of interests to the Commission • **Lauren-** there was a report posted, by the Grand Jury, regarding conservatorships that the Commission might want to be aware of. Maybe each Chair, can take on the duty of signing up for the notifications, in the areas of interest to the Committee and the Commission (i.e. - Chair of Finances will check the notifications regarding finances, the Quality of Care Chair will check on notifications regarding programs, Justice Systems Chair check on the notifications regarding forensics and detention, … make it a duty for each Chair?)	**Commission.**
VIII.	**DISCUSS what funding is available for housing those with serious mental illnesses** • **Lauren-** besides the MHSA funds, the Realignment funds and general funds are any in attendance are aware of other available sources for housing? What about the "Stepping Up Initiative," in the criminal justice system? • **Jill- "No Place Like Home"** will be available in the future. Both Lauren and Jill attended the quarterly Continuum of Care meetings, the issue of housing was discussed and according to the information provided at the meeting, on average, it can take up to eight years to develop a housing model. The "Stepping up Initiative" is a concept, not a funding stream, to address the connection between mental health and the Justice system, with the goal of diverting those people with mental illness into appropriate treatment and keep them out of the justice system. • **Lauren-** discussed a new perspective of diverting individuals away from jails and into a "diversion program" that would have housing. • **Jill-** The housing model in Contra Costa County is "Housing First," that is the goal, to be able to provide the necessary services to help individuals stay in their housing. Additional housing questions can be requested from the Director of Health, Housing and Homelessness (H3) - Lavonna Martin. In addition a new team is in the process of being created, to have a different response model regarding 5150. There are several different programs being considered to be able to provide the services needed. The Behavioral Health Court system is a State run organization. Prop 47 is a pilot program, in Antioch, to address a high rate of recidivism, in this community for those also experiencing mental health issues. They will be housed with vouchers	***Jill will forward a copy of Prop 47 to the Chair/EA**

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	provided by H3 and the program will provide wrap around services. Over 70% of the grant money will go to community based organizations (CBO's). • **Lauren- requested a copy and asked what agency will be in charge of the project.** • **Jill- will forward a copy to the Chair and the EA- Liza.** • The lead agency is Behavioral Health Services. Rebecca Brown will be the facilitator to start the program, through the office of Reentry and Justice. They will be working with the City of Antioch, Probation and Community Based Organizations (CBO's) to provide wraparound services. "**211**" will be the centralized system to get individuals connected with the services that they need. Currently, "Housing First" is a concept • **Margaret-** in the late 70's to the 80's there was a program, focused on child sexual abuse offenders, they received intensive counseling care and it was a nationwide program, very successful in its time. Maybe by looking back in history, at successful programs and procedures, can be revisited and utilized today? A lot of the counselors in the program were interns from JFK University and was not expensive; the program obtained a 2% recidivist rate. Appears that a lot of money is being wasted and fewer results are being achieved. The name of the program was called "Parents United".	
IX.	**DISCUSS funding for supportive housing and permanent housing and if they are two separate issues?** • **Lauren-** Jan Cobaleda-Kegler, Adults and Older Adults Program Chief, oversees some of the housing and the rest of the housing is overseen by the Director of H3, Lavonna Martin. Is there a schematic drawing of who heads what areas? • **Jill-** For the seriously mentally ill, the most successful model, as previously emailed, is **permanent supportive housing**, including onsite support. The closest to the model are the "Super Board and Cares". Transitional housing is for the Transitional Age Youth (TAY), substance use disorder and criminal justice population, or people with some mental disorders but not seriously mentally ill. • **Adam-** Augmented Board and Cares provide some health treatment and care, not usually mental health services, except for the new "TAY Oak Grove" pilot project. • **Lauren-** who does this falls under? What about the youth part? • **Jill-** Cynthia Belon (Director of Behavioral Health Services) and the youth will be under the Children's, Teens, TAY, and Youth Program Chief, Vern Wallace. Suggests that a "**Housing 101"** be facilitated to educate interested parties in the availability of the different housing available in the County and what division is overseeing each program. • **Adam-** Regarding **permanent supportive housing** in the future, that will fall under "**No Place Like Home**" **under H3 as the lead.**	

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In the MHSA THREE YEAR PLAN, there is a good summary regarding the housing continuum. • **Lauren**- Adam and Liza, who do we contact to obtain more information regarding housing? • **Adam- H3 is the division that is in charge of the housing aspect.** • **Liza- CPAW hosted H3, last month, and they did an in-depth presentation regarding housing and "No Place Like Home".** • **Lauren-** The BHS division has spent approximately $250 million dollars in mental health, per year, and we are still seeing a rise in the Psych Emergency Room numbers, not much progress has occurred for housing the mentally ill and homeless individuals and the costs keep rising and the wait times for an appointment take two to three months to be seen by a clinician or doctor. A lot of money is being spent but the outcomes are not comparable. • **Duane-** in observing areas throughout the county, wonders what is happening? Appears that not enough progress is being made. • **Jill-** what has happened is that the State has placed the responsibilities on to the county to resolve, without the proper funding. With the closing of the state run mental facilities, transfer of inmates from the state prison system to the county, and the closing of the state run youth group homes and transferring of the care of foster youth to the counties in foster homes. Traditionally, the detention system was not set up for rehabilitation. Voters pass mandates that do not contain a funding stream. Prop 47 was passed, releasing many into the community without funding for the services. The funding has now been released, several years later. **Prop 57 is coming and suggest that everyone reads and gives feedback.** Voters can ask who will be paying for the different mandates, before voting. • **Margaret –** discussed her knowledge regarding downfalls in the 5150 system. • **Jill-** There are 5150 alternate response systems that are developing.	
X. Adjourned at 2:54pm	

Respectfully submitted,
Liza Molina-Huntley
Executive Assistant to the Mental Health Commission
CCHS Behavioral Health Administration

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Year End Report MHSA Finance 2016

A priority of the MHSA/Finance Committee is to insure that funding for Mental Health is focused on improving the care and treatment for people diagnosed with a mental illness. At each meeting Warren Hayes provides an update on the MHSA spending and an overview of the Program & Fiscal Reviews. This committee also has asked to be updated and kept informed on Realignment I & II funding. We also received all County contracts for the first time. As a committee we are becoming more knowledgeable about how care and treatment is financed. In that vein, we have also asked to receive, on a regular ongoing basis, Federal Financial Participation (FFP, i.e. Medi-Cal and Medicare) reimbursement funding reports. FFP reimbursement comprises around 50% or greater of county mental health funding. Health Services Finance Department indicated they would try to comply. With this knowledge we hope to improve the lives of those who rely on the county for their care.

The committee will focus on understanding the systems in use in our county. We need to consider what the options are and collaborate with the Quality of Care Committee on housing issues. This committee has noted that there needs to be a plan in place that determines if the funds spent are: improving the quality of treatment and care, keeping the status quo, or causing treatment and care to deteriorate. We have improved our knowledge of homelessness, housing and shelter procedures for the mentally ill. We reviewed our housing partnerships, searching for models that work best to provide the most successful transitions and supports toward wellness. We did search for space and funding, to be used to improve and increase housing for our seriously mentally ill.

The main focus of a sub-committee was to prepare and collaborate with the Behavioral Health Department and the Behavioral Health Care Partnership to produce the Mental Health System & Budget Crisis document. It was contemplated, that this report would have an impact on how the budget for mental health is developed. The document and presentation, asked the Board of Supervisors to give budget priority to systemic deficits in care that are not being addressed in the current budget process.

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General Fund Summary

General Fund	2015-16 Actuals	2016-17 Budget	2017-18 Baseline	2017-18 Recommended	Change
Expense					
Salaries And Benefits	127,915,117	148,555,613	175,248,319	175,248,319	0
Services And Supplies	176,765,879	184,695,667	221,886,701	221,886,701	0
Other Charges	32,872,818	32,431,129	31,684,185	31,684,185	0
Fixed Assets	563,225	582,029	855,000	855,000	0
Expenditure Transfers	(12,713,419)	(14,056,721)	(16,405,334)	(16,405,334)	0
Expense Total	**325,403,621**	**352,207,717**	**413,268,872**	**413,268,872**	**0**
Revenue					
Other Local Revenue	104,185,888	113,481,361	150,313,056	150,313,056	0
Federal Assistance	78,300,342	83,962,319	103,926,211	103,926,211	0
State Assistance	55,527,667	58,957,209	64,029,605	64,029,605	0
Revenue Total	**238,013,897**	**256,400,889**	**318,268,872**	**318,268,872**	**0**
Net County Cost (NCC):	**87,389,724**	**95,806,828**	**95,000,000**	**95,000,000**	**0**
Allocated Positions (FTE)	**1,088.0**	**1,109.3**	**1,274.8**	**1,274.8**	**0.0**
Financial Indicators					
Salaries as % of Total Exp	39%	42%	42%	42%	
% Change in Total Exp		8%	17%	0%	
% Change in Total Rev		8%	24%	0%	
% Change in NCC		10%	(1%)	0%	
Compensation Information					
Permanent Salaries	71,777,266	83,400,098	102,071,221	102,071,221	0
Temporary Salaries	3,516,769	3,562,678	2,134,270	2,134,270	0
Permanent Overtime	818,853	798,040	820,277	820,277	0
Deferred Comp	465,344	570,955	1,108,900	1,108,900	0
Hrly Physician Salaries	79,886	90,556	159,586	159,586	0
Perm Physicians Salaries	2,532,822	2,924,799	3,280,750	3,280,750	0
Perm Phys Addnl Duty Pay	9,012	300,354	25,953	25,953	0
Comp & SDI Recoveries	(288,407)	(233,125)	(239,513)	(239,513)	0
FICA/Medicare	5,536,684	6,621,897	8,197,630	8,197,630	0
Ret Exp-Pre 97 Retirees	297,363	321,188	320,140	320,140	0
Retirement Expense	26,163,011	29,404,277	33,159,340	33,159,340	0
Employee Group Insurance	9,399,577	12,653,094	15,690,956	15,690,956	0
Retiree Health Insurance	3,841,499	4,031,825	4,042,189	4,042,189	0
OPEB Pre-Pay	1,474,600	1,474,600	1,514,134	1,514,134	0
Unemployment Insurance	234,739	252,375	187,111	187,111	0
Workers Comp Insurance	2,252,760	2,382,002	2,897,280	2,897,280	0
Labor Received/Provided	(196,661)	0	(121,905)	(121,905)	0

Table Description

The table above provides information in aggregate format summarizing expenditures and revenues in the General Fund budget units administered by the Health Services Department. This table includes the General Fund subsidy provided to the Contra Costa Regional Medical Center and Health Centers and the Contra Costa Health Plan (Enterprise funds I and III) but does not include the expenditures or other revenue for these functions. This information can be found in the individual tables for the enterprise funds, including the sections for the Contra Costa Regional Medical Center and Health Centers, the Contra Costa Health Plan, and the Contra Costa Community Health Plan.

Included in the table above are data for the following budget units:

0301 – Detention Facilities Programs
0450 – Public Health
0451 – Conservatorship/Guardianship
0452 – Environmental Health
0454 – Public Administrator
0460 – California Children's Services
0463 – Health, Housing and Homeless
0465 – Enterprise Fund Subsidy
0466 – Alcohol and Other Drugs Program
0467 – Mental Health

The table following this section summarizes the expenditures and revenue in aggregate for the bulk of the services provided by the department, including enterprise funds. Please refer to that table for aggregate information.

2017-18 Baseline to 2017-18 Recommended

Budget Unit Description	2017-18 Baseline Service Level			2017-18 Recommended Service Level			GF Change – FY 16/17 Adopted to Rec'd (Col 6 minus Col 3)
	Expenditure Authority	Less Revenue Collections	Required General Fund Contribution	Expenditure Authority	Less Revenue Collections	Required General Fund Contribution	
	(1)	(2)	(3)	(4)	(5)	(6)	
Enterprise Funds:							
Hospital & Clinics – EF I	$621,250,524	$598,875,762	$22,374,762	$621,250,524	$598,875,762	$22,374,762	$0
EF-2 M-Cal Plan	680,094,504	680,094,504	0	680,094,504	680,094,504	0	0
EF-3 Comm Plan	70,953,642	70,953,642	3,736,288	70,953,642	70,953,642	3,736,288	0
Major Risk Ins. Program	100,000	100,000	0	100,000	100,000	0	0
Sub-Total Enterprise Funds[A]	**$1,372,398,670**	**$1,350,023,908**	**$26,111,050**	**$1,372,398,670**	**$1,350,023,908**	**$26,111,050**	**$0**
General Fund Units:							
Behavioral Health:							
Mental Health	$211,700,874	$194,409,686	$17,291,188	$211,700,874	$194,409,686	$17,291,188	$0
Alcohol & Other Drugs	33,957,534	33,172,351	785,183	33,957,534	33,172,351	785,183	0
Homeless Programs	6,903,915	4,707,061	2,196,854	6,903,915	4,707,061	2,196,854	0
Public Health	74,673,785	54,258,815	20,414,970	74,673,785	54,258,815	20,414,970	0
Environmental Health	21,163,150	21,484,275	(321,125)	21,163,150	21,484,275	(321,125)	0
Detention	23,985,474	1,549,282	22,436,192	23,985,474	1,549,282	22,436,192	0
Conservatorship	3,700,765	613,034	3,087,731	3,700,765	613,034	3,087,731	0
California Children's Services	10,443,472	7,780,727	2,662,745	10,443,472	7,780,727	2,662,745	0
Public Administrator	628,853	293,641	335,212	628,853	293,641	335,212	0
Sub-Total General Fund	**$387,157,822**	**$318,268,872**	**$68,888,950**	**$387,157,822**	**$318,268,872**	**$68,888,950**	**$0**
Total General & Enterprise Funds	**$1,759,556,492**	**$1,668,292,780**	**$95,000,000**	**$1,759,556,492**	**$1,668,292,780**	**$95,000,000**	**$0**
Other Special Revenue Fund Units:							
	Expenditures	Revenue	Net Fund Cost	Expenditures	Revenue	Net Fund Cost	Change
Emergency Medical Services	$1,692,403	$1,692,403	$0	$1,692,403	$1,692,403	$0	$0
Ambulance Service Area	5,000,676	5,000,676	0	5,000,676	5,000,676	0	0
Total Special Funds:	**$6,693,079**	**$6,693,079**	**$0**	**$6,693,079**	**$6,693,079**	**$0**	**$0**
Grand Total All Funds:	***$1,766,249,571***	***$1,674,985,859***	***$95,000,000***	***$1,766,249,571***	***$1,674,985,859***	***$95,000,000***	***$0***

A. General Fund subsidy contribution to the Enterprise Funds is provided through General Fund unit 0465.

2016-17 Adopted to 2017-18 Recommended

Budget Unit Description	2016-17 Adopted Budget			2017-18 Recommended Service Level			GF Change – FY 16/17 Adopted to Rec'd (Col 6 minus Col 3)
	Expenditure Authority	Less Revenue Collections	Required General Fund Contribution	Expenditure Authority	Less Revenue Collections	Required General Fund Contribution	
	(1)	(2)	(3)	(4)	(5)	(6)	
Enterprise Funds:							
Hospital & Clinics – EF I	$548,463,622	$525,036,835	$23,426,787	$621,250,524	$598,875,762	$22,374,762	($1,052,025)
EF-2 M-Cal Plan	666,062,024	666,062,024	0	680,094,504	680,094,504	0	0
EF-3 Comm Plan	77,678,750	73,942,462	3,736,288	70,953,642	67,217,354	3,736,288	0
Major Risk Ins. Program	800,000	800,000	0	100,000	100,000	0	0
Sub-Total Enterprise Funds[A]	**$1,293,004,396**	**$1,265,841,321**	**$27,163,075**	**$1,372,398,670**	**$1,346,287,620**	**$26,111,050**	**($1,052,025)**
General Fund Units:							
Behavioral Health:							
Mental Health	$191,036,617	$173,763,444	$17,273,173	$211,700,874	$194,409,686	$17,291,188	$18,015
Alcohol & Other Drugs	17,843,311	17,132,858	710,453	33,957,534	33,172,351	785,183	74,730
Homeless Programs	5,737,745	4,006,387	1,731,358	6,903,915	4,707,061	2,196,854	465,496
Public Health	51,105,453	31,102,911	20,002,542	74,673,785	54,258,815	20,414,970	412,428
Environmental Health	20,825,500	21,103,728	(278,228)	21,163,150	21,484,275	(321,125)	(42,897)
Detention	23,566,313	1,126,648	22,439,665	23,985,474	1,549,282	22,436,192	(3,473)
Conservatorship	3,491,591	403,859	3,087,732	3,700,765	613,034	3,087,731	(1)
California Children's Services	10,148,932	7,368,702	2,780,230	10,443,472	7,780,727	2,662,745	(117,485)
Public Administrator	482,352	392,352	90,000	628,853	293,641	335,212	245,212
Sub-Total General Fund	**$324,237,814**	**$256,400,889**	**$67,836,925**	**$387,157,822**	**$318,268,872**	**$68,888,950**	**$1,052,025**
Total General & Enterprise Funds	**$1,617,242,210**	**$1,522,242,210**	**$95,000,000**	**$1,759,556,492**	**$1,664,556,492**	**$95,000,000**	**$0**
Other Special Revenue Fund Units:							
	Expenditures	Revenue	Net Fund Cost	Expenditures	Revenue	Net Fund Cost	Change
Emergency Medical Services	$1,692,403	$1,692,403	$0	$1,692,403	$1,692,403	$0	$0
Ambulance Service Area	5,012,779	5,012,779	0	5,000,676	5,000,676	0	0
Total Special Funds:	**$6,705,182**	**$6,705,182**	**$0**	**$6,693,079**	**$6,693,079**	**$0**	**$0**
Grand Total All Funds:	***$1,623,947,392***	***$1,528,947,392***	***$95,000,000***	***$1,766,249,571***	***$1,671,249,571***	***$95,000,000***	***$0***

A. General Fund subsidy contribution to the Enterprise Funds is provided through General Fund unit 0465.

Detailed Budget Table Description

The table above provides information by budget unit summarizing expenditures, revenues, and net County costs for each of the budget units administered by the Health Services Department and compares the 2016-17 Adopted Budget service level with the 2017-18 recommended service level.

Included are data for the following budget units:

0301 – Detention Facilities Programs
0450 – Public Health
0451 – Conservatorship/Guardianship
0452 – Environmental Health
0454 – Public Administrator
0460 – California Children's Services
0463 – Health, Housing and Homeless
0466 – Alcohol and Other Drugs Program
0467 – Mental Health
0540 – Hospital and Clinics
0853 – Hospital Fixed Assets
0860 – Contra Costa Health Plan
0861 – Contra Costa Community Health Plan
0862 – Major Risk Insurance Program
0863 – Health Plan Fixed Assets

Major Department Responsibilities

Contra Costa County is one of the few counties in the nation to offer the full spectrum of health-related services under one organizational structure. Doing business as Contra Costa Health Services (CCHS), it represents the largest department of this County government, employing approximately 4,400 individuals and 3,910 FTE's (Full-Time Equivalents). Approximately 5.4 percent of the CCHS budget is from General purpose revenue. The balance is supported by federal and state funding programs, such as Medicare and Medi-Cal, as well as program grants and fees.

The mission of Contra Costa Health Services is to care for and improve the health of all people in the County, with special attention to those who are most vulnerable to health problems. For low-income and uninsured residents of Contra Costa, CCHS is the safety net, providing medical services not available to them elsewhere.

CCHS has a long history of working in partnership with a broad range of stakeholders, including private hospitals, private physicians, community clinics, community-based organizations, schools, advisory boards and the media. Through the use of technology, including its extensive website and social media, CCHS is able to reach County residents with critical health care information on a daily basis.

CCHS is an integrated system of health care services, comprised of several divisions that work in concert to cover health at every level: the individual, the family, and the community.

The **Contra Costa Regional Medical Center and Health Centers** are the training ground for our family practice residency program. The Contra Costa Regional Medical Center (CCRMC) is a 167-bed general acute care hospital that provides a full range of services that include emergency care, psychiatric care, newborn labor and delivery, medicine, and surgery. Eleven ambulatory care health centers throughout Contra Costa provide comprehensive, personalized, patient-centered health care with a full range of specialty services.

The Brentwood Health Center has recently been expanded to add nine exam and treatment rooms, and construction will soon be completed at the Pittsburg Health Center that will add sixteen new exam and treatment rooms.

The **Contra Costa Health Plan** (CCHP) was the first federally qualified, state-licensed, county-sponsored Health Maintenance Organization (HMO) in the United States, and the first county-sponsored health plan in California to offer Medi-Cal Managed Care coverage. CCHP was also the first county-run HMO to serve Medicare beneficiaries. It subsequently expanded its programs to include County employees, businesses, individuals, and families, although CCHP exited the individual and family markets at the beginning of 2015. Currently CCHP has programs for Medi-Cal recipients, County employees, In Home Support Services, and a Medicare Cost Plan.

With the implementation of the Affordable Care Act (ACA) in January 2014, Medi-Cal coverage was expanded to cover individuals with incomes below 138% of the Federal Poverty Level. The ACA ensures all Medi-Cal health plans offer a comprehensive package of items and services, known as essential health benefits. Coverage includes a core set of services including doctor visits, hospital care, pregnancy-related services, skilled nursing facility care (SNF), home health and hospice care, as well as low-to-moderate mental health care, autism care, and some substance use disorder care.

As one of the State's Medi-Cal managed care health plans, CCHP has added more than 88,000 Medi-Cal members since the implementation of the ACA, and now provides comprehensive, quality health coverage to approximately 190,000 people in Contra Costa County. To meet this additional demand for services, CCHP has expanded its provider network by credentialing and contracting with needed specialty providers in the community. CCHP also provides 24/7 advice nurse services for patients, as well as case management and care coordination for high-risk patients.

Behavioral Health combines what was formerly the Mental Health and Alcohol and Other Drugs programs into a single system of care that supports independence, hope, and healthy lives by making services more accessible. This integration is an opportunity to respond to our culturally diverse residents who have complex behavioral needs through a systems approach that emphasizes "any door is the right door". By partnering with consumers, families, and community-based agencies, Behavioral Health staff is able to provide enhanced coordination and collaboration when caring for the whole individual; an approach that recognizes the increasing challenges in serving complex populations with multiple disorders.

To achieve the goal of care coordination and to better serve the needs of mental health and substance use disorder patients, the Behavioral Health Division will be implementing the ccLink Electronic Medical Record system. This will enable Health Services to have a single patient health record, no matter where the venue may be. Having a single patient health record will promote better communication and coordination of care. For budgetary purposes the Mental Health and Alcohol and Other Drugs programs will be reported separately.

The **Health, Housing and Homeless Services** Division integrates housing and homeless services across our health system; coordinates health and homeless services across County government and in the community; and works with key partners such as the Employment and Human Services Department, the Housing Authority, school districts, housing providers, law enforcement and cities to develop innovative strategies to address the community's health and social needs.

This new division was established in 2016 to meet the requirements of the Medi-Cal 2020 Waiver, which recognizes the nexus between improving population health and providing safe housing. Medi-Cal 2020 has new requirements for meeting the needs of our highest risk patients, many of whom are homeless. We have learned that we will never be able to end homelessness without addressing the upstream social determinants of health. Access to basic needs such as nutritious food, housing, and safe places to exercise and play have been found to impact the health of those whom we serve. The Medi-Cal 2020 Waiver requires that health systems like ours address these social needs, and funding is linked to our ability to do this successfully.

Contra Costa Public Health promotes and protects the health and well-being of the individual, family, and community in Contra Costa County, with special attention to communities and populations that are most at risk for poor health outcomes and those most affected by environmental inequities. Health is defined as the state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

As part of the integrated health system, Public Health uses a broad spectrum of strategies and offers an array of programs that focus on public health issues such as communicable disease and sexually transmitted disease; immunization; nutrition; and family, maternal, infant, and child health, including children's oral health. Services

include public health nursing and the public health laboratory, along with wellness, prevention, and education activities aimed at negative health conditions such as obesity, smoking, and lead poisoning. The Public Health Division is also responsible for the CCHS health emergency preparedness programs, data collection, and program evaluation.

The **Environmental Health** Division is a regulatory agency that provides oversight for businesses and property owners to protect and promote the health of the people of Contra Costa County. Environmental Health uses up-to-date standards, state laws, and ordinances to regulate programs for safe food, safe water for drinking and recreation, and the sanitary management of wastes.

The **Hazardous Materials** Division serves area residents by monitoring local industry and responding to emergencies to protect the public from exposure to hazardous materials. Hazardous Materials strives to maintain a clean, healthy, and safe environment by promoting pollution prevention, increasing process safety knowledge and environmental awareness, responding to incidents, and implementing consistent regulatory compliance and enforcement programs.

The **Emergency Medical Services** (EMS) Division serves Contra Costa communities by ensuring that quality emergency medical services are available for all people in the County. The Local EMS Agency (LEMSA) is the local governmental agency responsible for providing regulatory and medical oversight of medical dispatch, fire and law first responders, emergency and non-emergency ambulance services. Public and private EMS System partners function under Local EMS Agency policies and procedures that assure coordinated response and prompt medical transportation to community hospital emergency departments and specialty centers for definitive care. The EMS Agency sets standards to assure that prehospital personnel involved in an emergency response are properly trained and equipped so that medical care in the field is provided in a timely, efficient and professional manner.

The Emergency Medical Services Agency utilizes evidence based standards, statutory regulations and guidelines; and the local ambulance ordinance to protect the public safety. The Agency is charged with monitoring local non-emergency and emergency ambulance services and works with stakeholders to support EMS programs known to reduce death and disability. These programs include Public Access Defibrillation and CPR, medical health disaster response, Medical Reserve Corps, Hospital Preparedness Program, certification and licensure, ambulance permitting, quality improvement, patient safety, Heart Safe Communities, cardiac arrest, stroke, high risk heart attack (STEMI), trauma, and the EMS for Children program.

Major Changes that Could Impact the Budget

There is a lot of conjecture about what might happen to the health care delivery system after the recent presidential election, but so far there is nothing definitive. We know that many of the proposed health policy changes that the president has vowed to make will significantly impact CCHS operations. A dramatic increase in the number of uninsured, coupled with the loss of funding, could destabilize the health care delivery system.

The Governor has proposed a state budget for 2017-18 that does not involve any reduction in federal ACA funding. Health Services is taking the same approach in developing its 2017-18 budget, and we are not anticipating any reduction in our staff or services in the short-term.

Our integrated healthcare delivery system is now supported primarily with federal dollars in partnership with the state. A small percentage of the CCHS budget comes from the County's General Fund. Eliminating Medi-Cal expansion would greatly impact the Contra Costa Health Plan (CCHP), the Contra Costa Regional Medical Center and Health Centers, the Mental Health Division and all of our community health center partners. In Contra Costa, approximately 72,000 people are enrolled in the Medi-Cal expansion, and this brings approximately $90

million in federal revenues to the County. CCHP manages the care of 55,000 of those enrolled. The elimination of the Medi-Cal expansion would create a huge deficit in the Department's budget.

In August 2015, the Federal Centers for Medicare and Medicaid Services (CMS) approved California's Drug Medi-Cal (DMC) Organized Delivery System (ODS) Waiver amendment, which provides a continuum of care for Substance Use Disorder (SUD) treatment services for Medi-Cal beneficiaries. The DMC-ODS Waiver requires counties to provide greater administrative oversight, implement utilization controls to improve care, and maximize efficiency. Contra Costa County opted into the Waiver following the submission of a County Implementation Plan and a Fiscal Plan that was approved by the State Department of Health Care Services (DHCS) and CMS in November 2016. The DMC-ODS Waiver is an opportunity for counties to expand service capacity and the range of available benefits for Medi-Cal beneficiaries who meet medical necessity criteria and reside in our County.

Under the Medi-Cal 2020 Waiver, we received a five-year grant of $20 million annually to provide whole person care to high-need, high-utilizers of multiple services. We are currently building the information system infrastructure to support this new, innovative and highly integrated approach to health services.

We also continue to build upon our successful quality improvement efforts under the Delivery System Reform Incentive Payment Program (DSRIP) and began the hard work of setting benchmarks and milestones under the new Medi-Cal 2020 Waiver's Public Hospital Redesign and Incentives in Medi-Cal (PRIME) requirements.

The Contra Costa Health Plan has expanded its provider networks and enrolled thousands of new members who became eligible for coverage through the ACA expansion. Children have become eligible for state Medi-Cal regardless of immigration status, adults continue to take advantage of the new eligibility to Medi-Cal under the Affordable Care Act, and Contra Costa CARES, a local program supported by the County and local hospitals, now provides a health home to low-income adults who were ineligible for coverage under the ACA.

Contra Costa Regional Medical Center & Ambulatory Care Centers

Hospital and Clinics (Enterprise Fund I)	2015-16 Actuals	2016-17 Budget	2017-18 Baseline	2017-18 Recommended	Change
Expense					
Salaries And Benefits	341,857,787	351,236,887	374,314,697	374,314,697	0
Services And Supplies	188,470,257	177,248,145	194,692,378	194,692,378	0
Other Charges	340,011	11,029,590	12,429,289	12,429,289	0
Fixed Assets	(0)	8,949,000	39,814,160	39,814,160	0
Expense Total	**530,668,055**	**548,463,622**	**621,250,524**	**621,250,524**	**0**
Revenue					
General Fund Subsidy	23,071,767	23,426,787	22,374,762	22,374,762	0
Other Local Revenue	247,855,367	255,792,850	229,501,499	229,501,499	0
Federal Assistance	37,794,007	41,032,646	54,563,259	54,563,259	0
State Assistance	241,390,286	228,211,339	314,811,004	314,811,004	0
Revenue Total	**550,111,427**	**548,463,622**	**621,250,524**	**621,250,524**	**0**
Net Fund Cost (NFC):	**(19,443,371)**	**0**	**0**	**0**	**0**
Allocated Positions (FTE)	**2,494.0**	**2,474.8**	**2,474.8**	**2,474.8**	**0.0**
Financial Indicators					
Salaries as % of Total Exp	64%	64%	60%	60%	
% Change in Total Exp		3%	13%	0%	
% Change in Total Rev		0%	13%	0%	
% Change in NFC		(100%)	0%	0%	
Compensation Information					
Permanent Salaries	144,036,558	151,569,804	160,959,438	160,959,438	0
Temporary Salaries	21,976,506	21,727,015	21,797,001	21,797,001	0
Permanent Overtime	6,244,098	6,400,950	6,336,190	6,336,190	0
Deferred Comp	560,294	528,375	665,158	665,158	0
Hrly Physician Salaries	2,044,513	2,109,372	2,093,826	2,093,826	0
Perm Physicians Salaries	42,460,817	44,510,244	48,989,992	48,989,992	0
Perm Phys Addnl Duty Pay	2,723,473	2,552,559	2,805,682	2,805,682	0
Comp & SDI Recoveries	(495,646)	(562,172)	(562,172)	(562,172)	0
Vacation/Sick Leave Accrual	1,660,848	0	0	0	0
FICA/Medicare	15,024,634	10,756,031	17,972,042	17,972,042	0
Ret Exp-Pre 97 Retirees	683,936	682,774	679,694	679,694	0
Retirement Expense	61,517,269	64,271,620	67,592,976	67,592,976	0
Excess Retirement	137,912	315,332	315,332	315,332	0
Employee Group Insurance	25,579,217	30,716,308	28,738,683	28,738,683	0
Retiree Health Insurance	7,742,245	8,040,133	8,040,133	8,040,133	0
OPEB Pre-Pay	2,954,198	2,954,198	2,954,198	2,954,198	0
Unemployment Insurance	653,781	686,803	539,600	539,600	0
Workers Comp Insurance	6,278,379	3,977,541	4,396,924	4,396,924	0
Labor Received/Provided	74,756	0	0	0	0

* Capital assets expenditures are fully funded budgetarily in the year of acquisition; for Enterprise Fund Financial reporting depreciation rather than acquisition cost is recognized as a current year expense.

Description: Includes the operations of the Contra Costa Regional Medical Center (CCRMC) and emergency care services, ambulatory care centers, physician services, emergency medical services, charges from other County departments, department-wide administration, and fixed assets.

Workload Indicator: The recommended FY 2017-2018 budget is based on an average daily inpatient census of 131 patients, and 479,426 annual outpatient visits.

Impact: The recommended budget maintains the current level of services. The budget (a) includes ongoing funding for a renewed Medi-Cal Waiver and (b) includes cost estimates for labor agreements currently under negotiation.

1. Contra Costa Regional Medical Center

Description: A general acute care teaching facility, the 167 licensed bed Contra Costa Regional Medical Center (CCRMC) provides a full range of diagnostic and therapeutic services including medical/surgical, intensive care, emergency, prenatal/obstetrical, and psychiatric services. Ancillary services include pharmacy, rehabilitation, medical social work, laboratory, diagnostic imaging, cardiopulmonary therapy and ambulatory care surgery. CCRMC is licensed to provide basic medical emergency and psychiatric services. The Psychiatric Emergency Services (PES) is a designated psychiatric evaluation center.

CCRMC provides care to individuals with a variety of insurance coverage including Medicare, Medi-Cal and private insurance. The cost of care provided to these individuals is offset by the fees collected.

CCRMC provides services to individuals who cannot pay because the County has a general duty to provide care for indigents. That duty is specified by the State of California in the Welfare and Institutions Code section 17000. The County Board of Supervisors is authorized to adopt standards of aid and care for the indigent and has done so. The County provides indigent health care through various programs based on the Federal Poverty Level (FPL) guidelines.

In November 2010, The Federal Centers for Medicare and Medicaid Services (CMS) approved California's Section 1115 "California Bridge to Health Reform" Waiver. A key component of the State's Section 1115 Waiver was the Low Income Health Program (LIHP) that expanded coverage for individuals between 19 and 64 years of age, who were US Citizens or legal permanent residents. LIHP consisted of two programs, the Medical Coverage Expansion Program (MCE) and the Health Care Coverage Initiative Program (HCCI). The LIHP program, which ended December 31, 2013, was designed to bridge the care of these individuals from an episodic care approach to comprehensive healthcare coverage.

On January 1, 2014, with the implementation of the Federal Patient Protection and Affordable Care Act (ACA), California expanded Medi-Cal eligibility to include adults with incomes up to 138 percent of the federal poverty level. Actively enrolled LIHP/MCE individuals were automatically transitioned to Medi-Cal. LIHP/HCCI members became eligible for coverage through the State's health care exchange. This is known as the optional expansion. For three years, the federal government paid 100% of the costs of health care services provided to the newly eligible population. On January 1, 2017, the percentage dropped to 95%, and it will drop to 90% of costs on January 1, 2018.

California's Medi-Cal Section 1115 waiver "Bridge to Reform" expired in October 2015. Under the Bridge to Reform Waiver, the California Delivery System Reform Incentive Program (DSRIP) supported the initial steps of transforming and stabilizing the public safety net hospital system. California recently received approval from the Centers for Medicare and Medicaid Services (CMS) to implement a new waiver program known as the Medi-Cal 2020 Waiver.

The Public Hospital Redesign and Incentives in Medi-Cal program (PRIME) builds on the success of the DSRIP program under the previous Waiver, which helped us improve care

and safety in our hospital and health centers and make great strides toward improving access to care using a variety of innovative tools. With PRIME, the Hospital and Health Centers will be compensated for showing improvements in ambulatory care, targeting high-risk populations and using resources more efficiently. PRIME challenges us to meet certain agreed-upon benchmarks or risk substantial loss of funding that cannot be recovered. This ambitious pay-for-improvement portfolio will require smart realignment and investment of current and future human and technology resources.

The second component of the Waiver is the "global payment program," which retools the way the Hospital and Health Centers are compensated for treating the uninsured. The program provides financial incentives for cost-effective primary and specialty care by shifting the focus away from hospital-based inpatient care toward primary and preventive care. It includes changes in reimbursement structures that are based on health outcomes and not on process or solely on the number of visits.

The third component of Medi-Cal 2020 is what's known as "whole person care," offered to selected counties as a pilot to better coordinate physical and behavioral health care, and providing social services and other supports to help meet needs such as housing or food in a patient-centered manner.

Fourth and final is the dental transformation initiative aimed at helping children and young adults consistently and easily access high-quality dental services and maintaining good oral health.

Under this new Waiver, the Health Services Department will be addressing all aspects of health, including disparities and inequities. The new Waiver places a great deal of importance on addressing issues that affect health in our communities - not just those affecting the patients we serve. Because the Department is an integrated health system, we are ideally structured to meet these expectations. The Contra Costa Regional Medical Center and Health Centers will be working with the Contra Costa Health Plan, Behavioral Health, Public Health, and Emergency Medical Services (EMS) to fulfill the healthcare and community health obligations under the Medi-Cal 2020 Waiver.

In the first quarter of 2017, we expect to have the newly renovated and expanded Emergency Department. This expansion will increase the bed capacity from 17 licensed beds to 25 licensed beds.

Hospital and Emergency Care Services Summary		
Service:		Mandatory
Level of Service:		Mandatory
Expenditures:		$270,110,188
Financing:		267,016,633
Net Fund Cost:		3,093,555
Funding Sources:		
State	52.5%	$141,887,622
Local	38.3%	103,470,321
Federal	8.0%	21,658,690
General Fund	1.2%	3,093,555
FTE: 1,082.0		

2. Ambulatory Care Centers

Description: Eleven ambulatory care centers in East, West and Central Contra Costa County provide family practice oriented primary care, primary care with integrated behavioral health and group medical clinics, geriatrics, dental, rehabilitation, prenatal, pediatric and adult medical services, as well as specialty clinic services. Specialty clinics include: child developmental services, an opioid addiction treatment clinic, a Gender clinic, podiatry, infectious disease, eye, dermatology, orthopedics, urology, ENT, and gynecology clinics. We also operate the Hansen's Disease regional center for Northern California, a Transitions clinic for returning citizens, and other services.

A new integrated health center was constructed to replace the Antioch Health Center facilities on Lone Tree Way. The replacement Antioch Health Center, located at 2335 Country Hills

Drive in Antioch, houses the East County Children's Mental Health Clinic and the Antioch Health Center in the 23,000+ square foot location. Construction is complete and the facility opened for patient care on February 23, 2016 with increased capacity of primary care services to meet the growing demand for services in East County. This new facility offers three expanded services: group medical visits, mammography screening and ultrasonography.

The Brentwood Health Center expansion project includes the addition of eight exam rooms and one treatment room. The project is now licensed and is scheduled to open in February 2017. During the first quarter of 2017, the build out of the Pittsburg Health Center will be completed which will consolidate and co-locate primary care delivery services for efficiency and to enhance access. This project will result in an increase of 15 exam rooms and one treatment room. The expansion in East County is critical to meet the rapidly growing need in this region as the Contra Costa Health Plan has seen the largest growth of members in this geographical region.

Ambulatory Care Centers Summary		
Service:		Mandatory
Level of Service:		Mandatory
Expenditures:		$143,951,858
Financing:		142,303,187
Net Fund Cost:		1,648,671
Funding Sources:		
State	57.8%	$83,189,088
Local	24.3%	34,957,759
Federal	16.8%	24,156,340
General Fund	1.1%	1,648,671
FTE: 748.6		

3. Physician Services

Description: The interdisciplinary medical staff at Contra Costa Regional Medical Center and Health Centers includes 136 primary care physicians, as well as family nurse practitioners, dentists, psychiatrists, psychologists and 311 specialty physicians.

The Family Practice Residency Program provides clinical experience for 42 residents who rotate through all inpatient acute services, the emergency department and ambulatory care centers.

CCRMC recognized and emphasized the need for operational management of physician clinical practices. In response to this we are in the process of creating operational leadership. We have a new ambulatory care medical director, specialty care medical director and hospital medical director to lead the growth of services to our expanding patient base due to the ACA.

Physician Services Summary		
Service:		Mandatory
Level of Service:		Mandatory
Expenditures:		$109,101,055
Financing:		107,851,527
Net Fund Cost:		1,249,528
Funding Sources		
State	48.6%	$53,068,935
Local	42.2%	46,034,363
Federal	8.0%	8,748,229
General Fund	1.2%	1,249,528
FTE: 289.0		

4. Emergency Medical Services

Description: This program provides overall coordination of Contra Costa's Emergency Medical System. It regulates emergency and non-emergency ambulance services. The Local EMS agency is solely responsible for the medical and patient safety oversight of the County's trauma, STEMI (high risk heart attack) stroke and cardiac arrest systems of care. The EMS Agency establishes pre-hospital treatment protocols, certifies and accredits pre-hospital personnel and is responsible for assuring EMT and paramedic professional standards are met to assure the public safety. The EMS Medical Director approves and provides medical control and oversight for medical dispatch, paramedic programs and first-responder defibrillation programs, plans and coordinates medical disaster response, and reviews inter-facility patient transfers.

Emergency Medical Services Summary		
Service:		Mandatory
Level of Service:		Mandatory
Expenditures:		$2,407,879
Financing:		2,407,879
Net Fund Cost:		0
Funding Sources:		
Local	100.0%	$2,407,879
FTE: 5.0		

5. Support Services

a. *Administrative Services*

Description: This section includes costs of the Office of the Director, Health Services Personnel, Payroll, General Accounting, Information Technology, Purchasing, and Contracts and Grants.

Administrative Services Summary		
Service:		Discretionary
Level of Service:		Discretionary
Expenditures:		$27,053,087
Financing:		27,053,087
Net Fund Cost:		0
Funding Sources:		
Local	100.0%	$27,053,087
FTE: 350.2		

b. *Charges from Other County Departments*

Description: This section includes non-distributed costs charged to the Health Services Department by other County departments for various services.

Charges From Other County Departments		
Service:		Mandatory
Level of Service:		Discretionary
Total Expenditures:		$16,383,008
Financing:		0
Net Fund Cost:		16,383,008
Funding Sources:		
General Fund	100.0%	$16,383,008

Charges From Other County Departments include:

Auditor	$997,549
Purchasing	$182,966
County Counsel	$1,300,000
Human Resources	$1,786,107
Telecommunication	$4,839,047
Courier Service (PW-GSD)	$20,175
Sheriff's Office	$4,417,356
DoIT	$1,103,611
Occupancy-owned	$1,598,211
Occupancy-rented	$12,667
Travel-Co equip	$125,319
Total	$16,383,008

6. Hospital Capital Expense Cost

Description: To provide for the repayment of the principal portion of long-term debt; acquisition of replacement capital equipment; the cost of current capital projects; and for previously approved construction projects that may carry over to succeeding fiscal years. Major projects include emergent repair and replacement of the plumbing and renovation in the cafeteria including the kitchen; Emergency Department Expansion; enhanced facility and security personnel for the perinatal service; and the expansion of the Brentwood Health Center and the Pittsburg Health Center.

Note: Assets are capitalized and depreciation is adjusted at year-end.

Hospital Capital Project Cost		
Service:		Discretionary
Level of Service:		Discretionary
Expenditures:		$52,243,449
Financing:		52,243,449
Net Fund Cost:		0
Funding Sources:		
State	70.2%	$36,665,359
Local	29.8%	15,578,090

Contra Costa Health Plan

CCHP Medi-Cal (Enterprise Fund II)[A]	2015-16 Actuals	2016-17 Budget	2017-18 Baseline	2017-18 Recommended	Change
Expense					
Salaries And Benefits	20,455,022	27,100,487	27,748,363	27,748,363	0
Services And Supplies	593,040,325	563,818,577	572,431,903	572,431,903	0
Other Charges	30,653,624	75,142,960	79,914,238	79,914,238	0
Expense Total	**644,148,971**	**666,062,024**	**680,094,504**	**680,094,504**	**0**
Revenue					
Other Local Revenue	660,635,586	666,062,024	680,094,504	680,094,504	0
Revenue Total	**660,635,586**	**666,062,024**	**680,094,504**	**680,094,504**	**0**
Net Fund Cost (NFC):	**(16,486,615)**	**0**	**0**	**0**	**0**
Allocated Positions (FTE)[B]	**185.4**	**194.0**	**194.0**	**194.0**	**0.0**
Financial Indicators					
Salaries as % of Total Exp	3%	4%	4%	4%	
% Change in Total Exp		3%	2%	0%	
% Change in Total Rev		1%	2%	0%	
% Change in NFC		(100%)	0%	0%	
Compensation Information					
Permanent Salaries	9,826,070	14,251,483	14,938,106	14,938,106	0
Temporary Salaries	2,610,895	2,291,889	1,923,504	1,923,504	0
Permanent Overtime	598,577	644,796	681,480	681,480	0
Deferred Comp	73,018	81,106	101,400	101,400	0
Hrly Physician Salaries	84,186	0	0	0	0
Perm Physicians Salaries	162,909	415,756	373,232	373,232	0
Perm Phys Addnl Duty Pay	4,029	0	42,804	42,804	0
Comp & SDI Recoveries	(31,441)	(7,457)	(51,823)	(51,823)	0
Vacation/Sick Leave Accrual	139,468	0	0	0	0
FICA/Medicare	974,240	1,319,562	1,373,873	1,373,873	0
Ret Exp-Pre 97 Retirees	37,118	36,504	40,320	40,320	0
Retirement Expense	3,356,749	4,636,618	4,771,207	4,771,207	0
Employee Group Insurance	1,688,389	2,402,848	2,540,874	2,540,874	0
Retiree Health Insurance	363,202	365,364	351,336	351,336	0
OPEB Pre-Pay	147,959	147,959	147,959	147,959	0
Unemployment Insurance	39,660	47,486	48,264	48,264	0
Workers Comp Insurance	379,994	466,573	465,826	465,826	0

A. This table reflects figures for the Contra Costa Health Plan Medi-Cal product line only.
B. Number of Full Time Equivalent positions (FTE) shown serves Enterprise II and III of the Contra Costa Health Plan.

Description: The Contra Costa Health Plan (CCHP) is a County-operated prepaid health plan. Enterprise Fund II is used to account for the premiums and expenditures related to Medi-

Cal enrollees. Enterprise Fund III is used to account for the premiums and expenditures related to Medicare recipients, employees of participating private and governmental employers, and the Contra Costa CARES program. Enterprise Fund IV accounted for premium and expenditures related to the Access for Infants and Mothers (AIM) program and the Major Risk Medical Insurance Program (MRMIP). Participation in the AIM program ended June 30, 2015 and participation in the MRMIP program ended December 31, 2014.

Medi-Cal: Includes Aid to Families with Dependent Children members, Low Income Child Program, Medi-Cal Expansion (MCE) that transferred into Medi-Cal on January 1, 2014 from the Low Income Health Program, Seniors and Persons with Disabilities and Other Medi-Cal (non-crossover) members. Our Medi-Cal members are served by three contracting networks of providers: 1) Contra Costa Regional Medical Center (CCRMC) and Health Centers, 2) CCHP's Community Provider Network (CPN), and 3) Kaiser.

Workload Indicator: The recommended FY 2017/2018 budget is based on an average monthly enrollment of 180,000 Medi-Cal enrollees. Due to the impact of the Affordable Care Act (ACA), our FY 2017/2018 Medi-Cal enrollment budget increased 3.8% over our FY 2016/2017 Medi-Cal enrollment budget.

Impact: The recommended budget maintains the current level of services, but for a larger population.

1. AFDC/CalWORKS and Other Medi-Cal
(excludes Seniors and Persons with Disabilities)

Description: The Aid to Families with Dependent Children (AFDC) product line serves Contra Costa residents who qualify for Medi-Cal through the Public Assistance and Medically Needy Only categories of the Aid to Families with Dependent Children Program (subsequently replaced with the CalWORKs program). Instead of Medi-Cal cards and stickers, the Medi-Cal Managed Care member receives a CCHP member identification card and CCHP provides or arranges for all his or her covered health needs with the exception of some benefits that remain carved out of Medi-Cal Managed Care and become the responsibility of Fee for Service Medi-Cal.

The Other Medi-Cal (non-crossover) members include all Contra Costa Medi-Cal eligible individuals other than AFDC/CalWORKs.

Under the new ACA rules, as of January 1, 2014, the MCE populations of the Low Income Health Program became eligible for Medi-Cal. CCHP is required to enroll 75 percent of expansion members into the County Network.

Starting September 2016, children in the Basic Health Care program, under Enterprise Fund III, as well as others in the County with income under 200% of FPL were transitioned into regular Medi-Cal. By December 2016, CCHP had received approximately 1,500 children who had transitioned into full Medi-Cal.

There were some benefits and services added to Medi-Cal Managed Care Plans in 2016.

- Autism services for Medi-Cal children were transitioned from the East Bay Regional Centers into CCHP's Medi-Cal program.
- Non-Medical Transportation services for recipients of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) became a benefit. Non-Emergency Medical Transportation is also covered for diabetic, perinatal, dialysis and oncology patients. This benefit is handled by the Case Management Unit;
- In FY 2017/2018, the Case Management Unit will manage the expanded Non-Medical Transportation benefit for the entire Medi-Cal population;
- The CCHP Case Management department will also be expanding the Good Health Program to meet the Department of Health Care Services (DHCS) requirement of annual health reassessments for Seniors and Persons with Disabilities (SPD) members.

The average monthly enrollment for FY 2017/2018 for AFDC/CalWORKS and Other Medi-Cal is projected to be approximately 180,000.

Medi-Cal Members Summary (Excluding SPD)		
Service:		Mandatory per DHCS and DMHC Standards
Level of Service:		Mandatory
Expenditures:		$510,664,208
Financing:		510,664,208
Net Fund Cost:		0
Funding Sources:		
Local (Premiums)	100.0%	$510,664,208
FTE: 194.0		

2. Seniors and Persons with Disabilities (SPD's)

Description: Medi-Cal SPD categories include Old Age Security (OAS; persons aged 65 and older), Aid to the Totally Disabled, and Aid to the Blind. The member receives a CCHP identification card and CCHP provides or arranges for all his or her covered health needs. The average monthly enrollment for the SPD members for FY 2017/2018 is projected to be approximately 23,000.

Medi-Cal SPD Members Summary		
Service:		Discretionary
Level of Service:		Mandatory
Expenditures:		$166,008,377
Financing:		166,008,377
Net Fund Cost:		0
Funding Sources:		
Local (Premiums)	100.0%	$166,008,377

3. Charges from Other County Departments

Description: This section includes non-distributed costs charged to the Health Plan by other County departments for various services.

Charges From Other County Departments		
Service:		Discretionary
Level of Service:		Discretionary
Expenditures:		$3,421,919
Financing:		3,421,919
Net Fund Cost:		0
Funding Sources:		
Local (Premiums)	100.0%	$3,421,919

Charges From Other County Departments include:

Public Works	$448,499
Auditor-Controller	$2,682,772
Information Technology	$290,648
Total	$3,421,919

Contra Costa Community Health Plan (Enterprise Fund III)

CCHP Community Plan (Enterprise Fund III)	2015-16 Actuals	2016-17 Budget	2017-18 Baseline	2017-18 Recommended	Change
Expense					
Services And Supplies	83,660,017	76,475,571	69,245,079	69,245,079	0
Other Charges	397,301	1,203,179	1,708,563	1,708,563	0
Expense Total	**84,057,318**	**77,678,750**	**70,953,642**	**70,953,642**	**0**
Revenue					
General Fund Subsidy	4,236,288	3,736,288	3,736,288	3,736,288	0
Other Local Revenue	75,188,062	73,942,462	67,217,354	67,217,354	0
Revenue Total	**79,424,350**	**77,678,750**	**70,953,642**	**70,953,642**	**0**
Net Fund Cost (NFC)[A]:	**4,632,969**	**0**	**0**	**0**	**0**
Financial Indicators					
Salaries as % of Total Exp					
% Change in Total Exp		(8%)	(9%)	0%	
% Change in Total Rev		(2%)	(9%)	0%	
% Change in NFC		(100%)	0%	0%	

A. Amount necessary to meet Title 28 Tangible Net Equity Requirements

Description: The Contra Costa Community Health Plan is a County-operated prepaid health plan available to certain Medicare recipients; In-Home Support Service providers; and employees of participating private and governmental employers. This budget unit also reflects the costs for the Basic Health Care program which consists mainly of undocumented children who reside in the County and receive care from Contra Costa Health Services. Children in this program as well as others in the County with income under 200% of FPL were transitioned into regular Medi-Cal starting September 2016.

Beginning December 2015 CCHP established a pilot program, Contra Costa CARES, for the purpose of providing primary healthcare services to adults not covered by the Affordable Care Act (ACA).

Beginning July 1, 2016 a Managed Care Organization Provider Tax is being assessed on many of our CCHP commercial products. This is a new tax for our commercial business. In FY 2016/2017 the tax was $7.50 per member per month, and for FY 2017/2018 the tax will be $8.00 per member per month.

Workload Indicator: The recommended FY 2017/2018 budget is based on an average monthly enrollment of 9,500 recipients.

Impact: The recommended budget maintains the current level of services.

1. Commercial Coverage

Description: Provides coordinated comprehensive health benefits from physical check-ups to treatment of major health problems. There is an array of benefits, premiums and co-payments depending on the plan chosen. Premiums are paid by the members or their employers.

The County Employee Plans serve full time, part time and temporary employees and retirees of Contra Costa County, and some plans cover their eligible dependents in the Contra Costa Health Plan.

In addition, coverage is available to the state sponsored In-Home Supportive Services (IHSS) providers in Contra Costa County. IHSS providers who join CCHP receive coordinated comprehensive health care services ranging from physical check-ups to treatment of major health problems. Monthly premium costs are shared by the County and the IHSS providers.

Commercial Members Summary (Excludes IHSS)		
Service:		Discretionary
Level of Service:		Mandatory
Expenditures:		$53,665,489
Financing:		53,665,489
Net Fund Cost:		0
Funding Sources:		
Local (Premiums)	100.0%	$53,665,489

In-Home Supportive Services		
Service:		Discretionary
Level of Service:		Mandatory
Expenditures:		$17,288,152
Financing:		17,288,152
Net Fund Cost:		0
Funding Sources:		
Local (Premiums)	78.4%	$13,551,864
General Fund (Subsidy)	21.6%	3,736,288

2. Medicare Senior Health Plans

Description: This product line serves Contra Costa senior residents who are covered under Medicare and who choose CCHP as their medical gap insurer. In addition to the basic Medicare coverage under this program, there are various benefits covered by member premiums that reduce the member's medical expenses for Medicare co-payments and deductibles. On the Senior Health Plus Plan, the premium helps to pay for those services not covered by Medicare, such as eye and hearing exams as well as glasses, hearing aids, and some drugs not covered by Medicare Part D.

3. Basic Health Care (BHC)

Description: This program is designed to provide needed medical care to the formerly state-sponsored medically indigent children and other at-risk adult residents of Contra Costa County with incomes less than or equal to 300 percent of the federal poverty level. It offers limited health benefits compared to other groups. Services are primarily provided at the Contra Costa Regional Medical Center (CCRMC) and Health Centers.

4. Contra Costa CARES

Description: Beginning December 2015 CCHP established a pilot program, Contra Costa CARES, for the purpose of providing primary care services to adults not covered by the ACA. CCHP coordinates the program for primary care services via three providers: La Clinica de la Raza, Lifelong, and Brighter Beginnings. The providers receive a capitated payment on a per member per month basis.

Contra Costa CARES was initially approved and funded with a $500,000 contribution from the Board of Supervisors which was matched with an additional $500,000 from Kaiser, John Muir, and the Sutter hospitals. The program was structured and sized to run for approximately 12 months (dependent on enrollment ramp up) or until the funding was fully utilized. Enrollment reached 3,100 by December 2016.

Results indicated a positive trend from the pilot program with increased primary care visits to a medical home; medication compliance for chronic care conditions such as diabetes; preventive care such as mammograms; and a decrease in avoidable ER visits. Accordingly, the 2016/17 budget included $250,000 from one time CCHP revenues, and a $250,000 match by private hospital funds to extend the program though the end of the 2016/17 fiscal year.

The FY 2017/2018 budget includes $500,000 from CCHP funds to continue the program through the budget year.

5. Covered California Exchange Plans

Description: CCHP's participation in the Covered California Exchange ended on December 31, 2014.

Major Risk Medical Insurance Program (Enterprise Fund IV)

AIM/MRMIP (Enterprise Fund IV)	2015-16 Actuals	2016-17 Budget	2017-18 Baseline	2017-18 Recommended	Change
Expense					
Services And Supplies	150	800,000	100,000	100,000	0
Expense Total	**150**	**800,000**	**100,000**	**100,000**	**0**
Revenue					
Other Local Revenue	(69)	800,000	100,000	100,000	0
Revenue Total	**(69)**	**800,000**	**100,000**	**100,000**	**0**
Net Fund Cost (NFC):	**219**	**0**	**0**	**0**	**0**
Financial Indicators					
Salaries as % of Total Exp					
% Change in Total Exp		534,695%	(88%)	0%	
% Change in Total Rev		1,155,335%	(88%)	0%	
% Change in NFC		(100%)	0%	0%	

Description: This product served Contra Costa residents who qualified for the Access for Infants and Mothers (AIM) program and the Major Risk Medical Insurance Program (MRMIP). Contra Costa Health Plan was a contracted health plan carrier for these programs, which were administered by the State's Managed Risk Medical Insurance Board (MRMIB). Both programs were impacted by the Affordable Care Act.

AIM was a program for pregnant women that was not available to Medi-Cal or Medicare Part A and B recipients, and applied certain income guidelines. CCHP's participation in the AIM program ended June 30, 2015.

CCHP's participation in the Major Risk Medical Insurance Program (MRMIP) was terminated on December 31, 2014. This program had provided health insurance to Californians unable to obtain coverage in the individual market due to pre-existing conditions.

The FY 2017/2018 budget represents a potential payback to the State pending their reconciliation of the MRMIP program.

Major Risk Medical Insurance Program		
Service:		Discretionary
Level of Service:		Mandatory
Expenditures:		$100,000
Financing:		100,000
Net Fund Cost:		0
In meeting In Funding Sources:		
Local (Premiums)	100.0%	$100,000

Behavioral Health Division - Mental Health

General Fund	2015-16 Actuals	2016-17 Budget	2017-18 Baseline	2017-18 Recommended	Change
Expense					
Salaries And Benefits	50,039,693	57,940,193	61,630,317	61,630,317	0
Services And Supplies	125,971,967	131,051,217	149,515,268	149,515,268	0
Other Charges	5,564,185	5,257,325	5,572,464	5,572,464	0
Fixed Assets	23,781	28,700	28,700	28,700	0
Expenditure Transfers	(2,280,322)	(3,240,818)	(5,045,875)	(5,045,875)	0
Expense Total	**179,319,304**	**191,036,617**	**211,700,874**	**211,700,874**	**0**
Revenue					
Other Local Revenue	71,428,011	77,488,622	90,813,435	90,813,435	0
Federal Assistance	61,980,585	66,342,357	73,723,857	73,723,857	0
State Assistance	30,786,729	29,932,465	29,872,394	29,872,394	0
Revenue Total	**164,195,325**	**173,763,444**	**194,409,686**	**194,409,686**	**0**
Net County Cost (NCC):	**15,123,979**	**17,273,173**	**17,291,188**	**17,291,188**	**0**
Allocated Positions (FTE)	**456.7**	**458.7**	**474.0**	**474.0**	**0.0**
Financial Indicators					
Salaries as % of Total Exp	28%	30%	29%	29%	
% Change in Total Exp		7%	11%	0%	
% Change in Total Rev		6%	12%	0%	
% Change in NCC		14%	0%	0%	
Compensation Information					
Permanent Salaries	27,770,077	32,161,707	35,139,375	35,139,375	0
Temporary Salaries	1,551,233	1,239,171	1,089,655	1,089,655	0
Permanent Overtime	142,389	122,328	226,631	226,631	0
Deferred Comp	211,588	270,198	377,640	377,640	0
Hrly Physician Salaries	76,799	90,556	73,845	73,845	0
Perm Physicians Salaries	1,663,524	2,313,776	1,688,976	1,688,976	0
Perm Phys Addnl Duty Pay	2,208	1,499	172	172	0
Comp & SDI Recoveries	(95,540)	(114,768)	(114,768)	(114,768)	0
FICA/Medicare	2,253,389	2,779,451	2,953,424	2,953,424	0
Ret Exp-Pre 97 Retirees	110,720	124,116	125,596	125,596	0
Retirement Expense	10,029,554	10,960,760	11,762,778	11,762,778	0
Employee Group Insurance	3,817,542	5,084,324	5,502,087	5,502,087	0
Retiree Health Insurance	1,305,439	1,435,615	1,374,490	1,374,490	0
OPEB Pre-Pay	410,737	410,737	410,737	410,737	0
Unemployment Insurance	93,186	103,115	102,201	102,201	0
Workers Comp Insurance	893,507	957,608	1,039,383	1,039,383	0
Labor Received/Provided	(196,661)	0	(121,905)	(121,905)	0

Description: To serve serious and persistent mentally disabled adults and seriously emotionally disabled children and youth.

Workload Indicator: The recommended FY 2017-2018 budget is based on 418,316 visits and an inpatient psychiatric average daily census of 18.0 patients.

Impact: The recommended budget maintains the current level of services. The budget includes a three percent (3%) cost of living adjustment for the Mental Health Community Based Organization (CBO) Adult, Children, and MHSA contract providers.

1. Child and Adolescent Services

Description: Child and Adolescent Services provides services to children under age 18, and up to age 21 for emotionally disturbed individuals.

a. Local Institutional/Hospital Care: Acute psychiatric inpatient treatment for children and adolescents is provided in private hospitals in order to avoid placing minors in the same psychiatric unit as adults at the Contra Costa Regional Medical Center. Case management services are provided by the Children's Intensive Treatment Services Case Management Team.

b. Out-of-Home Residential Care/Treatment Service Programs: Mental Health works in collaboration with Probation and Social Service to support these placements and their mental health component. Structured Short Term Residential Treatment Program services (STRTP) for seriously emotionally disturbed (SED) children and adolescents provides individual, group, family therapy and wrap-around teams. Case management services are provided at various STRTP's in California and the nation.

c. Intensive Day Treatment Services: Therapeutic treatment and activity programs (less than 8 hours per day) for children/adolescents who have behavioral/emotional disorders or are seriously emotionally disturbed (SED), psychosocially delayed or "at high risk." All of these services are attached to Residential Treatment Centers outside Contra Costa County.

d. Outpatient Clinic Treatment and Outreach Services: Outpatient clinic, school-site and in-home services, including psychiatric diagnostic assessment, medication, therapy, wrap-around, collateral support, Family Partnership, and crisis intervention services for seriously emotionally disturbed (SED) children and adolescents and their families.

e. Child/Adolescent Case Management Services: Case managers provide screening, assessment, evaluation, advocacy, placement and linkage services to assist children and adolescents in obtaining continuity of care within the mental health, Juvenile Probation Health Care, and Social Service systems. Community and school-based prevention and advocacy programs provide community education, resource development, parent training, workshops, and development of ongoing support/advocacy/action groups. Services are provided to enhance the child's ability to benefit from their education, stay out of trouble, and remain at home.

f. EPSDT (Early and Periodic Screening Diagnosis and Treatment) Program: Provides comprehensive mental health services to Medi-Cal eligible severely emotionally disturbed persons under age 21 and their families. Services include assessment; individual, group and family therapy; crisis intervention; medication; day treatment; and other services as needed.

g. Therapeutic Behavior Services **(TBS):** TBS provides one-on-one behaviorally focused shadowing of children and youth on a short-term basis to prevent high level residential care or hospitalization, and to ameliorate targeted behaviors preventing success.

h. Mobile Response Team: The mobile crisis response team, comprised of a Masters level therapist and a family support partner, provides short-term triage and emergency services to seriously emotionally disturbed children, adolescents and their families in order to prevent acute psychiatric crises and subsequent hospitalization. With expanded hours being

added the team will be better able to respond to the entire County population of East County, West County, and Central County with far less wait time and many more hours of availability. The Behavioral Health Division is looking to expand this program and program expansion will be a work-in-progress pending funding availability.

i. Mental Health Services for Children 0-5 Years of Age: Several contract agencies provide a wide array of outpatient, and in-home services to SED children, children in foster care, or children at risk of significant developmental delays and out-of-home placement.

j. Special Education Services – Educationally Related Mental Health Services (ERMHS). Mental Health Services are provided as part of a youth's Individualized Education Plan (IEP) to fulfill a mandate under federal law to provide a free and appropriate public education to students with special needs in the least restrictive educational environment. Services include: individual, group, or family psychotherapy, day treatment services, collateral, and case management.

In Contra Costa County there are approximately 166,000 public school students. Over 33,000 of these students, or approximately 20%, are enrolled in Special Education. Prior to FY 2010/2011, funding for these mandated services had been federal IDEA funds, State Mandate Claims (SB-90), Medi-Cal and State General Funds. In the Budget Act of 2010-2011, the mandate was suspended and the responsibility to fund these services was transferred from County Mental Health to the local school districts and SELPA's (Special Education Local Plan Areas). An MOU was developed and signed by County Mental Health and the SELPAs, with supporting contracts going before the Board for approval. This budget assumes that the responsibility for funding continued ERMHS Non-Medi-Cal services will remain with the local school districts and SELPA's.

As part of the State 2004-05 Budget, all 2003-04 and prior SB-90 claims were deferred with the requirement to pay them over no more than five years beginning in 2006-07. In the State 2005-06 Budget, Government Code Section 17617 was amended to pay these claims over 15 years from 2006-07 through 2020-21. Subsequent budgets suspended payments.

The proposed 2014-2015 Governor's budget included $900 million in funding for payment of 2004 and prior outstanding mandated claims. The 2004 and prior years claims were fully paid as of July 16, 2015. The corresponding interest was fully paid as of October 12, 2015.

k. Olivera: A first step alternative to, as well as a step down from, residential placements that provides a non-public school with Intensive Day Treatment and wrap services. The program includes five classrooms – three for the Mt. Diablo Unified School District and two for other SELPAs within Contra Costa.

l. Oak Grove Treatment Center: The County facility at 1034 Oak Grove Road in Concord is in program development and currently houses the First Hope program for the early intervention for psychosis, with emphasis on multi-family treatment consistent with the Psychosis Intervention Early Recovery (PIER) model.

m. Katie A. Programming: Children's Mental Health, in partnership with Child and Family Services, is in the fourth year development stage of a new legally mandated service delivery system to serve Katie A. youngsters in the foster care system. These youngsters meet specific criteria to be included in the Katie A. subclass and receive augmented services as defined in the legal settlement. These new services are identified as Intensive Care Coordination (ICC) and In Home Behavioral Services (IHBS). All youngsters in the subclass will receive ICC services, and the need for IHBS will be determined by the Child and Family Teams.

n. Mentally Ill Offender Crime Reduction Grant (MIOCR): The MIOCR 2003 Act was passed to address the following:

- Create mental health courts;
- Offer specialized training to criminal justice staff in identifying symptoms in order to respond appropriately to people with mental illness;

- Develop programs to promote public safety;
- Develop programs to support intergovernmental cooperation between state and local government agencies with respect to the mentally ill offenders.

The County Probation Department applied for and was awarded the MIOCR Grant. The amount is approximately $1,000,000 for a 3 year period. An RFP went out and the Community Options for Families and Youth (COFY) was selected as the vendor who will work closely with the County Probation Department to prevent recidivism. The Behavioral Health Division will provide technical assistance and support.

o. Continuum of Care Reform (CCR): In 2017 Continuum of Care Reform will serve to expand Katie A. services and provide needed treatment to all children in foster care. CCR effectively eliminates the Rate Classification Level (RCL) system and implements the Short-Term Residential Programs (STRTPs) model while requiring interagency development of child serving partnerships. It is currently in development and Residential Treatment Centers are transitioning to STRTP status and Foster Family Agencies are converting to Resource Family Agencies providing vitally needed services to our most at risk youth. This is a new program and will be a work-in-progress pending funding availability.

p. Evidenced Based Practices: Children's Mental Health has instituted system wide training in several evidenced based practices (EBP's) including Cognitive Behavioral Therapy, Trauma Focused Behavioral Therapy, Cognitive therapy for depression, Dialectic Behavioral therapy, and Wraparound services. Additionally, we are adding an EBP for eating disorders and are in the early stages of development for that initiative. Evidenced Based Practices are being supported by placing EBP team leaders in each of the regional clinics with centralized training and ongoing supervision groups. Additionally, these teams are part of a Bay Area Collaborative to further trauma focused care regionally.

Child & Adolescent Services Summary		
Service:		Mandatory
Level of Service:		Discretionary
Expenditures:		$63,476,541
Financing:		62,722,888
Net County Cost:		753,653
Funding Sources:		
Federal	50.1%	$31,429,476
Local	43.5%	27,253,498
Transfer	6.4%	4,039,914
General Fund	1.2%	753,653
FTE: 85.5		
Note: Excludes Support Services Costs included under the Administrative component of the budget.		

2. Adult Services

Description: Provides services to consumers over 18 years old.

***a. Crisis/Transitional/Supervised Residential Care*:** Short-term, crisis residential treatment for clients who can be managed in an unlocked, therapeutic, group living setting and who need 24-hour supervision and structural treatment for up to 30 days to recover from an acute psychotic episode. This service can be used as a short-term hospital diversion program to reduce the length of hospital stays. This service also includes 24-hour supervised residential care and semi-supervised independent living services to increase each client's ability to learn independent living skills and to transition ("graduate") from more restrictive levels of residential supervision to less restrictive (i.e., more independent) living arrangements, including board and care facilities.

b. Outpatient Clinic Treatment and Outreach Services: Provides scheduled outpatient clinic services, including psychiatric diagnostic assessment, medication, short-term individual and group therapy, rehabilitation, and collateral support services for seriously and persistently mentally ill (SPMI) clients and their

families with acute and/or severe mental disorders. Also includes community outreach services not related to a registered clinic client.

c. Case Management Services: Case managers provide screening, assessment, evaluation, advocacy, placement and linkage services in a community support model. Case management is also provided through supportive housing services, as well as the clinics in West, East and Central County. County clinics include peer providers on case management teams.

d. Mental Health Homeless Outreach/ Advocacy Services: The homeless shelter in Antioch assists the homeless mentally ill to secure counseling, transportation, clothing, vocational training, financial/benefit counseling, and housing. Case management can be arranged through this program, if determined necessary.

e. Vocational Services: The Mental Health Division contracts with the California Department of Rehabilitation under a cooperative agreement with the State Department of Health Care Services to provide comprehensive vocational preparation and job placement assistance. Services include job search preparation, job referral, job coaching, benefits management, and employer relations. This is one of the only mental health collaborations providing services to individuals with co-occurring disorders in the State.

f. Consumer-Run Community Centers: Centers in Pittsburg, Concord and San Pablo provide empowering self-help services based on the Recovery Vision, which is the concept that individuals can recover from severe mental disorders with peer support. The Centers, which are consumer operated, provide one-to-one peer support, social and recreational activities, stress management, money management, and training and education in the Recovery Vision.

g. Substance Abuse and Mental Health for CalWORKs (SAMHWORKs): Mental health and substance use disorders specialty services provided for CalWORKs participants referred by the Employment and Human Services Department to reduce barriers to employment. Services include outpatient mental health, substance use disorders, and supportive services for participants and their immediate family members.

h. The Behavioral Health Access Line is a call center serving as the entry point for mental health and substance use services across the county. The Access Line, staffed with licensed mental health clinicians and an Alcohol and Drug counselor, operates 24 hours a day, seven days a week. The Access Line provides phone screenings, risk assessments, referrals, and resources to consumers seeking mental health or substance use services.

i. Forensics Mental Health Services: This Unit is comprised of three areas of service delivery through Adult Felony Probation involvement (AB 109 and General Supervision), Court Ordered services, and co-responding with local Law Enforcement agencies (Mental Health Evaluation Team). Forensics Clinicians are co-located at the Probation Department and Law Enforcement agencies for field based outreach, mental health screening and linkage to the adult mental health system of care. The court involved services include restoration for Incompetent to Stand Trial (IST) misdemeanor cases and the implementation of Assisted Outpatient Treatment (AOT), also known as Laura's Law. Forensics clinicians receive referrals to AOT from qualified requestors; complete an investigation to determine eligibility for AOT; and make appropriate referrals to AOT services for those who meet criteria and refer to other services for those who do not meet criteria. This is AOT's first year of implementation.

j. Rapid Access: Provide drop-in services at the mental health clinics to clients that have recently been admitted to Psychiatric Inpatient Hospital Services, the CCRMC Crisis Stabilization Unit, or Detention. Provides needs assessments, short term case management/therapy, referrals and linkage to appropriate services including medication assessments, individual therapy, group therapy, case management, Alcohol and Other Drugs (AOD) services, homeless services and financial counseling.

k. Oak Grove Residential Program: The Behavioral Health Division is planning to develop and implement a transitional residential program with three components: a residential treatment program, a step down program, and an outpatient services program. The Oak Grove program will provide a highly effective, comprehensive standard of care. This program will serve an age group ranging from 18 to 26 year's old with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). The program will include eligible young adults struggling with serious life challenges as well as 21 to 26 year old Medi-Cal eligible Transition Aged Youth (TAY) grappling with the new emotional challenges presented by the transition to adulthood. By partnering with these consumers and providing comprehensive, whole person care, Oak Grove will support these young adults as they transition back to their communities. This is a new program and will be a work-in-progress pending funding availability.

l. Older Adult Program: The Older Adult Mental Health Program provides mental health services to Contra Costa's seniors who are age 60+, including preventative care, linkage and outreach to under-served at risk communities. The Senior Peer Counseling Program reaches out to isolated and mildly depressed older adults who are 55+ in their home environments and refers them to appropriate community resources, as well as provides lay-counseling in a culturally competent manner. The IMPACT Program uses an evidence-based practice which provides problem-solving short-term therapy for depression (moderate to severe) treatment to individuals age 55+ in a primary care setting. The Intensive Care Management Program provides mental health services to severely mentally ill older adults who are 60+ in their home, the community, and within a clinical setting. There are three multi-disciplinary teams, one for each region of the county. Services include screening and assessment, medication management, and case management services including advocacy, placement, linkage and referral.

m. Transition Team: The Transition Team provides short term intensive case management services and linkage to ongoing services for severely and persistently mentally ill adults age 18-59 who are in need of mental health services. Transition Team referrals come primarily from inpatient psychiatric hospitals, psychiatric emergency, homeless services, and occasionally from law enforcement. The consumers range from individuals who are experiencing their first psychiatric symptoms to those who have had long term psychiatric disabilities but have been unable or unwilling to accept mental health treatment on their own. The Transition Team provides these consumers with the additional support and guidance to successfully access these services and to stay in treatment. Once consumers are stable enough, Transition Team refers them to one of our Outpatient Mental Health Clinics for ongoing treatment and support.

n. Evidence Based Practice (EBPs): have been primarily developed in the children's system of care and as a result their staff culture has started to change. However the adult system of care has experienced fewer strides in implementing evidence based practices. In 2017, the adult system of care plans to implement two Evidence Based Practice Models across the Division, in all three regions. EBP trainings will include training for therapists as well as peer providers, and will be available to both Substance Use Disorder (SUD) staff as well as Mental Health staff. Planning is underway to identify leadership to support the change and implement on-going supervision of the practice of EBPs. Similar to the children's system of care, evidence based practice should be supported by EBP team staff leaders in each of the regional clinics with centralized training and ongoing supervision groups. The goal is to develop "train the trainer capacity" within the adult system of care, build a community of practice that supports professional growth and development, and provides quality training in best practices. The overall goal is to improve outcomes. Planning is underway to choose an appropriate outcomes tool for use in the Adult System of Care. This pilot will provide important learning and information to guide implementation of outcomes across the Division as a whole.

***o.* Mobile Crisis Intervention Team (MCIT):** The Behavioral Health Division is planning to develop and implement a 24/7 mobile crisis

response team for consumers experiencing mental health crisis. The Mobile Crisis Intervention Team (MCIT) will be an interdisciplinary team composed of mental health clinicians, community support workers, and a Family Nurse Practitioner who will provide assessment, brief crisis response, short-term triage, and emergency services to severely persistently mentally ill consumers and their families in order to prevent acute psychiatric crises and subsequent hospitalization. The MCIT will work closely with law enforcement partners to decrease 5150s and PES visits, and to refer consumers to appropriate services in their communities. This is a new program and will be a work-in-progress pending funding availability.

Adult Services Summary		
Service:		Mandatory
Level of Service:		Discretionary
Expenditures:		$55,560,393
Financing:		52,806,620
Net County Cost:		2,753,773
Funding Sources:		
State	52.8%	$29,355,123
Federal	32.9%	18,303,279
Local	7.6%	4,214,252
Transfer	1.7%	933,966
General Fund	5.0%	2,753,773
FTE: 127.3		
Note: Excludes Support Services Cost included under the Administrative component of the budget.		

3. Support Services

Description: Functions include personnel administration, staff development training, procuring services and supplies, physical plant operations, contract negotiations and administration, program planning, development of policies and procedures, preparation of grant applications and requests for proposals, monitoring service delivery and client complaints, utilization review and utilization management, quality assurance and quality management, quality improvement, computer system management, and interagency coordination.

Support Services Summary		
Service:		Discretionary
Level of Service:		Discretionary
Expenditures:		$12,799,648
Financing:		1,841,574
Net County Cost:		10,958,074
Funding Sources:		
Federal	13.8%	$1,767,150
Transfer	0.6%	71,995
Local	0.0%	2,429
General Fund	85.6%	10,958,074
FTE: 76.5		

4. Local Hospital Inpatient Psychiatric Services

Description: Provides acute inpatient psychiatric care at Contra Costa Regional Medical Center, involuntary evaluation and crisis stabilization for seriously and persistently mentally ill clients who may be a danger to themselves or others.

Local Hospital Inpatient Psychiatric Services Summary		
Service:		Mandatory
Level of Service:		Mandatory
Expenditures:		$10,777,951
Financing:		9,820,858
Net County Cost:		957,093
Funding Sources:		
Federal	82.6%	$8,906,955
Local	7.5%	804,292
State	1.0%	109,611
General Fund	8.9%	957,093

5. Outpatient Mental Health Crisis Service

Description: The outpatient clinic provides crisis intervention and stabilization, psychiatric diagnostic assessment, medication, emergency treatment, screening for hospitalization and intake, disposition planning, and placement/ referral services. Services are provided at the CCRMC Crisis Stabilization Unit.

Outpatient Mental Health Crisis Service Summary		
Service:		Mandatory
Level of Service:		Mandatory
Expenditures:		$13,893,610
Financing:		13,012,104
Net County Cost:		881,506
Funding Source:		
Federal	73.7%	$10,234,305
Local	19.8%	2,751,713
State	0.2%	26,086
General Fund	6.3%	881,506

6. Medi-Cal Psychiatric Inpatient/Outpatient Specialty Services (Managed Care)

Description: The Behavioral Health Division operates the County Mental Health Plan, a Managed Care Organization (MCO). The Behavioral Health Division provides Medi-Cal Psychiatric Inpatient and Outpatient Specialty Services through a network of providers. The Behavioral Health Division maintains a network of inpatient psychiatric care providers within Contra Costa County and throughout the Bay Area in order to meet the needs of our patients. The Behavioral Health Division also maintains a network of over 240 contracted outpatient providers who provide services to Medi-Cal beneficiaries. These outpatient services include individual therapy, group therapy, and medication management services for both children and adults who require Specialty Mental Health Services.

Medi-Cal Managed Care Services Summary		
Service:		Mandatory
Level of Service:		Mandatory
Expenditures:		$8,664,040
Financing:		7,676,951
Net County Cost:		987,089
Funding Sources:		
Local	48.6%	$4,212,685
Federal	35.6%	3,082,693
State	4.4%	381,573
General Fund	11.4%	987,089
FTE: 21.0		

7. Mental Health Services Act/ Proposition 63

Description: Approved by California voters in November 2004, Proposition 63 imposes a one percent tax on incomes in excess of $1 million and directs those collections to the provision of mental health services. The Mental Health Services Act (MHSA) has expanded mental health care programs for children, transition age youth, adults, and older adults. Services are client and family driven and include culturally and linguistically appropriate approaches to address the needs of underserved populations. They must include prevention and early intervention as well as innovative approaches to increasing access, improving outcomes and promoting integrated service delivery. The MHSA added Section 5891 to the Welfare & Institutions Code, which reads in part, "The funding established pursuant to this Act shall be utilized to expand mental health services. These funds shall not be used to supplant existing state or county funds utilized to provide mental health services".

The first yearly MHSA Program and Expenditure Plan for Community Services and Supports was approved by the Board of Supervisors and submitted to the State Department of Mental Health on December 22, 2005. The Prevention and Early Intervention component was added in

2009, and the remaining components of Innovation, Workforce Education and Training, and Capital Facilities/Information Technology were added in FY 2010 -11. Each subsequent year an Annual Update was approved, which included program refinements, program changes when indicated, and the development of new programs identified by a local stakeholder driven community program planning process. Contra Costa's first integrated Three Year Program and Expenditure Plan was submitted and approved for fiscal years 2014-17.

FY 2017-18 will be the first year of Contra Costa's MHSA Three Year Program and Expenditure Plan for fiscal years 2017-20.

Revenues to the MHSA Trust Fund tend to change from year to year due to the dynamic nature of the revenue source. Any expenditures in excess of annual MHSA revenues can be funded from the Trust Fund carryover surplus. However, for the last three fiscal years average total expenditures have been less than the average of annual revenues. The projected FY 2017/2018 MHSA expenditures are described below.

Program Type	$ in Millions
Community Support System	$37.6
Prevention and Early Intervention	8.7
Work Force Education & Training	2.5
Capital Facilities	0.6
Innovation	2.1
Total MHSA Allocation	$51.5

For the MHSA Three Year Program and Expenditure Plan for FY 2017-20 (Three Year Plan) the statutorily required Community Program Planning process concludes with a 30 day public comment period and public hearing in April 2017. Responses to substantive stakeholder input will be incorporated in the final Three Year Plan that will be submitted for Board of Supervisor consideration on or after April 2017.

Mental Health Services Act

Service:		Mandatory
Level of Service:		Discretionary
Expenditures:		$51,574,566
Financing:		51,574,566
Net County Cost:		0
Funding Sources:		
Local (Transfers from the MHSA Fund)	100.0%	$51,574,566

FTE: 157.0

Goal: Implement comprehensive, web-based Patient self-health risk assessment and associated tools to help Medi-Cal members improve their health status.

Outcome: Successfully implemented the web-based health patient self-risk assessment. Paper version was delayed due to contracting, but is expected to go live April 2017. Associated self-care tools have been developed and posted to the website.

Goal: Provider Relations will increase the Community Provider Network (CPN) Primary Care Provider's (PCP) by 3% to meet the increasing membership needs. This will be done by working collaboratively with three major medical groups, that are now exclusive, to contract with CCHP.

Outcome: Provider Relations Unit met the goal of increasing the number of CPN PCP's by 3% to meet the increasing member needs. Provider Relations recruited fourteen PCP's by working collaboratively with two large groups to increase the number of PCP's under contract. In addition, we had several PCP's move into the Contra Costa area and open a PCP office.

Mental Health:

Goal: Children's mental health will continue to move to offer all three current best practices in each regional clinic and expand our MST and MDFT Programming.

Outcome: Partially achieved. We have implemented most of the goals in two of the three clinics.

Goal: Children's mental health and Alcohol and Other Drugs will integrate Alcohol and Other Drugs services into each of the regional clinics two days per week.

Outcome: Integrated into the West County Clinic and working to develop an Intensive Outpatient SUDS program in West County.

Goal: Conduct a Community Program Planning Process and develop the MHSA Three Year Program and Expenditure Plan for FY 2017-20.

Outcome: A quantitative needs assessment was completed that informed Behavioral Health staff of the sufficiency of care provided to each County region, demographic sub-population, and quantified the resources expended for each level of care. Three community forums were conducted in each County region where mental health needs were prioritized, and over 400 stakeholders discussed strategies to meet those needs. The results of the completed Community Program Planning Process have been incorporated into the MHSA Three Year Program and Expenditure Plan for FY 2017-20 that will be submitted for Board of Supervisor consideration on or after April 2017.

Goal: Implement program and data reporting adjustments brought about by newly promulgated state regulations in the Prevention and Early Intervention (PEI) and Innovation (INN) components of MHSA.

Outcome: All PEI and INN programs have been analyzed and adjusted to comply with new regulatory program requirements, and new data forms were developed to comply with new reporting requirements. All programs are now compliant with regulations and are reporting data needed for both MHSA components.

Goal: Children's Behavioral Health will partner with Homeless Services to implement and plan for a method of assessing and intervening with family homelessness.

Outcome: In discussion. With the separation of Homelessness from Behavioral Health, it is more difficult to address this issue. However Mental Health has joined the monthly Homelessness meeting and is represented by a Program Manager.

Goal: Children's system of care will implement the CANS (Child and Adolescent Needs Survey) as the standard system wide assessment tool for children's mental health. This will be implemented in stages with the first step being a pilot of the tool within a suitable identified program. A learning management system will

need to be researched and identified to support outcomes data collection, reporting and analysis as well as to provide an automated tickler system to clinical staff for outcomes assessment and reassessment.

Outcome: This is on hold until the State determines whether the CANS or the Treatment Outcome Package (TOP) tool should be used. The State is piloting these tools right now and will then evaluate.

Goal: Adult system of care will select and implement one evidence base practice. The adult system will apply lessons learned from the Children's system of care, and will adopt a similar workforce structure to lead implementation. The Adult system will gear up to offer at least one evidence based practice implemented across the three regional clinics.

Outcome: Adult system of care will implement two evidence based practices: Cognitive Behavioral Social Skills Training (CBSST) in March 2017 and Cognitive Behavioral Therapy for Psychosis (CBTp) in May 2017. These are two full day trainings with follow-up consultation calls for one year with the trainer. Staff from programs across the Adult system of care will participate in the training and actively follow-up implementation of the treatment models in their clinics offering group and individual services. Champions have been identified to help implement and build infrastructure to support Evidence Based Practice (EBP).

Goal: Access Line is continuing to focus on decreasing the number of abandoned calls (callers who hang up after waiting for the line to be answered) by increasing the response time (decreasing the time it takes for the call to be answered). With the launch of a new phone system, InContact, the Access Line and Care Management Unit hope to have better metrics on the volume and type of calls to and from both departments, and more enhanced call features that improve workflow and the customer service. With the launch of EPIC's Tapestry managed care module scheduled for early 2016, the Access Line and Care Management Unit will have access to more accurate data, better coordination of care across the system of care, and increased focus on timely access to care. The Access Line will be continuing to expand the new Community Support Worker's outreach follow up role to include a satisfaction survey to track timely access to service, satisfaction, and outcome measures.

Outcome: Goals met. With implementation of In Contact and the expansion of the Community Support Worker follow-up role, the ACCESS Line continues to decrease the number of abandoned calls. EPIC's Tapestry launch was completed in 2016.

Goal: Forensic Mental Health Services is a county wide outreach team that engages criminal justice involved clients who are challenged by behavioral health issues. The goal of the team is to connect clients to outpatient services to decrease utilization of crisis services. Clients are assisted with reentry from the custody setting back to the community to avoid repeat incarceration.

Outcome: Goals are being met by the Forensic Mental Health team. The Forensic team supports clients involved in the criminal justice system with behavioral health issues; connecting these clients to appropriate outpatient services. They support consumers with re-entry from custody back to the community. Facilitating and increasing access to services helps to decrease utilization of crisis services.

Goal: The aim of Rapid Access is to provide a rapid response in providing services to the client from within the clinic. If the client recognizes the clinic as an open door to resources, the client is more likely to reach out to his/her team and decrease his/her usage of high levels of services such as crisis stabilization, psychiatric inpatient, crisis residential, and detention. This will allow the client to sustain stabilization at a lower cost.

Outcome: Goal is being met. Rapid Access is actively providing services to consumers. Staff changes in East Adult clinic prevented implementation across Division. Work has begun to fill the empty position.

Goal: The primary goal of Intensive Care Management (ICM) is to support aging in place for older adults (60 and over) experiencing severe mental illness as well as to improve consumers' mental and physical health, prevent

psychiatric hospitalization and placement in a higher level of care, and provide linkage to specialty appointments, community resources and events, and public transportation in an effort to maintain independence in the community. The primary goals of the IMPACT Program are to prevent more severe psychiatric symptoms in older adults (55 and over) who are experiencing moderate to severe depression by providing short-term evidence-based therapy designed to treat depression, assisting clients in accessing community resources as needed and reducing stigma related to accessing mental health treatment for this underserved population. Primary goals of the Senior Peer Counseling Program are to prevent more severe psychiatric symptoms and loss of independence in older adults (55 and over) experiencing mild depression and other age-related stressor reduce stigma related to seeking mental health services, and increase access to counseling services to these underserved populations.

Outcome: This program continues to meet its goals of supporting Older Adults to improve their mental and physical health, increase access and provide linkage to community resources and mental health services; prevent psychiatric hospitalization, and placement in higher levels of care. During FY 16-17, the ICM Program decreased inpatient psychiatric hospitalizations by 44 % and decreased visits to Psych Emergency Services by 48.1%. Over the past five years, ICM decreased inpatient psych hospitalizations by 67.13% and decreased visits to Psych Emergency Services by 43.48%.

Goal: The Transition Team provides short term intensive Case Management services to individuals who need extra support and linkages to multiple services which in addition to mental health care, includes health insurance, a source of income and housing. This level of service allows these consumers to successfully get connected to needed Mental Health treatment and provides the support needed to keep them linked to treatment services. Connections to these services are crucial to their ability to become and remain stable in the community. The Transition Team is committed to providing services in the community, wherever our clients are located, if they are unable or unwilling to receive services in a clinic setting. By being flexible with our service provision, we help remove the barriers that keep consumers from receiving the mental health treatment that they need.

Outcome: The Transition Team continues to perform a critical role in providing short term intensive case management services to individuals needing extra support and linkage to multiple services. They serve clients in non-traditional settings such as shelters, streets, homes of their own, crisis residential programs, board and care homes, hospital, dual diagnosis, and substance abuse programs; meeting the client wherever they are and connecting them to needed community resources-mental health, primary care, and housing. They continue to meet goal of increasing access by supporting and linkage and coordination of care.

Alcohol and Other Drugs (AOD):

Goal: Expand the Drug Medi-Cal (DMC) provider base from four to six. Encourage existing and potential providers to expand or modify their services into diverse levels of care, and/or to target culturally diverse populations. Encourage providers to increase utilization of DMC revenue among all DMC eligible clients proportionate to Block Grant allocations. By adding new providers, we increase access to services, decrease wait list time, expand underutilized resources, and reduce health disparities.

Outcome: We met this goal as some of our existing agencies certified additional programs within their agencies. We continued to provide ongoing technical assistance on as needed basis in the preparation of DMC applications to various providers that have demonstrated interest in providing SUD treatment services. Additionally, we were able to include SUD services as part of other Behavioral Health's Request For Proposal processes conducted this year.

Goal: Support local efforts to establish the development of Medication Assisted Treatment (MAT) for opioid dependent individuals as a new SUD treatment benefit option under ACA.

Outcome: Health Care for the Homeless Ambulatory Care was awarded a HRSA grant to serve MAT homeless patients. We have an established cadre of MAT physicians who have taken the lead to implement an Outpatient Based Buprenorphine Treatment for Opioid Disorders. "The Choosing Change" Buprenorphine clinics treat opioid addiction at most County Health Centers. We visited San Francisco's MAT clinic and we have incorporated strong clinical practices into our programming. The Choosing Change Clinics are a partnership between Health Care for the Homeless and Behavioral Health Services. Access to MAT services starts at the Behavioral Health Access Line where our Substance Abuse counselor plays a critical role in screening and helping clients navigate the clinics.

Goal: Support the goals of the Behavioral Health Division Integration efforts in Contra Costa. AOD will integrate services within Mental Health and Homeless Services to provide efficient and effective care to individuals with complex and diverse needs through the following objectives or initiatives:

1. Continue to improve quality of implementation processes of SUD treatment at the Mental Health El Portal Clinic, a behavioral health integrated treatment, and apply for State DMC certification. In FY16/17, we increased the number of admissions into SUD treatment at El Portal by 10% from previous admission level data.

2. Continue providing outreach, engagement, groups and linkages to treatment at the Homeless Adults Shelter and Calli House. Strengthen the structure of POWER programs in collaboration with Anka to ensure immediate access to SUD treatment for homeless clients. Continue to support the presence of the Housing Specialist at the Discovery House and expand the model to include an additional residential facility.

3. Support discussions and activities intended to update the Behavioral Health Cultural Competency Work Plan and Workforce Development.

4. Participate in Primary and BH Integration efforts including Miller Wellness Center, Case Management, HealthCare for the Homeless, and SBIRT.

5. Maintain staff support in the newly Integrated Access Line, support the development of procedures intended to streamline referrals and co-location. Track referral data and follow up to clients. Participate in Value Stream Mapping and Rapid Improvement Kaizen events.

6. Continue documenting admission of clients with co-occurring disorders at Discovery House; develop formal internal and external protocols for meeting their needs, and support long term recovery.

7. Continue work at West County Mental Health Children and Adolescent Clinic.

8. Maintain SBIR Women Services at the three Healthy Start Clinics and WIC programs, and increase the number of screenings and referrals by 5%.

Outcomes:

Outcome 1. We have increased our admissions at El Portal as proposed, but have not yet applied to DMC certification. Our County Implementation Plan and Fiscal Plan were approved in 2016 but we proposed a starting date of July 1, 2017.

Outcome 2. We have met this goal. The Housing Specialist has been temporarily disrupted due to staff attrition. Nonetheless, we added a Mental Health Clinical Specialist at Discovery House which has increased our ability to treat individuals with behavioral health needs.

Outcome 3. This goal was met. Behavioral Health now has an Integrated Cultural Competence Work Plan and we maintained presence at every meeting this year.

Outcome 4. We met this goal.

Outcome 5. We have met this goal. Under the ODS-DMC Waiver, the Access Line plays a key role, therefore we anticipate expanding the number of clinical staff who will assist with access into the system.

Outcome 6. We have met this goal.

Outcome 7. While we conducted interviews for this position, current hiring practices prevented us from hiring a counselor to be placed at West County Children's Mental Health, hence services remain discontinued. We plan to resume as soon as we are able to fill the position.

Outcome 8. We discontinued services at those locations due to the fact that SBIRT has been institutionalized in all primary health care settings as expected by ACA.

Goal: Increase the engagement and retention rate among clients connected to realignment who are served in our treatment services.

Outcome: We have slightly met this goal through the implementation of case management services targeting our most hard to engage clients.

Goal: Continue supporting the goals and objectives of the AOD Prevention Strategic Plan.

Outcome: This goal has been met. This year we conducted a Case Study focusing on the value of involving young people in the development of public policy. Our Case Study is a tool that can help communities implement youth development programs and provide youth with opportunities to develop their leadership skills and positively contribute to their own communities.

Goal: Expand and Enhance SAMHWorks: Wellness to Independence behavioral health services to individual clients to include new CalWORKS Family Stabilization services for SAMHWorks families.

Outcome: This goal has been met.

Goal: Develop Readiness for the Implementation of the Terms and Conditions of the Organized Delivery System Drug Medi-Cal Waiver County Implementation Plan.

Outcome: By addressing the objectives below, Contra Costa County will be prepared to serve the number of projected beneficiaries under the DMC Waiver.

a) Develop a stronger administrative structure to provide the required County oversight with regard to provider compliance, service quality and, with regard to clients, appropriate placement, care coordination and utilization review.
b) Implement procedures and protocols with other health care systems to further integration
c) Increase Behavioral Health system capacity through workforce development and adoption of two Evidence Based Practices
d) Increase adherence to the Culturally and Linguistically Appropriate Service Standards (CLAS) to ensure Cultural Competence and access to services for beneficiaries whose primary language is not English.
e) Promote and support sound implementation and utilization of Medication Assisted Treatment

Outcome: This goal will continue in FY17-18 as we prepare for DMC-ODS Waiver implementation. We developed an MOU with the Contra Costa Health Plan depicting the referral and coordination process for Medi-Cal beneficiaries who meet SUD medical necessity.

Goal: Restore residential and detoxification services for West County Residents
Outcomes:

a) Continue provision of services during the interim period by utilizing existing capacity and avoid service disruption.
b) Identification and selection of a permanent local provider.

Outcome:
This goal will continue in FY17-18, although we selected a provider, and service was not disrupted we have yet to find a site to restore much needed services to West County residents.

Goal: Collect quantifiable SAMHWorks data on the initial behavioral health treatment assessment of incoming SAMHWorks clients and subsequent utilization to determine future allocation of treatment resources.

Outcome: Implementation of programs are driven by the needs of the clients.

Goal: Increase service delivery to Spanish speaking SAMHWorks clients.

Outcome: We have conducted a needs assessment and found a low number of Latinos served in the SAMHWorks program. We hired a Latino Outreach staff at the end of 2016, and hope to capture more data and provide more services to Latino families in far East County.

Homeless Programs:

Housing and Services

Goal: Add more permanent supportive housing through various resources that provide rental vouchers and other support services.

Outcome: A new rental assistance program was implemented within the homeless continuum of care to support 12 chronically homeless families in FY 16-17.

Data/Evaluation

Goal: Change the Homeless Management Information System software to better meet the needs of the community and comply with HUD's Data and Technical Standards.

Outcome: The Homeless Program and its stakeholders selected new software and is in the process of transitioning its homeless management information system to a new vendor. The new Clarity software, by BitFocus, has a more user friendly interface and incorporates data visualization features.

Policy/Planning/Systems Development

Goal: Fulfill our commitment as a Community Solutions Zero:2016 participating community to end homelessness for chronically homeless in Contra Costa by end of 2016.

Outcome: The work to end homelessness for veterans and chronically homeless adults continues. As a result, Contra Costa has experienced a 31% decrease in veteran homelessness and has improved its capacity to identify the number of chronically homeless individuals in our community. The national campaign organized by Community Solutions has extended its target dates through 2017 and rebranded the campaign to Built for Zero. Contra Costa continues to participate in the new initiative.

Goal: Develop and implement a Coordinated Entry system that includes prevention, diversion, crisis services, and permanent housing by June 2017.

Outcome: Contra Costa's Coordinated Entry system stakeholder design process successfully concluded mid-year and Phase I implementation is underway that focuses on coordinated, streamlined access to the homeless system of care.

Goal: Recruit to fill our expanded Council on Homelessness Advisory board seats by 2017.

Outcome: The recruitment efforts to fill the expanded Council on Homelessness advisory board seats was successful. Nine of twelve vacancies were filled in March 2017. Work continues to fill the remaining vacant seats.

Public Health:

Goal: Complete a Strategic Plan for the Public Health Division by December 2016.

Outcome: Major components of the plan were completed including the focus of the following 4 key Strategic Directions, 1) Vulnerable Populations, 2) Maternal, Child and Adolescent Health, 3) Chronic Disease and 4) Public Health Capacity & Infrastructure. We anticipate completing the entire plan by the Spring of 2017.

Goal: Affirm a decision and time line for making application for National Public Health Accreditation.

Outcome: We continue to develop the infrastructure for possible accreditation. Completing the Strategic Plan is the first major component. By late Fall 2017 we will have a

A REPORT BY
THE 2016-2017 CONTRA COSTA COUNTY GRAND JURY
725 Court Street
Martinez, California 94553

Report 1703

Mental Health Services for At-Risk Children in Contra Costa County

APPROVED BY THE GRAND JURY:

Date: 5/11/17

JIM MELLANDER
GRAND JURY FOREPERSON

ACCEPTED FOR FILING:

Date: May 19, 2017

JOHN T. LAETTNER
JUDGE OF THE SUPERIOR COURT

Contact: Jim Mellander
Foreperson
925-608-2621

Contra Costa County Grand Jury Report 1703

Mental Health Services for At-Risk Children in Contra Costa County

TO: County Board of Supervisors, Behavioral Health Services

SUMMARY

The Grand Jury conducted a detailed investigation concerning the County's delivery of mental health services to at-risk children ("At-Risk Children"), which is defined as foster children or those in danger of becoming foster children, Commercial Sexually Exploited Children victims (CSEC), youth detained in Juvenile Hall, and children in domestic violence or sexual abuse situations. Over the course of a seven-month investigation, the Grand Jury found that at-risk children are not receiving timely access to mental health treatment. Several factors were preventing timely access, all of which are within the control of Behavioral Health Services and its subdivision Children's Mental Health Services. The Board of Supervisors should consider identifying funds to provide timely treatment for children.

METHODOLOGY

The Grand Jury researched the statutes, agreements and regulations on mental health services for children that pertain to the County. It also researched official reports from State and County agencies, and conducted numerous interviews with County personnel who are involved in the delivery of mental health services.

BACKGROUND

This Grand Jury conducted a detailed investigation of mental health services for at-risk children in Contra Costa County. For purposes of this investigation, the Grand Jury defined at-risk children as:

- Foster children or those in danger of becoming foster children
- Commercial Sexual Exploitation of Children (CSEC) victims
- Youth detained in Juvenile Hall
- Children who have experienced domestic violence and sexual abuse.

The Mental Health Commission White Paper

The Mental Health Commission (MHC), an advisory body appointed by the Board of Supervisors to serve as the watchdog group in the County for mental health services, issued a white paper in April 2016 "*to encourage discussion around the current crisis in the county public mental health care system and deficits in the county mental health budget process that contribute to this crisis."*

While the white paper was issued by MHC, Behavioral Health Services (BHS) assisted MHC with the data and the contents of the paper. The paper describes key points that are pertinent to at-risk children:

"The wake-up call of the crisis at Psychiatric Emergency Services (PES) that points to an impacted system that is unable to provide the right treatment at the right moment in time and is therefore struggling to truly meet the needs of people with a serious mental illness,"

"The compromised ability of… Child/Adolescent Clinics to meet the needs of patients due to understaffing as evidenced by three to four months wait times and a migration of patients to PES for intervention that is not meant to be a stand-in for treatment,"

"The underlying theme of inadequate staffing levels due to the inability of treatment facilities to attract and keep high quality psychiatrists and nurses because of uncompetitive compensation and such practices as closing of lists,"

"The underlying theme of dedicated, quality staff struggling to offer excellent care but undercut by budgets that are generated by a formulaic, top down process rather than a process that builds up a budget from program needs."

The Katie A. Requirements

In delivering mental health services, the County must comply with the terms of the *Katie A.* requirements. Katie A. was the lead plaintiff in a multiple-plaintiff lawsuit filed against Los Angeles County and the State of California in 2002. The lawsuit alleged that significant gaps existed in mental health services provided to children in the foster care system. By the age of 14, Katie A. had been shuffled through 37 foster homes and had endured 19 confinements in psychiatric hospitals.

Los Angeles County settled with the plaintiffs in 2003. The State of California agreed to the following *Katie A.* child definition and mental health service requirements in 2011:

Children who are in or at risk of entering foster care will be identified as the "Katie A. subclass." A child will be part of the subclass if wraparound or specialized services are being considered for the child, or the child has been hospitalized three times in the past 24 months for behavioral reasons or is currently hospitalized for a behavioral issue.

Pursuant to this agreement, California counties must adhere to a protocol, called a "core practice model," for screening and treating foster children. In accordance with this protocol, children may be eligible for the following services:

- Intensive Care Coordination (ICC)
- Intensive Home-Based Services (IHBS)
- Therapeutic Foster Care in specially-trained foster homes.

The County hired several coordinators and appointed a *Katie A.* specialist manager to handle the new protocol.

DISCUSSION

The Grand Jury used the new *Katie A*. requirements and the MHC white paper as starting points to investigate Contra Costa County's delivery of mental health services to at-risk children.

Youth confined in Juvenile Hall receive a consistent and well-regulated package of children's mental health services from the County since these children are in a controlled confinement. Of the 110 youth currently at the Hall (some of whom are CSEC victims), 30% have been identified as having mental health problems. BHS has assigned three County clinicians and a program manager to work exclusively at the Hall to provide treatment, which involves medication and therapy. All three therapists are grant-funded, and the grants require regular data reports on the outcome of the treatments.

CSEC victims and children in domestic violence and sexual abuse situations are sometimes discovered by police responding to a complaint. The police refer the children to the Victim Advocates in the District Attorney's Office. After securing the child in a safe environment, the advocate arranges for the child to receive therapy so that the child can better assist in the legal prosecution of their abusers. BHS is not usually involved in this process. Rather, the Victim Advocate arranges for the victim to receive treatment from a private therapist or psychiatrist. This treatment is funded by the State Victim Compensation Fund and continues for the months or years that the victim needs to recover. Despite receiving mental-health treatment, some CSEC victims are reluctant to testify against their pimp abusers.

An estimated 85-90% of foster children need some form of mental health services. Given this statistic, it is not surprising that a significant component of the estimated 7,000-plus children in the County who are serviced for mental health annually are foster children, estimated at over 1,700, or those who are in danger of becoming foster children. Only 300 of these children currently belong to the "Katie A. subclass." The County's compliance in the *Katie A*. requirements is a work in progress. Satisfactory

compliance depends upon skilled coordination between the social workers in Children and Family Services (CFS) and the clinicians at BHS.

Children who may need mental health services are generally assessed and evaluated within 7-10 days. However, children wait much longer, weeks or months, to receive treatment.

After assessment and evaluation, the social workers at CFS arrange for treatment for the child client through the BHS liaisons. The liaisons provide the social workers and child guardians with three referrals of available psychiatrists or therapists from their database. The social workers or guardians call these mental health professionals to schedule treatment. Oftentimes, the social workers or guardians find that the three referrals they have been given by the BHS liaisons are not available. Then they must go back to the liaisons to arrange for another set of three referrals. This is the cause of many delays. The CFS social workers state that the child has an average waiting time for treatment of three months and the BHS liaisons state that the average is only 4 to 6 weeks. These two sets of County workers are working from different perspectives and from different calendar counts. The BHS liaisons also state that they do not have an updated list of unavailable psychiatrists or therapists.

After the screening and evaluation phase, each of the 7,000-plus children are classified into two groups:

1. Medium to severe

2. Mild to medium

The mild to medium cases are scheduled for appointments with psychiatrists and therapists in non-profit community-based organizations (CBOs) and private therapists contracted by BHS. The medium to severe cases are scheduled for appointments with the psychiatrists and therapists in the County's three regional mental health clinics.

There are several factors that prevent children from accessing mental health services in a timely manner. These factors differ depending on whether the child is classified as medium to severe, or mild to medium.

Medium to Severe Cases

The three mental health clinics are understaffed in terms of psychiatrists, the doctors who diagnose the children and prescribe medication for them when appropriate. Children's Mental Health Services estimates it needs to hire six more psychiatrists to handle the workload and resolve the inequitable distribution among the regional clinics. The County pays $30-50,000 less than what psychiatrists can earn in private practice.

Table 1 shows the distribution of the medium to severe cases assigned to the three clinics and the corresponding distribution of psychiatrists in those three clinics.

TABLE 1

	Antioch	Concord	West County	TOTAL
Children	630	740	800	2170
Psychiatrists*	2.2	3.5	1.3	7
Ratio	286.4	211.4	615.4	310

Note: * Full time equivalent

As shown on Table 2, the distribution of 85 County therapists across the three clinics is inequitable relative to the distribution of medium to severe mental cases.

TABLE 2

	Antioch	Concord	West County	TOTAL
Children	630	740	800	2170
Therapists	22	47	16	85
Ratio	28.6	15.7	50	25.5

The normal management response to such uneven distribution is to reallocate some therapists from Concord, to Antioch and to West County. The Grand Jury found no evidence that any such plan is being considered.

Mild to Medium Cases

BHS contracts with 34 non-profit Community Based Organizations (CBOs) to treat the estimated 5,000 children considered mild to medium cases. Twenty percent of these 34 CBOs were at capacity as of February 2017, meaning that seven of the CBOs had no appointment availability. The BHS liaisons, who provide the appointment referrals for the guardians/patients, do not have current data on the clinicians' availability. Thus, social workers or guardians call to CBOs that have no availability, causing delays in the children's treatment.

In addition to providing mental health treatment through CBOs, BHS can assign the 5,000 children who are diagnosed as mild to medium cases to the over 200 individual private therapists that it contracts with. Like CBOs, these private therapists have limited availability. Table 3 shows the availability of those private therapists in February 2017 and their distribution in the three regions.

TABLE 3

	East County	Central	West County	TOTAL
Private Therapist	60	100	47	207
Available	13	33	21	67
Not available	47 (78%)	67 (67%)	26 (55%)	140 (68%)

Overall, 68% of the private therapists were not available for appointments. Thus, children must wait longer for mental health services.

While no-shows for appointments also contribute to longer wait times, this factor is not under the control of BHS. The tables show what is within the control of BHS and its subdivision that manages treatment delays for at-risk children.

FINDINGS

F1. The County provides timely and consistent mental health services to detained youth in Juvenile Hall, CSEC victims, and children in domestic violence and sexual abuse situations.

F2. Under the terms of the *Katie A.* requirements, upper and middle management levels of CFS and BHS have started to coordinate their efforts.

F3. Many at-risk children are not receiving mental health treatment for several weeks to several months after the County assesses their mental-health needs.

F4. Children's Mental Health Services estimates that the County needs an additional six psychiatrists for its three clinics.

F5. County salaries for psychiatrists are not competitive with private practice.

F6. The shortage of psychiatrists causes delays in the diagnosis and treatment of medium to severe mentally ill children.

F7. West County clinic, which has the most medium to severe patients, also has the highest patient to therapist ratio.

F8. The 85 County therapists, who treat medium to severely mentally ill children, are not equitably distributed among the three clinics based on workload.

F9. Twenty percent of the CBOs and 68% of the individual private therapists are not available for appointments.

F10. BHS liaisons are not provided with current information about the availability of CBOs and private therapists for appointments.

RECOMMENDATIONS

R1. The Board of Supervisors should consider identifying funds to add six psychiatrists at the three regional mental health clinics.

R2. The Board of Supervisors should consider directing Human Resources to review the compensation packages for County psychiatrists to ensure their compensation packages are competitive compared with the private market.

R3. The Board of Supervisors should consider directing BHS to redeploy therapists with a view to a more equitable ratio of children per therapist among the County's three mental health clinics.

R4. The Board of Supervisors should consider identifying funds to enable BHS to review and improve systems related to the real time availability of CBOs and individual private therapists for mental health service appointments.

R5. The Board of Supervisors should consider directing BHS to monitor and report on the wait times for mental health treatment for at-risk children.

REQUIRED RESPONSES

	Findings	Recommendations
Contra Costa County Board of Supervisors	F1 to F10	R1 to R5

These responses must be provided in the format and by the date set forth in the cover letter that accompanies this report. An electronic copy of these responses in the form of a Word document should be sent by e-mail to ctadmin@contracosta.courts.ca.gov and a hard (paper) copy should be sent to:

Civil Grand Jury – Foreperson
725 Court Street
P.O. Box 431
Martinez, CA 94553-0091

A REPORT BY
THE 2016-2017 CONTRA COSTA COUNTY GRAND JURY
725 Court Street
Martinez, California 94553

Report 1710

Law Enforcement Use of Force and Mental Health Awareness

APPROVED BY THE GRAND JURY:

Date: 6/15/17

JIM MELLANDER
GRAND JURY FOREPERSON

ACCEPTED FOR FILING:

Date: 6/16/17

JOHN T. LAETTNER
JUDGE OF THE SUPERIOR COURT

Contact: Jim Mellander
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925-608-2621

Contra Costa County Grand Jury Report 1710

Law Enforcement Use of Force and Mental Health Awareness

TO: Contra Costa County Sheriff

SUMMARY

There has been widespread national news and social media discussion about excessive use of force by law enforcement agencies. The Grand Jury examined Use of Force policies and hiring practices of 24 law enforcement agencies in Contra Costa County (County) to determine the risks and safety issues of local community policing conditions.

All surveyed County law enforcement agencies have strict and well-enforced Use of Force policies. They also have rigorous hiring and training practices. One key hiring criterion is the ability to communicate with a wide variety of people, including those afflicted with mental issues.

Two programs, the Crisis Intervention Team (CIT) and the Mental Health Evaluation Team (MHET), have been identified as innovative approaches to dealing with those who have mental health issues. These programs should be expanded where feasible.

METHODOLOGY

The Grand Jury:

- Conducted internet and document research
- Surveyed 24 County law enforcement agencies about Use of Force policies and incident review procedures
- Interviewed senior police officials whose departments cover approximately 85% of County's population
- Interviewed senior officials in the Office of the Sheriff and the District Attorney's Office
- Visited the Contra Costa Law Enforcement Academy

DISCUSSION

Use of Force Policies

County law enforcement agencies are governed by departmental policies. A Use of Force policy is based on the law, best practices, and the concept of "reasonableness." That concept is the requirement that an officer use the amount of force that reasonably appears necessary to bring an incident under control. The decision is made by the officer in the field based on circumstances and training. In some cases, deadly force may be used when officers believe that they or another person are presented with an imminent threat of death or serious injury.

All twenty-four surveyed police departments in the County have a Use of Force policy that provides guidelines on the uses of force. Seventeen of these police departments have a Use of Force policy designed by Lexipol, a vendor of various policy documents for police, custody, and fire departments. Lexipol provides regular periodic policy and training updates to keep its clients current on changes in the law, and emerging best practices. The Lexipol policy may be adapted by an individual department to reflect the makeup of the community. Three police departments in the County have designed their own Use of Force policies. Three of the cities contract with the Office of the Sheriff (Sheriff) for police services and, therefore, their police departments use the same Use of Force policy as the Sheriff. The AC Transit agency, which contracts with the Alameda County Sheriff for police services, uses the Alameda County Sheriff's Use of Force policy.

All policies describe when and how force is to be used, when medical aid is needed, and how an incident is to be reported and reviewed. The policies cover a wide range of force, including handcuffing, striking by hand or baton, use of electronic devices, and use of firearms.

Investigating Use of Force Incidents

Investigations are required after each use of force incident, as specified by the local policy. Three levels of investigation can be applied to each incident involving use of force:

1. **Jurisdictional Agency**

Under one type of investigation, the law enforcement agency where the incident takes place has jurisdiction and performs the investigation. Typically, this investigation would start with a filed report and a review by the supervising Sergeant, and senior officers as necessary.

2. Contra Costa Protocol

A second type of investigation is performed pursuant to Contra Costa Protocol, which was adopted based on a 1984 agreement among law enforcement agencies in the County and the District Attorney's Office. Pursuant to this protocol, a team from the District Attorney's office investigates any officer involved shooting and any incident resulting in serious injury or death; for example, those resulting from a vehicle pursuit. The sole purpose of the District Attorney's investigation is to determine if the suspect or the police officer violated the law. The protocol is used to insure a fair and impartial investigation and to ensure that charges are filed appropriately.

3. Coroner's Inquest

In the event of a law enforcement-related death, a Contra Costa Coroner's inquest is convened. The inquest involves a public hearing where a jury is impaneled and sworn testimony is taken. The inquest adds transparency and open access to the circumstances surrounding the death and all aspects of the investigation. The hearing officer takes testimony from witnesses and gives instructions to the jury to determine the manner of death.

Officer Selection and Training

Police officer hiring is a rigorous process. Candidates are held to high standards, including the ability to communicate with a wide variety of people. Applicants for employment with law enforcement agencies undergo extensive background examinations and psychological testing in addition to interviews and tests of physical ability. In a recent hiring cycle, of 1,000 potential candidates for the Sheriff, 22 were accepted.

All California police officer candidates must complete a curriculum that complies with the California Commission on Peace Officer Standards and Training (POST). Accepted candidates, who have not already completed POST certification elsewhere, attend the Basic Course taught at the Law Enforcement Training Center. This Center is operated by the Contra Costa County Sheriff, and is one of 38 POST-certified police academies in California.

Police officers then receive additional field training during an initial probationary period from the departments where they are employed. That training reinforces the training that they received at the police academy and introduces the policies and procedures used by that department, including use of force. Training is an ongoing process that continues throughout an officer's career.

Dealing with Mental Health Issues

Two innovative mental health-related programs may reduce or eliminate the need to use force:

Crisis Intervention Team (CIT) Training

In many police encounters, mental illness or intoxication is a factor. CIT was originally developed in Memphis in 1988 following a police shooting of a mentally ill man.

Scientific studies have found that CIT trained officers are better able to identify someone with a potential mental illness. The trained officers are more likely to refer that person to treatment, feel better prepared to respond to such incidents, and are more aware of local treatment availability. Less formal studies that have been published in law enforcement journals report CIT trained officers have a significant drop in their injury rates and are less likely to escalate to a SWAT response. There is no formal tracking method or analysis of the use of CIT techniques to determine its effectiveness locally.

The Sheriff and the County Behavioral Health Services conduct CIT training as a 32-hour course open to police officers from all police departments in the County. CIT teaches police officers to recognize persons in crisis from mental illness or substance abuse. When they identify such a person, they will attempt to get the person medical attention, rather than into the justice system, if no crime has been committed. Techniques taught include slowing down the approach to a subject, giving him or her space, and speaking in calm tones because the subject may not be able to understand the officer's commands.

CIT has been attended by officers from most local police agencies. It is estimated that approximately 30% of the police officers in the County have CIT training. However, there is no formal system in place that tracks how many officers in the field have had CIT training. The Sheriff is not informed when a trained local police officer retires, transfers, or when a new hire is already trained.

There are preliminary plans to expand CIT training. The Contra Costa Police Chiefs Association is exploring the creation of a CIT program that would be similar to the Sheriff's course and coordinated with it. The goal of creating such a course would be to provide CIT training to all police officers as soon as possible. The California POST Commission is considering inclusion of CIT training.

Mental Health Evaluation Teams

The Behavioral Health Services division of the Contra Costa County Health Services Department and the police departments of Concord, Pittsburg and Richmond have created regional Mental Health Evaluation Teams. These teams, which include a clinician from Behavioral Health Services and a police officer, provide follow-up help to people referred to the police for possible mental health issues. The team's goal is to

offer treatment and benefits, to potentially avoid further police intervention, and to mitigate the possibility of violence.

The MHET program was started in 2015 with funding by a $380,000 grant from the California Public Safety Realignment Act (AB 109) and a three-year $550,000 grant from the California Health Facilities Financing Authority. Since inception, there have been 223 referrals from police departments and mental health agencies. Of the people assisted by a MHET team, 61% had no follow-up incidents.

FINDINGS

F1. There are at least three possible agencies that may investigate a use of force incident involving the Sheriff's Office.

F2. The agency or agencies responsible for investigating a use of force incident involving the Sheriff's Office depend on the severity of force and if it resulted in injury or death.

F3. During the hiring process, selection of candidates for police officer training is detailed and thorough.

F4. CIT training provides effective techniques for law enforcement officer to engage with persons in mental crisis or intoxicated with drugs or alcohol.

F5. CIT training may reduce or eliminate the need for a law enforcement officer to use force.

F6. A substantial number of law enforcement officers in the County have not yet attended CIT training.

F7. The Sheriff's Office does not have a method to provide updated CIT training material for past attendees of CIT training.

F8. The Sheriff's Office does not operate a MHET team.

F9. The Sheriff's Office has not studied whether implementing a MHET team would be an effective way to reduce the number and severity of Sheriff deputy responses to mental health related calls.

RECOMMENDATIONS

R1. The Sheriff should consider broadening and enhancing CIT training to educate all law enforcement officers.

R2. The Sheriff should consider coordinating with the Contra Costa Police Chiefs Association in their effort to create additional CIT training in the County.

R3. The Sheriff should consider researching methods to document the effectiveness of CIT training, and identifying funds to do so.

R4. The Sheriff should consider providing annual updates of CIT training course materials to police departments in the County, and identifying funds to do so.

R5. The Sheriff should consider conducting a feasibility study to determine the benefits of establishing additional MHET teams.

REQUIRED RESPONSES

	Findings	**Recommendations**
Contra Costa County Sheriff	F1 to F9	R1 to R5

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