CONTRA COSTA
MENTAL HEALTH COMMISSION

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MENTAL HEALTH
COMMISSION
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Mental Health Commission (MHC)

Wednesday, April 6th, 2022, ◊ 4:30 pm - 6:30 pm

VIA: Zoom Teleconference:

https://cchealth.zoom.us/j/6094136195
Meeting number: 609 413 6195
Join by phone:
1 646 518 9805 US
Access code: 609 413 6195

AGENDA

I. Call to Order/Introductions (5 min.)

II. Public Comments (2 min. per person, 10 min max.)

III. Commissioner Comments (2 min. per Commissioner, 10 min. max.)

IV. Chair Comments/Announcements (5 min.)

i. **Third module of Commissioner Orientation (Introduction to Behavioral Health Services Financing and Budgeting) will be presented BEFORE THE MAY Commission meeting at 3:30 to 4:20 PM**
ii. **MHSA Three Year Plan 2022-23 Update Public Hearing at MHC May meeting – Update available to review now**
iii. **County 2022-23 Recommended Budget is available now at https://www.contracosta.ca.gov/770/Budget-Documents and will be presented at the Board of Supervisors April 26th meeting**
iv. **Presentation to the Developmental Disabilities Council on March 23rd**

V. APPROVE March 2nd, 2022 Meeting Minutes (5 min.)

VI. PRESENT MHC Conduct Guidelines (10 Min.)

VII. PRESENT the "Psychiatric Advanced Directives" (PADS) program, Jennifer Bruggeman, Program Manager, Mental Health Services Act (MHSA) (15 Min.)

(Agenda continued on Page Two)

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Mental Health Commission (MHC) Agenda (Page Two)

Wednesday, April 6th, 2022 ◊ 4:30 pm - 6:30 pm

VIII. DISCUSS basics of the Behavioral Health Continuum Infrastructure Program (BHCIP), Dr. Suzanne Tavano, Behavioral Health Services (BHS) Director (5 Min.)

- **Overview of BHCIP grants and timeline**
- **Behavioral Health Services (BHS) Steering Committee**
- **Consultant-moderated stakeholder planning process – Roberta Chambers**
- **First stakeholder meeting**

IX. DISCUSS Mental Health Housing placements summary and budget, Dr. Suzanne Tavano, BHS Director (15 min.)

X. DISCUSS BHS 2022-23 Recommended Budget (15 min.)

- **Overview of BHS 2022-23 budget**
- **Revenue Sources**
- **Summary of BHS Major Program and Service budgets**
- **BHS priorities: Budget goals and grant program applications**

XI. DISCUSS MHC budget priorities and advocating for MHC priorities (5 min.)

XII. HEAR Director of BHS Report, Dr. Suzanne Tavano (10 min.)

- **Civil Grand Jury Report No. 2102 Tele-Mental Health**

XIII. 6:30 Adjourn

ATTACHMENTS:

A. Mental Health Commission Conduct Guidelines
B. Psychiatric Advance Directive (PADS) program description
C. CCBHS Grant Summary
D. Overview of BHCIP grants
E. Mental Health Services Housing placements summary and budget
F. Summary of BHS Service budgets and goals excerpted from the County 2022-2023 Recommended Budget
G. Civil Grand Jury Report No. 2102 Tele-Mental Health

MHC Conduct Guidelines

Last updated 3/27/22

I. Purpose

The purpose of the Mental Health Commission (MHC) Conduct Guidelines is to encourage professional behavior that leads to open and respectful dialog in meetings, electronic communications and other media, and that supports effective business operations, consensus decision-making and positive action.

II. All Meetings: In-person and Virtual

- Act with integrity, treat everyone with mutual respect, trust, and dignity, and assume that they are acting in the best interest of the Commission.
- Come prepared to discuss the agenda items and handouts.
- Value other perspectives. It's okay to disagree politely and respectfully -- different perspectives are welcomed and encouraged.
- Turn off or mute cell phones.
- Focus on the subject matter and issues. No side bars.
- One speaker at a time. Raise your hand to be acknowledged and do not interrupt.
- Avoid dominating a meeting and encourage everyone to participate.
- Keep your comments within the time limit and be brief and to the point. Be committed to starting and finishing on time.
- Use person-first language when talking about people with mental illness. For example, not "He's bipolar" but "He has bipolar disorder".

III. Zoom Meetings

- Mute your microphone when you are not speaking to keep background noise to a minimum.
- Avoid making background noise like shuffling papers when you are off mute.
- Use the "Raised Hand" icon in the "Reaction" options to raise your hand virtually.
- Use chat sparingly, only to ask related questions, share contact information, and share helpful links and information that are on topic. Refrain from side-bar conversations, shout-outs, advertisements, and anything else off-topic that may be distracting.

- Position your camera properly and keep your camera on if possible. Keep your web camera in a stable position and focused at eye level to create a more direct sense of engagement with other participants.

- Maintain a stable image of yourself to avoid distracting other meeting participants. If using a digital background, make sure your image is displaying properly and not moving around.

- Avoid multi-tasking like emailing and texting during the meeting. You'll participate more and retain more if you focus solely on the meeting.

- Prepare to share materials in advance. If you will be sharing content during the meeting, make sure that you have your files and/or links ready to go before the meeting begins.

IV. Digital Communications: Email, Text Messaging and Social Media

- Act with integrity, treat everyone with mutual respect, trust, and dignity, and assume that they are acting in the best interest of the Commission.

- Write as you are intending to be perceived, i.e., professional and respectful.

- Do not share confidential information.

- Think before you share. Assume that whatever you write will be shared. Commissioners may be the subject of a public records request.

- Don't mix business and pleasure. Keep work and personal communications separate.

- Don't be reactive. Think before you respond.

- Consider your tone. Don't shout, i.e., using all capital letters.

- Don't vent online.

- Use person-first language when talking about people with mental illness.

- Use person-first language when talking about people with mental illness. For example, not "He's bipolar" but "He has bipolar disorder".

V. Officially Representing the Mental Health Commission

- Do not commit the MHC to any action unless authorized to do so by the MHC Chair and/or by vote of the Commission.

- Do not make any statement on behalf of the MHC or purport to represent the MHC through any public medium, including the press and digital social media, unless specifically authorized to do so by the MHC Chair and/or by vote of the Commission.

VI. Conflict of Interest

- Commissioners should not act or vote in situations where they may have or it may appear that they have a conflict of economic interest, such as employment by an organization related to the matter at hand or hold a business interest related to the matter at hand. In the case of a conflict of interest, Commissioners should recuse themselves from discussing or voting on the matter at hand. This requires that they should leave the meeting before any discussion or voting occurs.

- No member of the Mental Health Board or his or her spouse shall be a full-time or part-time county employee of a county mental health service, an employee of the State Department of Mental Health, or an employee of, or a paid member of the governing body of a mental health contract agency. If they do, they may not be appointed to the Commission. Any Commissioner who becomes such an employee while serving on the Commission must resign from the Commission.

VII. Agenda Language to Communicate Conduct Guidelines (adopted from CPAW)

This language will be included on MHC meeting agendas:

Opening language: The input of all participants at Mental Health Commission meetings is highly valued. To ensure that all voices can be expressed in a productive and respectful environment, the MHC has adopted the following self-governance agreement for all participants at all MHC meetings: (list Meeting Conduct Guidelines for in-person meetings; if virtual list Zoom Conduct Guidelines as well).

Closing **in-person meeting** language: The Chair or the Vice Chair, at their discretion, may remove anyone not abiding by the MHC conduct guidelines from the meeting.

Closing **Zoom meeting** language: The Chair or the Vice Chair, at their discretion, may mute or remove from the meeting, anyone not abiding by the MHC conduct guidelines

VIII. Sources

- Contra Costa County Advisory Body Handbook, 2021
- California Behavioral Health Board and Commission (CALBHBC) Conduct Agreement
- Contra Costa County Form 700 Statement of Economic Interest
- Contra Costa County Grand Civil Jury
- Contra Costa County Mental Health Commission By-Laws
- Consolidated Planning Advisory Workgroup (CPAW) Meeting Working Agreement
- League of Women Voters Minnesota Code of Conduct

Overview of Psychiatric Advanced Directives (PADs)

An MHSA Innovation Project

Presented to

Mental Health Commission (MHC)

4/6/22

Background

MHSA Innovation component requires all project proposals be approved by the MHSOAC

Multi-County PADs Collaborative is pre-approved and launch-ready

Concepts Forward and its sub-contractors will provide all project oversight including training, TA, evaluation

Psychiatric Advanced Directives – identified by the state and local community as a priority issue

What is a PAD?

- Legal tool that can assist with planning in the event of a psychiatric emergency
- Created by the individual when they are doing well
- Specifies their wishes in the event of a mental health crisis
- Promotes self-determination and choice
- May include designation of a health care agent, instructions.

How does the PADs Innovation Project Work?

- Includes 7 Counties; Oversight by a project management team
- Extensive stakeholder (peer) input
- Elements include:
  - Create a statewide PAD template through stakeholder engagement
  - Provide coordination, training and technical assistance
  - Create *technology – cloud-based system for document storage
  - Provide evaluation

Local Community Program Planning

6 Public Stakeholder Meetings – discussion, presentation, voting

Surveys

1 Innovation Community Forum

Next Steps……

- Public Posting 4/4/22-5/4/22
  - MHSA Website
    - Mental Health Services Act (MHSA) in Contra Costa County :: Behavioral Health :: Contra Costa Health Services (cchealth.org)
  - MHSOAC
- Submit to BOS for requested approval by June 2022
- Project projected launch: 7/1/22

Questions?

CCBHS Grant Summary

Funding Source	Acronymn	Status	Description	Amount	Pefromance Period
Federal Allocation	Federal Earmark Request	Awarded/ Waiting contract	Funds for renovation for Oak Grove	$1,000,000	unknown
Federal Allocation	Federal Earmark Request	Awarded / Awaiting Contract	Expansion of exisitin MCRT teams	$1,061,552.00	unknown
MHBG CRRSAA	Mental Health Block Grant Coronavirus Response and Relief Supplemental Appropriations Act	Awaiting Approval/ No Contract required	Equipment and software for HUB dispatch services, First Episode Set-Aside	$1,095,579	9/15/2021-6/30/2023
MHBG ARPA	Mental Health Block Grant American Rescus Plan Act	Awaiting Approval/ No Contract required	Level 1 and Housing Crisis response staffing and training	$2,597,143	9/15/2021 - 6/30/2025
BHCIP CCMU (Round 1)	Behavioral Health Care Infrastructure Project - Community Crisis Mobile Unit	Awarded/Awaiting Contract	Call system implementation, equipment, software and licensing, vehicles, project management, training and peer support (time limited)	$2,992,679	9/15/2021 - 6/30/2025
Measure X	Contra Costa Local Funding	Awarded		$5,000,000 one time, $20,000,000 annual	Ongoing
BHJIS	Behaviora Health Justice Innovation Services	Requested	Spanish language specialty mobile crisis teams pilot	$699,647	TBD
BHCIP Planning Grant (Round 2)	Behavioral Health Care Infrastructure Project - Community Crisis Mobile Unit	Awarded/Awaiting Contract	Planning for Infrastructrue	$150,000	1/31/2022 - 12/31/2022
BHCIP Launch Ready (Round 3)	Behavioral Health Care Infrastructure Project	RFA Released 1/31/22	Launch ready infrastructure projects for Medi-Cal benificiaries	TBD	TBD
CCE	Community Care Expansion	RFA Released 1/31/22	Infrastructure/Adult Resisdiential and senior care for SSI/SSD recipients and those experiencing homelessness	TBD	TBD
BHCIP - Child/Youth (Round 4)	Behavioral Health Care Infrastructure Project	RFA Not Issued at this time	TBD	TBD	TBD
BHCIP Round 5	Behavioral Health Care Infrastructure Project	RFA Not Issued at this time	TBD	TBD	TBD
BHCIP Round 6	Behavioral Health Care Infrastructure Project	RFA Not Issued at this time	TBD	TBD	TBD
BHQIP Planning Grant	Behavioral Health Quality Improvement Program	Awarded	Participation in state EHR scoping and review	$200,000	
QI Implementation	Behavioral Health Quality Improvement Program	Awarded	CalAim Implementation. Incentive based. Deliverables required.	$1,983,440.00	
CHFFA Wellness Grant	California Health Facility Finance Authority	Contract Signed	Children's Crisis Stabilization Unit	$2,322,571.00	4/21/2021 - 12/31/2024
AOD CRRSAA	Alcohol and Other Drugs Coronavirus Response and Relief Supplemental Apporpriations Act	Awarded	AOD HER Implementaion (compliments ARPA)	$3,488,600.16	9/15/2021-6/30/2023
AOD ARPA	Alcohol and Other Drugs American Recover Plan Act	Awarded	County EHR and 1Mill to support technology and staff for prevention CBOS	$2,508,138.66	9/15/2021 - 6/30/2025
Opioid Settlemenmt		Awarded	Funds 1FTE Addiction Psychiatrist, Treatment in the Jail 2FTE counselors, 1FTE Manager, Expands Residential Adolescent Treatment, Increases rates for AOD CBOS 3% COLA	$2,000,000	Annual
RSAT		Awarded	Treatment in West County Detention Facility	$1,500,000	7/1/2022 - 6/30/2025
P-64		Awarded	Cannabis, Youth and Social Media	$1,000	

The Behavioral Health Continuum Infrastructure Program

Latest Updates

For information on the latest updates for the Behavioral Health Continuum Infrastructure Program, please visit the project webpage.

Overview

The Behavioral Health Continuum Infrastructure Program (BHCIP) provides the Department of Health Care Services (DHCS) funding to award competitive grants to qualified entities to construct, acquire and rehabilitate real estate assets or to invest in mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources. A portion of the funding is available for increased infrastructure targeted to children and youth 25 years of age and younger.

Background

The Department aims to reduce homelessness, incarceration, unnecessary hospitalizations, and inpatient days and improve outcomes for people with behavioral health conditions by expanding access to community-based treatment. The Department proposes to invest in the expansion of beds, units, or rooms by building new behavioral health continuum infrastructure and expanding capacity. These resources would expand the continuum of services by increasing capacity for short-term crisis stabilization, acute and sub-acute care, crisis residential, community-based mental health residential treatment, substance use disorder residential treatment, peer respite, mobile crisis, community and outpatient behavioral health services, and other clinically enriched longer-term treatment and rehabilitation opportunities for persons with behavioral health disorders in the least restrictive and least costly setting.

Trailer Bill Language

An entity shall meet all of the following conditions in order to receive grant funds pursuant to Section 5960.5(a), to the extent applicable and as required by the department: (a) Provide matching funds or real property. (b) Expend funds to supplement and not supplant existing funds to construct, acquire, and rehabilitate real estate assets. (c) Report data to the department within 90 days of the end of each quarter for the first five years. (d) Operate services in the financed facility for the intended purpose for a minimum of 30 years. More information on the Trailer Bill.

BHCIP Resources

- Meetings and Events
- RFA Announcements
- BHCIP CCE Infrastructure Status Update
- Behavioral Health Assessment

Contact Us

Questions? Contact the BHCIP Team at BHCIP@dhcs.ca.gov.

Last modified date: 2/14/2022 9:24 AM

Behavioral Health Housing Summary

Housing Types - Summary

- Permanent Supportive Housing
- Shelter Beds
- Crisis Residential
- Transitional Residential
- Board and Cares
- Mental Health Rehabilitation Center (MHRC)/Institute for Mental Disease (IMD)

On-Going Budgeted Housing Expenditures		
MHSA Master Lease Housing	97 Units	$2,456,732
MHSA FSP Housing Flex Funds	Variable Use	$700,000
Shelter Beds	95 Beds	$3,133,097
Crisis Residential	32 Beds	$3,456,668
Transitional Residential	32 Beds	$2,502,323
Board and Cares	304 Beds	$10,231,451
MHRC/IMD	108 Beds*	$7,566,534
TOTAL	**668 Beds**	**$30,046,805**
One-Time Captial Investments and State Loan Programs		
MHSA Housing Program/SNHP	52 Units	$8,832,724
No Place Like Home	31 Units	$11,841,577
TOTAL	**83 Units**	**$20,674,301**
* Current approximate count of beds		

Permanent Supportive Housing

Scattered Site Housing	Shelter Inc. (on-going contract)	BHS	97 Units	$2,456,732
				One Time Investments
MHSA Housing Program/Special Needs Housing Program (SNHP)	Villa Vasconcellos, Walnut Creek	BHS/H3-Coordinated Entry	3	$700,000
	Lillie Mae Jones Plaza, North Richmond		8	$1,090,000
	Virginia Street Apartments (MHSA&SNHP)		8	$1,739,000
	Robin Lane, Concord		5	$560,000
	Ohlone Gardens, El Cerrito		5	$1,124,860
	Arboleda/Third Avenue Apartments, Walnut Creek		5	$1,368,864
	Garden Park, Concord		1	Services
	Shared Housing (3 Houses) Hope Solutions		12	$1,750,000
	SP Commons (SNHP)		5	$500,000
				State Loans backed by MHSA
No Place Like Home	Veteran's Square	BHS/H3-Coordinated Entry	10	$3,609,840
	Galindo Terrace		13	$6,000,163
	699 YVR (Non-Competitive)		8	$2,231,574
MHSA Housing Flex Funds	Hume	Adult FSP Providers		
	* East			$250,000
	* West			$250,000
	MHS			
	*AOT			$200,000

Shelter Beds

Shelter Beds	Bissel Cottages	H3	75 Beds (est)	$2,100,001
	Appian House			
	Calli House			
	Brookside			
	Concord Shelter			
	Respite Shelter			
	Don Brown	BHS	20	$1,033,096

Crisis Residential (Social Rehabilitation Facilities)

Crisis Residential	Telecare FY 21/22	BHS	16	$1,909,065
	Formerly Nireka (20/21) Contract		16	$1,547,623

Transitional Residential

Transitional Residential	Crestwood Pathway	BHS	16	$1,315,220
	*Residential			$1,220,618
	*Services			$94,602
	Formerly Nevin (FY 20/21 Contract)		16	$1,187,103

Board and Cares

Board and Care Facilities	A & A Health Services	BHS	10	$730,000
	Afu's One Voice Care		6	$39,338
	Baltic Sea Manor		2	$34,038
	Blessed Care Home		6	$38,193
	Concord Royale		1	$23,856
	Crestwood - The Bridge Program		64	$3,504,000
	Crestwood - Hope Center		1	$49,275
	Crestwood - Our House		30	$1,642,500
	Divine's Home		3	$107,148
	Ducre's Residential Care		5	$47,117
	Everwell		7	$496,764
	Family Courtyard		40	$325,200
	Gine's Residential Care Home III		1	$37,080
	God's Grace		12	$380,651
	Margarita's Villa		6	$39,338
	Menona Drive Care Home		12	$94,680
	Modesto Residential Living Center		12	$306,567
	Oak Hills Residential Facility		6	$39,338
	Paraiso Homes		6	$39,192
	Pleasant Hill Manor		26	$986,640
	Psynergy		9	$790,684
	JVCTM (Harmony Home, Romona Care Home)		9	$275,268
	Springhill Home		6	$47,232
	Williams Board and Care Home		12	$78,676
	Woodhaven Home		6	$39,338
	Yvonne's Home Care Services		6	$39,338
			* Contract start and end dates may not align on fiscal Year	
			** All contracts adjusted to represent a 12-month term ***Number of available beds may not reflect actual usage. Rates vary based on acuity	

MHRC (Locked Facilities)

MHRC	California Psychiatric Transitions	BHS		$1,826,956
	Helios			$473,840
	Telecare			$1,815,818
	Canyon Manor			$255,719
	Crestwood			$3,194,201

Health Services
Health and Human Services

Behavioral Health Division - Mental Health

General Fund	2020-21 Actuals	2021-22 Budget	2022-23 Baseline	2022-23 Recommended	Change
Expense					
Salaries And Benefits	65,890,147	85,420,188	86,185,000	86,185,000	0
Services And Supplies	178,231,414	172,073,817	187,889,000	187,889,000	0
Other Charges	3,613,821	3,945,000	3,614,000	3,614,000	0
Fixed Assets	2,809	0	0	0	0
Expenditure Transfers	(15,434,327)	(9,487,005)	(8,978,000)	(8,978,000)	0
Expense Total	**232,303,864**	**251,952,000**	**268,710,000**	**268,710,000**	**0**
Revenue					
Other Local Revenue	95,447,621	100,237,073	119,954,000	119,954,000	0
Federal Assistance	78,600,388	91,853,882	97,708,000	97,708,000	0
State Assistance	41,037,966	34,306,045	33,743,000	33,743,000	0
Revenue Total	**215,085,975**	**226,397,000**	**251,405,000**	**251,405,000**	**0**
Net County Cost (NCC):	**17,217,889**	**25,555,000**	**17,305,000**	**17,305,000**	**0**
Allocated Positions (FTE)	**564.2**	**562.2**	**575.0**	**575.0**	**0.0**
Financial Indicators					
Salaries as % of Total Exp	28%	34%	32%	32%	
% Change in Total Exp		8%	7%	0%	
% Change in Total Rev		5%	11%	0%	
% Change in NCC		48%	(32%)	0%	
Compensation Information					
Permanent Salaries	38,947,263	47,447,147	50,654,439	50,654,439	0
Temporary Salaries	1,202,854	1,517,848	1,173,286	1,173,286	0
Permanent Overtime	236,961	349,335	205,596	205,596	0
Deferred Comp	484,324	689,020	784,581	784,581	0
Hourly Physicians Salaries	2,013	0	0	0	
Perm Physicians Salaries	1,340,182	4,945,630	4,208,578	4,208,578	0
Perm Phys Addnl Duty Pay	32,820	22,584	47,971	47,971	0
Comp & SDI Recoveries	(71,657)	(114,768)	(114,768)	(114,768)	0
FICA/Medicare	3,074,587	3,860,153	4,285,497	4,285,497	0
Ret Exp-Pre 97 Retirees	113,124	146,212	146,606	146,606	0
Retirement Expense	11,733,986	15,064,464	12,748,716	12,748,716	0
Employee Group Insurance	6,381,995	8,958,410	9,789,688	9,789,688	0
Retiree Health Insurance	1,385,825	1,344,998	1,505,687	1,505,687	0
OPEB Pre-Pay	577,086	554,955	0	0	0
Unemployment Insurance	45,629	105,156	109,600	109,600	0
Workers Comp Insurance	547,113	673,000	783,479	783,479	0
Labor Received/Provided	(143,956)	(143,956)	(143,956)	(143,956)	0

Note: The 2021-22 Budgeted Net County Cost of $25,555,000 includes Measure X funding of $8,250,000. any unspent balance will be rolled over into Fiscal Year 2022-2023.

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

Workload Indicator: The recommended FY 2022-23 budget is based on 380,302 Mental Health encounters; an average daily census of 36 patients at the CCRMC inpatient psychiatric unit; 22,808 days in Institute for Mental Disease (IMD); 66,516 days in Board and Care; and 188 days in State hospitals.

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

- The Department of Health Care Services (DHCS) released its Medi-Cal Healthier California for All, formerly known as California Advancing and Innovating Medi-Cal (CalAIM) proposal in October 2019. The proposed changes represent an important shift in the way Medi-Cal plans and providers must provide care and services to the state's Medi-Cal population.

  Fundamentally, it is a framework for the upcoming Medicaid waiver renewals, (including the Drug Medi-Cal Organized Delivery System [DMC-ODS]), that will encompass "broader delivery system, program and payment reform across Medi-Cal." The key goals of the proposal include:

  - o Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
  - o Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
  - o Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

1. Child and Adolescent Services

Description: 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 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 placing agencies (Probation, Social Services and Education) to support young people in need of residential out-of-home care. Mental Health supports the mental health components of these highly structured, Short-Term Residential Treatment Program (STRTP) services for seriously emotionally disturbed (SED) children and adolescents. STRTPs provide mental health services, crisis intervention, case management, and psychiatric services. Contra Costa BHS plans to increase the number of contracts for STRTP mental health services to assure timely access for this level of support.

c. Qualified Individual Program: With the implementation of Families First Prevention Services Act (FFPSA) and to comply with federal law, the Department of Health Services introduced a mandate that a Qualified Individual (QI) completes a mental health assessment for any young person referred to a STRTP by a placing agency (Child & Family Services and Probation). A QI Assessment Report is to determine whether the youth would benefit from residential treatment over family-based placement. CCBHS, Child Welfare and Probation collaborated on putting procedures in place to comply with timeliness and process requirements of the mandate. CCBHS identified staff to fulfill this highly specialized role.

d. Outpatient Clinic Treatment and Outreach Services: Outpatient clinic, school-site and in-home services including psychiatric diagnostic assessment, medication, therapy, case management, wraparound, collateral support, Family Partnership, and crisis intervention services for SED children and adolescents and their families. In 2020, Contra Costa BHS reconstituted its Mentorship Program to help youth struggling with severe emotional

disturbance improve family, school, and social functioning by providing non-traditional therapeutic support. The hiring process for Mental Health Specialist I and II positions was completed to bring mentors on board.

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 services 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 or adolescent's ability to benefit from their education, stay out of trouble, and remain at home.

f. Early and Periodic Screening Diagnosis and Treatment (EPSDT) 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. The Board of Supervisors has approved a one-time allocation of Measure X funds to create a revolving fund account for future rate increases. A one-time fund was approved to match the Federal Financial Participation to provide up to 10% Cost of Living Adjustment for EPSDT providers effective July 1, 2022.

***g. Therapeutic Behavior Services* (TBS):** Provides one-on-one behaviorally focused shadowing of children and adolescents 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 is comprised of six teams of masters-level therapists who provide short-term triage, assessment, de-escalation, stabilization and emergency services to SED children and adolescents and their families in order to prevent acute psychiatric crises and subsequent hospitalization. The Behavioral Health Services Division expanded this program in 2018. With added hours of operation and additional staff, the team is better able to respond to the entire County population. The expanded hours of operation for in-field services are from 7 a.m. to 11 p.m. on weekdays, and from 11 a.m. to 9 p.m. on weekends.

The Mobile Response Team will be instrumental in creating a county-wide Family Urgent Response Team (FURS) to respond to family crises of children/youth who were at any point in their lives involved with the foster care system. SB 80 (2019) obligates placing agencies (Child Welfare and Probation) and Behavioral Health to establish FURS.

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. In collaboration with the Employment & Human Services Department's (EHSD) Community Services Bureau, mental health supports are provided to preschoolers at Head Start program sites throughout the County. In 2021, a Mental Health Services contract was awarded (via competitive application process) to a local coalition of early childhood mental health providers to implement a Prevention & Early Intervention program that includes: Family Engagement and Outreach, Early Childhood Mental Health Home-based Support, and Parent Education and Empowerment.

j. School-Based Partnerships for School-Based Mental Health Services and Educationally Related Mental Health Services (ERMHS): CCBHS recognizes that schools are not only places of academic learning, but also places of social/emotional growth. Supporting mental health of students is critical for all domains of development.

In 2020-2021, the Division has continued to foster collaborative relationships between Behavioral Health and Local Educational Agencies (LEAs) for provision of mental health services for students in general education and special education. Collaboratives include West Contra Costa Unified School District, Martinez

Unified School District, Mt. Diablo Unified School District, Pittsburg Unified School District, and Antioch Unified School District. Children's Behavioral Health supports the mental health component of various levels of educational intervention, including general education, counseling enriched classrooms, and day treatment programs in non-public schools by contracting with Community Based Organizations (CBOs) to provide onsite mental health services. Providers work with the care teams of schools to identify mental health challenges of students early and refer them for services. Services include individual-, family-, and group therapy, care coordination, and consultation regarding student mental health needs.

In 2021, the Division received a grant aimed at building a collaborative between CCBHS, Contra Costa Office of Education, and school districts. The goal of the collaborative is to build out school based mental health supports. With the help of the grant the Collaborative has created the Wellness in Schools Program (WISP) and expanded mental health services at Antioch Unified School District middle schools.

k. Pathways to Wellbeing (Katie A. Programming): Following the 2011 court settlement in Katie A. v Bonta, Children's Mental Health, in partnership with EHSD Children and Family Services (CFS) and the Probation Department, has developed a legally mandated service delivery system to serve youth needing augmented supports, particularly youth involved with CFS and the Probation Department. These services are identified as Intensive Care Coordination (ICC) and In-Home Behavioral Services (IHBS). All youth who meet specified eligibility criteria are offered ICC services. The need for IHBS is determined by the Child and Family Team.

l. Probation Mental Health: In collaboration with and supported by funding from the Probation Department, Children's Mental Health provides a full range of services to youth involved in the justice system. Children's Mental Health provides assessment, treatment, and case management to youth in detention and diversion programs. Mental Health is contracting with Embrace Mental Health (formerly Community Options for Families and Youth [COFY]) to provide Functional Family Therapy (FFT) and Multi-Systemic Therapy (MST) aimed at reducing recidivism for youth struggling with mental illness and delinquent behavior. With SB 823 the State of California transfers the responsibility for managing all youthful offenders from the State to local jurisdictions (DOJ realignment). Due to this reform, Juvenile Probation is expecting a significant increase in volume and acuity of mental health treatment needs. Juvenile Probation is partnering with CCBHS to expand mental health services in Juvenile Detention and the community to meet these increased needs.

m. Continuum of Care Reform (CCR): The Continuum of Care Reform (CCR) is the legislative and policy framework for implementing the understanding that youth who are forced to live apart from their families are best served in nurturing family homes. To achieve that end, CCR requires close interagency collaboration between Child Welfare, Probation, and Behavioral Health.

CCR effectively eliminates the Rate Classification Level (RCL) system for group homes and implements the Short-Term Residential Treatment Program (STRTP) model based on the idea that congregate care should be a short-term treatment intervention, not a permanent solution. CCR also introduces a new service category, Therapeutic Foster Care (TFC), for foster home-based intensive treatment. In Contra Costa County, EHSD Children and Family Services (CFS), Probation Department and Mental Health have worked very closely in rolling out CCR. It was widely understood that Mental Health would have to expand services for foster youth to support home-based treatment. In 2018, the Division pursued phase two of CCR expansion by increasing staffing for Wraparound, the Family Partner program, and Utilization Review. Mental Health and EHSD also renewed their Interagency Agreement whereby $2 million in realignment funds are reallocated from EHSD to Mental Health to support three contracts for a range of outpatient services to support a step down in placement levels and sustain home-based care. These funds will continue to sustain these programs in the coming fiscal year. In

2019, Mental Health continued its CCR expansion by establishing five Mental Health Specialist and one Mental Health Program Supervisor positions for a Mentorship Program. Mental Health is contracting with providers that successfully transitioned their group homes to STRTPs. Mental Health has selected a provider for Therapeutic Foster Care (TFC) and entered a contract to provide TFC services.

n. Presumptive Transfer: The State passed AB 1299, enacting an initiative to attempt to correct the issue of foster children who were placed out of their county of jurisdiction and were not receiving behavioral health services in a timely manner. AB 1299 allows the county of jurisdiction to transfer the responsibility for the provision of specialty mental health services to the county of residence. Policy and procedures are in development both at the State and local level. With respect to resolving financial demands between counties and as a result of Presumptive Transfer, Contra Costa decided to participate in the Joint Power Authority facilitated by the California Mental Health Services Authority (MHSA).

o. Evidenced Based Practices: Child and Adolescent Mental Health has instituted system-wide trainings and support for several evidence-based practices (EBPs), including Trauma-Focused Cognitive Behavioral Therapy, Cognitive Behavioral Therapy for Depression, Dialectical Behavioral Therapy, Family Based Treatment of Eating Disorder (FBT) and Wraparound Services. EBPs 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 promote trauma-focused care regionally.

p. First Hope: The First Hope program provides services aimed at early intervention in psychosis. It has two components: the Clinical High Risk Program (CHR) and the First Episode Program (FEP). First Hope staff performs an extensive initial assessment to determine whether a young person is at risk of developing a psychosis (Clinical High Risk program) or whether the person already had a first break (First Episode Program). The aim of the CHR program is to prevent a psychotic disorder, and the aim of the FEP is to mitigate the impact of the first episode of psychosis, restore functioning and prevent further progress of psychosis. While the CHR program has been active since 2014, the FEP started providing services in 2019. Hiring for the First Episode Program has largely been completed. In October 2018, First Hope moved to a new location to accommodate for its new program component.

q. CANS Implementation. Following a State mandate, Mental Health implemented the Child/Adolescent Needs and Strengths (CANS) assessment. Regulations require monthly reporting to the State. The Division is contracting with vendors regarding data gathering and reporting systems and ongoing technical assistance regarding CANS implementation.

Child & Adolescent Services Summary

Service:		Mandatory
Level of Service:		Discretionary
Expenditures:		$80,401,019
Financing:		79,181,120
Net County Cost:		1,219,899
Funding Sources:		
Federal	42.3%	$31,670,047
Local	48.1%	40,974,896
Transfer	5.0%	3,998,189
State	3.2%	2,537,988
General Fund	1.5%	1,219,899

FTE: 117.5

Note: Excludes Support Services costs included under the Administrative component of the budget.

2. Adult Services

Description: Provides services to clients 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 with acute and/or severe mental disorders and their families. 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 Don Brown 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 Behavioral 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. Client-Run Community Centers: Centers in Pittsburg, Concord and San Pablo provide empowering self-help services based on the Recovery Vision, a concept that individuals can recover from severe mental disorders with peer support. The centers, which are client 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 disorder specialty services provided for CalWORKs participants who are referred by the Employment and Human Services Department to reduce barriers to employment. Services include outpatient services for mental health and substance use disorders plus supportive services for participants and their immediate family members.

h. The Behavioral Health Access Line: 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 substance abuse counselors, 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 1.) Adult Felony Probation involvement (AB109 and General Supervision), 2.) Court Ordered and court-involved services, (Restoration for Incompetent to Stand Trial (IST)

misdemeanor cases, Assisted Outpatient Treatment, and Mental Health Diversion), and 3.) co-responding with local law enforcement agencies.

Forensics mental health 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. Per the SMART Reentry MOU between the Behavioral Health Division and the Office of Reentry and Justice (ORJ), Forensic staff provide mental health services to East County Transitional Age Youth (TAY) referred from the Probation Department during their reentry to the community from custody. Services provided are: medication support, case management, Wellness Recovery Action Planning, and Seeking Safety groups.

Court-ordered and court-involved services include Restoration for Incompetent to Stand Trial (IST) misdemeanor cases, the implementation of Assisted Outpatient Treatment (AOT), also known as Laura's Law and Mental Health Diversion. Forensics clinicians receive referrals to AOT from qualified requestors, complete an investigation to determine eligibility for AOT, make appropriate referrals to AOT services for those who meet criteria and refer to other services for those who do not meet the criteria.

j. Mental Health Diversion provides pre-trial Mental Health Diversion services via AB 1810 funding for individuals referred from the court with serious mental illness. Per penal code 1001.36, clients charged with a misdemeanor or felony, who suffer from a serious mental disorder listed in the DSM5, the symptoms of which could respond to treatment, are eligible to receive Mental Health Diversion if the mental disorder played a significant part in the commission of the charged offense. The Forensic Diversion team provides mental health treatment and wraparound services across a continuum of care to meet clients' needs to effectively manage their mental health symptoms and live successfully in the community. Services include medication evaluation and ongoing medication support, assessment, and group and individual therapy.

Mental Health Evaluation Teams (MHETs), pair a licensed clinician with a police officer to engage with a target population of individuals with mental illness who have frequent contact with law enforcement. Via MOUs with three police departments (Pittsburg, Walnut Creek, and Richmond) the MHETs provide clients and families across the three County regions with psychiatric follow-up and much needed linkage to services and community resources. Via a grant from the Concord Police Department, one MHET clinician was funded to partner with a Concord police officer. Three MHET clinicians were also funded via AB 109 funds to partner with Sheriff's deputies across the three regions of the county supported by the Sheriff's Department.

k. A3 (Anyone, Anywhere, Anytime) Community Crisis Initiative: A Board of Supervisors approved initiative funded by Measure X. This initiative is designed to develop a system where timely and appropriate behavioral health crisis services can be accessed in Contra Costa County by anyone, anywhere, at any time. The projected results:

- Create the conditions for wellness and provide for the safety of individuals who are most in need of critical mental health and substance use services.
- Enhance community safety and well-being through culturally sensitive therapeutic response.
- Address the identified community need of alternative destinations for people in crisis.
- Provide a new level of care for those seeking behavioral health services.
- Expand the current limited system to a comprehensive crisis response available across Contra Costa.
- Reduce involvement of other local government resources including dispatch services, law enforcement and emergency medical services to respond to behavioral health crises.
- Reduce the number of emergency medical calls related to behavioral health, acute crisis episodes, and involuntary psychiatric holds.

Planning is underway to develop the Miles Hall Community Crisis Hub to house a multi-disciplinary crisis response hub which will house a continuum of BH crisis services to support the A3 Community Crisis Initiative. The ***Mobile Crisis Response Team (MCRT***) will be part of the Miles Hall Community Crisis Hub.

Measure X will provide on-going funding to support a robust array of services that will be deployed to our community in new and unique ways, including the initial creation of 73 staff positions (administrative support staff, peer support specialists, and licensed clinicians).

Miles Hall Crisis Call Center staffing will include medical and psychiatric oversight, administrative and project management support and licensed and peer staff to answer the calls and triage and dispatch mobile crisis teams; Mobile crisis teams that are stationed and available 24 hours a day, 7 days a week across the county with flexible staffing to meet the needs of the community; Development of additional community crisis services as alternative destinations to emergency rooms, psychiatric emergency services and detention facilities that provide multi-disciplinary medical and psychiatric support; Expanded outreach and education across the county of existing and new crisis and behavioral health resources; On-going administration, program support, infrastructure maintenance and quality improvement activities for A3 Community Crisis Initiative.

In addition, Measure X also provided funding in FY 2021-22 one-time startup costs. The unused portion of this funding will be rolled over to FY 2022-23

The MCRT provides crisis intervention response to clients experiencing mental health crises seven days a week, Monday through Friday from 8:30 am to 10:30 pm and Saturday and Sunday from 8:30 am to 5:00 pm. MCRTs coordinate crisis response and 5150s with law enforcement and County emergency services. The goal is to decrease 5150s, reduce psychiatric emergency services (PES) visits, and refer clients to appropriate services in their communities.

l. Rapid Access*:* Provides drop-in services at the mental health clinics to clients who have recently been admitted to and subsequently discharged from Psychiatric Inpatient Hospital Services, the CCRMC Crisis Stabilization Unit, or Detention. Provides needs assessments; short-term case management/therapy; and 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.

m. Older Adult Program: Provides mental health services to Contra Costa's seniors, 60 years of age or older, including preventive care, linkage, and outreach to under-served and/or at-risk communities. The Senior Peer Counseling Program reaches out to isolated and mildly depressed older adults (age 55-plus) 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 that provides problem-solving short-term therapy for individuals aged 55 and older with moderate to severe depression, anxiety, and PTSD. The Intensive Care Management Program provides mental health services to severely mentally ill older adults aged 60-plus 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.

n. Transition Team: Provides short-term intensive case management services and linkage to ongoing services for severely and persistently mentally ill adults ages 18-59 who are in need of mental health services. Transition Team referrals come primarily from inpatient psychiatric hospitals, Psychiatric Emergency Services, homeless services, and occasionally from law enforcement. The clients 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 clients with the additional support and guidance to successfully access these services and to stay in treatment. Once clients are stable enough, the Transition Team refers them to one of our outpatient mental health clinics for ongoing treatment and support.

o. Evidence Based Practice (EBPs): The adult system of care has instituted trainings in several evidence-based practices (EBPs) across all three regions of the Division. These include Cognitive Behavioral Social Skills Training (CBSST), and Cognitive Behavioral Treatment for Psychosis (CBTp), Cognitive Behavioral Therapy for Depression (CBT for Depression), Dialectical Behavioral Therapy (DBT), Wellness Recovery Action Plan (WRAP), and Multifamily Groups in the Treatment of Severe Psychotic Disorders. To support successful implementation of EBPs, EBP Team Leaders have been identified in each of the three adult regional clinics as well as in the Older Adult and Forensics programs. EBP Team Leaders provide ongoing consultation and support to staff using EBPs, as well as monitor the use of outcome measures identified to collect data and outcomes of the clients receiving EBP services. Outcome measures being implemented are the Patient Health Questionnaire (PHQ9), the Generalized Anxiety Disorder (GAD7), the Independent Living Skills Survey (ILSS), and the Recovery Assessment Scale (RAS).

The Adult Needs and Strengths Assessment (ANSA) was implemented across the Adult System of Care in December 2020. The ANSA is an open domain assessment tool for use in service delivery systems that address the mental health of adults and their families. It is a reliable information integration tool to aid in developing individual plans of care, monitoring outcomes, and assisting with planning systems of care for adults with behavioral health issues. Behavioral Health contracts with vendors for data gathering, reporting systems, and ongoing technical assistance regarding ANSA implementation.

***p. Augmented Board and Cares for Older Adult Mental Health Clients*:** The Behavioral Health Division's Adult System of Care expanded its bed capacity for older adult Behavioral Health consumers requiring supports for activities of daily living and medical care as well as supports for their mental health needs. Increasing the bed capacity has greatly reduced wait lists for older adult clients needing specialized care services. Case management services are provided by Older Adult Mental Health.

q. Trauma Informed Systems of Care: Behavioral Health's strategic plan identifies trauma informed care as a priority. Behavioral Health strives to deliver trauma informed care through the adoption of a strengths-based framework for service provision, grounded in an understanding of and responsiveness to the impact of trauma on client behavioral health and recovery. Behavioral Health coordinates with system partners – EHSD, H3, Public Health, First Five, Primary Care - to provide trauma-informed trainings and activities via trauma informed learning collaboratives and trauma informed leadership trainings.

Adult Services Summary

Service:		Mandatory
Level of Service:		Discretionary
Expenditures:		$67,799,657
Financing:		67,134,109
Net County Cost:		665,548
Funding Sources:		
State	44.5%	$30,173,042
Federal	38.2%	28,203,026
Local	9.4%	4,030,243
Transfer	7.0%	4,727,798
General Fund	0.9%	665,548

FTE: 166.4

Note: Excludes Support Services costs 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.

ccLink Optimization Efforts:
The Behavioral Health Division has been using ccLink (Electronic Health Record) for clinical documentation since late 2017, and as a result, is more effectively coordinating care with providers across all of Health Services. Since the implementation and subsequent enhancements, clients have benefited from improved access to and understanding of their own care, as well as more efficient workflows for staff providing services to clients. ccLink has also helped to support data collection and outcomes-oriented program evaluation for the benefit of clients served. In 2020 and 2021 there were numerous significant enhancements to ccLink including but not limited to:

- A Community Based Organization (CBO) Portal for all MH and AOD CBOs: The Provider Portal allows designated staff members at each CBO to "view" necessary medical and mental health information for the purpose of coordinating care.
- Clinical Services Information (CSI) Timeliness workflows to capture CSI Timeliness for foster youth, including the implementation of the Acuity Screening and timeliness data capture for children referred to Emergency Foster Care and Community Wide Assessment Team.
- New ccLink departments for Youth Hospital and Residential, Child and Family MH, and countywide Wraparound.
- Automatic sharing of the Behavioral Health Partnership Plan notes through MyChart to comply with the 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program regulations.
- Adult Needs and Strengths Assessment (ANSA) Implementation.
- Implemented Utilization Review (UR) Chart Alerts system across all Behavioral Health System programs for clinicians and psychiatrists to more effectively track UR documentation that requires action; this replaced the prior UR checklist which previously replaced the "red sticker" on the paper chart.
- COVID-19 related enhancements:
  - Implemented method for tracking in-person, telephone, and video visits based on patient preference.
  - Implemented Zoom software to clinicians, nurses, and psychiatrists for the purpose of telehealth due to COVID-19.
- COVID-19 vaccinations and testing/ telehealth:
  - Vaccinated over 1,100 county and CBO staff with first and second round doses of the Moderna vaccine.
  - Vaccinated over 100 BHS clients with Janssen vaccine at BHS clinics.
  - Conducted outreach, organized and arranged transportation through RoundTrip, and scheduled appointments in ccLink for BHS clients to receive their COVID-19 vaccination at County Public Health, Ambulatory and BHS clinics.
  - Implemented appointment eCheck-In and beneficiary eSignature through MyChart for HIPAA, Patient Rights, Advanced Directives, and Consent for Services forms for clients 18 and older.
  - Implemented Epic's Haiku across the system for all clinical staff. Haiku allows for mobile access to clinical records in the EHR for staff working in the field or remote from an office setting.
  - Promoted client access to health records with the client portal, MyChart. Currently approximately 50% of adult clients have a MyChart account.
  - Began testing new software for Mobile Community Response (A3) initiative for

Call Center Hub as well as Field Dispatch management and communication.
- o Developed changes necessary for CalAIM Medical Necessity criteria, including assessment and Acuity Screening updates; and went live in January 2022.
- o EHR Vendor Selection and Preparation for CalAIM 2022 and 2023 Requirements.
- o Participated in CalMHSA EHR Vendor review process, including participation in demos by 4 EHR vendors.
- o Initiated gap analysis to determine whether Epic can meet the needs for replacing ShareCare and implementing requirements for CalAIM Payment reform, state, and regulatory reporting.

Support Services Summary		
Service:		Discretionary
Level of Service:		Discretionary
Expenditures:		$19,567,836
Financing:		9,627,662
Net County Cost:		9,940,174
Funding Sources:		
State	5.3%	$1,031,970
Federal	40.0%	7,823,009
Local	3.3%	650,368
Transfer	0.6%	122,315
General Fund	50.8%	9,940,174
FTE: 96.4		

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.

In October 2020, the expansion of the inpatient psychiatric care unit increased bed capacity by an additional twelve (12) beds. The purpose of this expansion was to improve access to acute services and overcrowding and wait times for acute in-patient hospital admissions for adults.

Local Hospital Inpatient Psychiatric Services Summary		
Service:		Mandatory
Level of Service:		Mandatory
Expenditures:		$19,038,430
Financing:		17,058,403
Net County Cost:		1,980,027
Funding Sources:		
Federal	81.0%	$15,427,616
Local	7.9%	1,501,089
Transfer	0.7%	129,698
General Fund	10.4%	1,980,027

5. Outpatient Mental Health Crisis Services

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:		$16,039,349
Financing:		14,257,816
Net County Cost:		1,781.533
Funding Sources:		
Federal	69.5%	$11,150,000
Local	19.4%	3,107,816
General Fund	11.1%	1,781,533

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 its patients. The Behavioral Health Division also maintains a network of over 200 contracted outpatient providers (therapists and psychiatrists) 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:		$11,571,709
Financing:		9,853,890
Net County Cost:		1,717,819
Funding Sources:		
Federal	29.7%	$3,434,302
Local	55.5%	6,419,588
General Fund	14.8%	1,717,819
FTE: 21.0		

7. Mental Health Services Act (MHSA)/ Proposition 63

Description: Approved by California voters in November 2004, Proposition 63 imposes a 1% 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"*. Funds are transferred to specific Health Services Behavioral Health programs and fund approximately 170 FTEs.

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.

For the most recent 2021-22 Plan Update, the statutorily required Community Program Planning process concluded with a 30-day public comment period and public hearing which took place on July 7, 2021. Responses to substantive stakeholder input were incorporated into the final Three-Year Plan Update that was approved by the Board of Supervisors on August 3, 2021.

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. The following table summarizes a budget estimate of total MHSA spending authority by component for FY2022-23.

Program Type	$ in Millions
Community Support System	$47,899,000
Prevention and Early Intervention	9,849,000
Work Force Education & Training	2,943,000
Capital Facilities	250,000
Innovation	2,329,000
Total MHSA Allocation	$63,270,000

Mental Health Services Act

Service:	Mandatory
Level of Service:	Discretionary
Expenditures:	$63,270,000
Financing:	63,270,000
Net County Cost:	0
Funding Sources:	
Local 100.0%	$63,270,000
(Transfers from the MHSA Fund)	
FTE: 173.7	

Mental Health Services Act (MHSA) Trust Fund/Proposition 63

Mental Health Services Act Fund (Prop 63)	2020-21 Actuals	2021-22 Budget	2022-23 Baseline	2022-23 Recommended	Change
Expense					
Expenditure Transfers	60,439,665	54,397,000	63,270,000	63,270,000	0
Expense Total	**60,439,665**	**54,397,000**	**63,270,000**	**63,270,000**	**0**
Revenue					
Other Local Revenue	432,978	1,458,000	243,000	243,000	0
State Assistance	69,870,758	52,939,000	63,027,000	63,027,000	0
Revenue Total	**70,303,736**	**54,397,000**	**63,270,000**	**63,270,000**	**0**
Net Fund Cost (NFC):	**(9,864,071)**	**0**	**0**	**0**	**0**
Financial Indicators					
% Change in Total Exp		(10%)	16%	0%	
% Change in Total Rev		(23%)	16%	0%	
% Change in NFC		(10%)	16%	0%	

Description: Approved by California voters in November 2004, Proposition 63 imposes a 1% tax on incomes in excess of $1 million and directs those collections to the provision of mental health services. These collections are deposited into the Trust Fund and maintained per regulation. Periodically, funds are transferred from this fund to the Mental Health General Fund budget unit to finance mental health programs approved in the Mental Health Services Act (MHSA) Three Year Plan.

Mental Health Services Act		
Service:		Mandatory
Level of Service:		Discretionary
Expenditures:		$63,270,000
Financing:		63,270,000
Net Fund Cost:		0
Funding Sources:		
State	99.62%	$63,027,000
Local	0.38%	243,000

2021-22 Performance Measurement

The following outcomes represent a mid-year report of the progress made toward reaching the goals identified in the 2021-22 recommended budget.

Mental Health

Goal: The Division is assessing their programs and services from an equity lens, including identifying metrics to appropriately measure the current state and progress toward achieving racial equity in our services.

Outcome: Partially met.

- CCBHS continued dialogue between CCBHS Reducing Health Disparities (RHD) Workgroup and CCBHS Leadership to identify methods to support equity as it relates to CCBHS and the public behavioral health system in Contra Costa.
- CCBHS added languages outside of threshold languages to the Community Program Planning Process surveys for CCBHS.
- CCBHS works with stakeholders to support community defined practices for the Asian and African American/Black communities.
- CCBHS provides training to CCBHS staff and contracted providers, based on feedback from 2020 CCBHS Workforce Survey on topics such as Racial Trauma, working with various ethnic and cultural groups, and undocumented people.
- CCBHS participates in student Loan Repayment Program provided by the California Department of Health Care Access and Information (HCAI) in prioritizing those with language capacity, lived experience, systems involvement experience, and those who are culturally responsive to better meet the identified needs of CCBHS clients and community.
- CCBHS is developing the Anyone, Anywhere, Anytime (A3) Community Crisis Response Program, a multi-disciplinary, county-wide team with diverse experiences. The initial framework is to develop a system where anyone in Contra Costa County can access timely and appropriate behavioral health crisis services anywhere, anytime.

Goal: Continue using Objective Arts to optimize data reporting and meet compliance for monthly Child Adolescent Needs and Strengths (CANS) and Pediatric Symptom Checklist (PSC) data submission to DHCS, including integrating Objective Arts with ccLink so there is streamlined data exchange between County and contractor systems.

Outcome: Partially met. Contra Costa continues to utilize Objective Arts for CANS/PSC data submissions to DHCS on behalf of contract providers and we continue to be in compliance with data submissions. For FY 20-21 there were 4,305 completed CANS assessments and 4.004 completed PSCs among our contract providers. Contract providers have the ability to see assessment results for their clients in real time within the Objective Arts system. However, they do not have the ability to see assessments completed by other providers. Contra Costa is currently working to better coordinate care and build efficiencies by sending a monthly report to provider folders that they access to indicate the date of any CANS assessments completed by other Contra Costa providers for shared clients. This will reduce redundancies and help share recent/current assessment information on clients access shared providers. Contra Costa will be testing new reports with contract providers in early 2022.

Goal: Ensure County and contract providers recertify on CANS and Adult Needs and Strengths Assessment (ANSA) annually by purchasing Praed Foundation vouchers for certification.

Outcome: Met. Contra Costa has contracted with Praed Foundation for required annual recertification to conduct and ANSA.

Goal: Implement Family Urgent Response Services (FURS). SB 80 (2019) mandates County Behavioral Health, Child Welfare, and Probation Departments to implement a mobile response system for current and former foster youth. Contra Costa will build on the BHS Mobile Response Teams (MRT) to meet state requirements for FURS for the purpose of greater placement stability for youth experiencing foster care.

Outcome: Completed. Contra Costa BHS and Child & Family Services completed an Interagency Services Agreement to utilize the annual State allocation for the implementation of the Family Urgent Response System to expand the contract for the Mobile Response (MRT) contract with Seneca to introduce the capability for overnight in-person response and add youth peer providers to the Mobile Response Team. Data for Mobile Response services for youth/families that meet criteria for FURS are reported to Child & Family Services.

Goal: Continue to implement Evidence Based Practices in the Children's system of Care, including Dialectical Behavior Therapy (DBT), Trauma Focused Cognitive Behavior Therapy (TF-CBT), Family Based Treatment of Eating Disorders (FBT), Child Parent Psychotherapy (CPP), and the Piers Model (early psychosis program) by providing ongoing training and consultation opportunities, ongoing development of outcome tracking, and fostering a culture of commitment to best practice models that is oriented on outcomes.

Outcome: Completed. Contra Costa BHS contracted with training consultants to offer state of the art ongoing consultation and training for staff practicing Evidence-Based Practices (EBPs). The DBT consultant provided quarterly half day trainings for DBT practitioners and supported clinic-based team leads to lead weekly case consultations. The consultant for Family-based Treatment of Eating Disorders (FBT) provided case consultation in regular intervals to support clinician with this high-risk population. In coordination with the Lead for EBPs, the regional clinics arranged that newly hired employees were trained in Trauma Focused Cognitive Behavior Therapy (TF-CBT) by California Institute for Behavioral Health Solutions (CIBHS) and that existing providers receive booster trainings. Program staff at our program for early intervention in psychosis continues to receive trainings by trainers and consultants that are certified by the PIER institute. The EBP work group has worked with our ccLink team to include EBP metrics in our electronic health record system. Further, CCBHS contracts with community-based organizations to provide evidence-based practices, including multi-dimensional therapy for individuals with co-occurring mental health and substance use disorders, Multi-Systemic Therapy and Functional Family Therapy for youth involved with Juvenile Justice.

Goal: Continue to develop crisis continuum of care for children and youth experiencing mental health crises that includes Mobile Response Team for home/field-based crisis intervention and child/youth/family friendly alternatives for crisis stabilization when more intensive supports are required. Develop the continuum with the goal of reducing involvement of law enforcement in crisis.

Outcome: Met. Contra Costa BHS expanded scope and staffing of Children's Mobile Crisis Team (MRT) to meet the requirements for the Family Urgent Response System and by using FURS funding allocation. Further, MRT participated in value stream mapping and rapid improvement events for the community crisis response initiative. This process has led to launching the Miles Hall Crisis Hub and the A3 (Anyone, Anywhere, Anytime) initiative, which will be further developed and implemented in the coming fiscal year. The Children's MRT will be integral in meeting the goals for the A3 program to provide differential response for mental health crises and reduce the role of law enforcement in navigating crises situations. Further, Contra Costa applied for and was awarded CHFFA grant money to build a Crisis Stabilization Unit for minors. Upon completion of the Children's Crisis Stabilization Unit (CSU) minors experiencing mental health crises will no longer co-located with adults at Psychiatric Emergence Services (PES), which has been a long-standing request of stakeholders.

Goal: Continue to implement cross departmental Children's System of Care (CSOC) by operationalizing MoU between Child Welfare, Probation, Office of Education, Regional Center of East Bay, and Behavioral Health.

Outcome: Met. Children and Family Services (CFS), Probation, Regional Center of the East Bay (RCEB), Contra Costa Office of Education (CCCOE), and Contra Costa Behavioral Health Services (CCBHS) finalized a Memorandum of Understanding, which was approved by the

Department of Health and Human Services. The MoU has designed a structure whereby the executive leadership and the administrative leadership teams of the five agencies meet quarterly to address topics of mutual concern, including increased coordination between agencies, program gaps and development for Contra Costa youth, and data sharing.

Goal: Continue the implementation of EBPs in the Adult System of Care (SOC), including Cognitive Behavioral Social Skills Training (CBSST), Cognitive Behavioral Treatment for Psychosis (CBTp), Cognitive Behavioral Treatment for Depression (CBTd), Dialectical Behavior Therapy (DBT), Wellness Recovery Action Plan (WRAP), Motivational Interviewing, Seeking Safety, Multi-Family Groups. Develop "train the trainer" capacity with CBTp. Maintain a community of practice that supports professional growth and development and provides quality on-going training in best practices.

Outcome: Goal met. Adult SOC conducted trainings in CBSST and CBTp during 2021-22 for Adult SOC staff. EBP Team Leaders are being trained as "train-the-trainer" in CBTp and leading consultation groups in Adult SOC with supervision of trainer from Stanford. CBSST continues monthly follow up consultation calls with trainer. The MHP also offers CBT for Depression/Anxiety, DBT, Seeking Safety, and WRAP as EBPs in the adult clinics. Adult SOC continues to build a community of practice**.**

Goal: Develop a data governance structure for the Adult EBPs to improve data gathering, track and evaluate outcomes, and monitor overall efficacy of EBPs.

Outcome: Goal Met. In 2021 the EBP Outcomes Workgroup continued its work of developing an EBP Governance Structure to help augment care-coordination of EBP clients, assess EBP fidelity, and to monitor the accuracy of EBP Enrollment and Outcome Measures data tracking. During 2021, the Quality Improvement/Quality Assurance (QI/QA) team and the EBP Outcomes Workgroup also began collaborating with the Business Intelligence team and the Informatics team to develop an EBP Tracking Project Charter which identified various goals and governance gaps that are both technical and operational as project aims to solve. The EBP Data Governance tool is a work-in-progress and still requires an operational governance scaffold to be developed.

Goal: Continue to train and certify Adult County and CBO staff-clinicians, psychiatrists, nurses-in implementation of Adult Needs and Strengths Assessment (ANSA). Continue to work with vendor for data management system, Objective Arts, to support data gathering from contract providers. The MHP will work with Praed/Kentucky University, for technical assistance with the ongoing training of staff. The MHP will work with Chapin Hall to develop a level of care algorithm to utilize in the Adult System of Care.

Outcome: Goal partially met. Effective December 1, 2020, the ANSA Full was implemented in the Adult SOC. To support this implementation virtual ANSA 101 trainings were developed and embedded in Relias for staff to access when needed. While Adult clinicians have been trained and certified to complete the ANSA Full, and a training was developed in ANSA Brief for Adult Psychiatrists, not all Adult psychiatrists have completed the training and certification.

Goal: Coordinate Levels of Care. An integrated health system supports clients to navigate through higher and lower levels of care as their needs change over time. Adult system will re-convene "coordinating levels of care" (CLOC) a workgroup to identify and coordinate step-down options for clients with improved outcomes including step-down through our housing continuum as well as through treatment services. Algorithm data from ANSA will help to inform CLOC workgroup.

Outcome: Goal partially met. Because of shifting priorities due to the COVID-19 pandemic, the CLOC workgroup did not convene. Nor did we access algorithm data from ANSA. However, the Adult SOC manager team meets at weekly Bed Review committee where step-down treatment options for our clients through the housing continuum are reviewed.

Goal: The Adult system will continue to improve coordination of care in three areas to support linkage to vital services in the community:

1. Clients discharging from CCRMC 4C/psychiatric in-patient setting to the community.
2. Clients transitioning and stepping down from long-term psychiatric care to the community.
3. The Transition Team provides essential short term intensive case management services to individuals needing support and linkages to multiple services. The goal for the Transition Team is to continue to coordinate and provide innovative care for clients making contact with many service entry points.

Outcome: Goal met. Adult/Older Adult BH convenes a weekly multi-disciplinary "Bed Review" meeting to coordinate services for clients between settings of care, including appropriate discharge planning for short and long-term hospital and institutional stays. In 2021, Adult BH designed and implemented a new organizational format, exchanging Zoom for Microsoft Team. The MS Teams platform allows for the outpatient teams and the hospital teams to create a master file/record of hospital admissions and discharges. This Teams site also includes other valuable information that the team members update, access, and share at any time. Other files added to the Bed Review Teams site are court referral cases, MHRC step down list, Outside Hospital list, cases needing further discussion.

Goal: Mobile Crisis Response Team-MCRT- and the Mental Health Evaluation Team-MHET- will continue to provide crisis response to clients and families experiencing mental health crises and coordinate with system and law enforcement partners. The goal will be to reduce 5150s and PES visits and support and link clients and families to services and resources in the community.

Outcome: Goal met. Since July 2018, MCRT has received 4,381 calls of which 44% were identified as "crisis". MCRT was dispatched to 61% of the calls identified as crisis calls. In 50% of these calls, where MCRT was able to intervene and assist, the crisis was de-escalated, and the client did not need to be 5150d to PES.

2022-23 Administrative and Program Goals

Mental Health

Goal: The Access Line will provide beneficiaries with accurate information on how to access mental health services. During business hours, Access Line will meet the requirements for quarterly test calls 85% of the time.

Goal: The Access Line will answer all business hour calls within 3 minutes 75% of the time. 95% of after-hours calls will be answered within one minute.

Goal: Develop a strategic framework for a unified Electronic Health Record (EHR) system that includes functionality for clinical documentation, claims submission and remittance, mandated reporting, and care management. This goal is in alignment with broader healthcare reform efforts under DHCS's California Advancing and Innovating Medi-Cal (CalAIM), including the payment reform milestone set for July 2023.

Goal: Continue implementation of Evidence Based Practices (EBPs) in the Adult SOC; including Cognitive Behavioral Treatment for Psychosis (CBTp), Cognitive Behavioral Social Skills Training (CBSST), Cognitive Behavioral Treatment for Depression (CBTd), Dialectical Behavior Therapy (DBT), Wellness Recovery Action Plan (WRAP), Seeking Safety, Multi-Family Groups. Continue to develop "train-the trainer" capacity in CBTp with EBP Team Leads.

Target: 90 % of staff to be trained in at least one EBP.

EBP Team Leads will support training efforts by providing two trainings per year.

Goal: Develop a data governance structure for the Adult EBPs to improve data gathering, track and evaluate outcomes, and monitor overall efficacy of EBPs. EBP data governance tool requires an operational governance scaffold to be developed.

Target: Develop with Business Intelligence an operational governance scaffold for EBPs.

Goal: Adult Needs and Strengths Assessment (ANSA) implementation. Adult SOC clinicians have been trained and certified to conduct the ANSA Full. However, while an ANSA Brief training/certification program was developed for the Adult Psychiatrists, very few Adult Psychiatrists have completed the training and certification. The goal will be to train and certify all Adult Psychiatrists in the ANSA Brief.

Target: 90 % of Adult Psychiatrists will be trained in the ANSA Brief.

Goal: The Adult SOC will improve coordination of care in three areas to support linkage to vital services in the community:

- Clients discharging from CCRMC 4C/4D psychiatric in-patient setting to the community
- Clients transitioning and stepping down from long-term psychiatric care to the community
- Clients supported by the Transition Team who provide essential short term intensive case management services to individuals needing support and linkage to multiple services. The Transition Team will continue to coordinate and provide innovative care for clients making contact with many service entry points.

Target:

- 80% of hospital discharges will have timely f/u treatment appointments within 7 days of discharge to the community in outpatient clinics and/or residential settings.
- Clients requiring step-down placement to the community from locked long-term care will be placed in community placements within 60 to 90 days of treatment discharge date identified by the treatment team.
- Transition Team will provide follow-up care to clients requiring support and linkage from multiple service points such as Don Brown Shelter, crisis residential, H3 shelters, discharges from outside hospitals to other service points in the community. 90% of behavioral health clients accessing crisis residential, Don

Brown shelter, and H3 shelters will be supported by Transition Team.

Goal: Successful implementation of Qualified Individual (QI) Program. CCBHS will complete QI Reports for 100% of individuals that are considered for a Short-Term Residential Treatment Facility (STRTP) within 30 days of referral for a QI report by the placing agency (Children & Family Services, Juvenile Probation).

Goal: Successful Implementation of Children's Crisis Stabilization Unit. Contra Costa will complete the remodeling of the Behavioral Health wing of Miller Wellness Center to accommodate the new Children's Crisis Stabilization Unit (CSU). Contra Costa will select a Community Based Organization to operate the CSU. The facility will be fully certified to operate as a CSU.

Goal: Expansion of school-based mental health services in Antioch Unified School District. Contra Costa will utilize Mental Health Student Services Act funding to expand school-based mental health services. Through an RFP process, Contra Costa BHS will identify a Community Based Organization (CBO) to operate school-based mental health services at two Antioch Middle Schools. Up to 60 students will receive Specialty Mental Health Services.

Goal: Develop a supportive services housing team. Hire and train three staff to provide services in support of clients in CCBHS identified housing and care placements.

Goal: Provide quarterly support to board and care operators and maintain small board and care beds. Small board and care beds provide an opportunity for clients to remain in the with support.

Goal: Identify and acquire an effective system to track data, bed usage and financial management.

Grand Jury

Contra
Costa
County

725 Court Street
P.O. Box 431
Martinez, CA 94553-0091

October 18, 2021

Monica Nino
Contra Costa County
1025 Escobar Street
Martinez, CA 94553

Dear Monica Nino:

Attached is a copy of Grand Jury Report No. 2102, "Tele-Mental Health: Expansion of Remote Access to Care" by the 2020-2021 Contra Costa County Grand Jury.

Sincerely,

Samil Beret, Foreperson
2020-2021 Contra Costa County Civil Grand Jury

Enclosure

A REPORT BY

THE 2020-2021 CONTRA COSTA COUNTY CIVIL GRAND JURY

725 Court Street
Martinez, California 94553

Report 2102

Tele-Mental Health: Expansion of Remote Access to Care

APPROVED BY THE GRAND JURY

Date 10/15/2021

/s/ Samil Beret

SAMIL BERET
GRAND JURY FOREPERSON

ACCEPTED FOR FILING

Date 10/12/21

JILL C. FANNIN
JUDGE OF THE SUPERIOR COURT

Contra Costa Grand Jury Report

Tele-Mental Health: Expansion of Remote Access to Care

To: Contra Costa County Behavioral Health Services
Contra Costa County Board of Supervisors

SUMMARY

Barriers to people receiving mental health intervention include the limited availability of mental health clinicians, geographic distances, transportation difficulties, and insufficient financial resources to afford treatment costs. Research indicates that tele-mental health services are comparable to in-person mental health services regarding patient satisfaction, efficacy, and cost effectiveness with diverse populations. Identifying the need and benefit of telehealth services, the California Telehealth Advancement Act of 2011 promotes the parity of telehealth with in-person health care services.

Although Contra Costa County Behavioral Health Services (BHS) identifies the priority of increasing access to mental health services, this investigation determines that BHS does not incorporate tele-mental health services in its service delivery model. In addition, BHS lacks adequate resources to collect data to improve the quality of outpatient mental health services offered to the community.

The Grand Jury recommends that BHS develop a hybrid plan to integrate tele-mental health services with in-person services in both their outpatient clinics and network provider groups. In addition, the Grand Jury recommends that BHS collect outcome data from their clinics and network provider groups to improve the quality of outpatient mental health services offered to the community. Toward this goal, the Grand Jury recommends that BHS modernize the electronic data collection capabilities of the quality management program, seeking grants and funding through the Mental Health Services Act (MHSA). The Grand Jury also recommends that the Contra Costa County Board of Supervisors provide funds to BHS to upgrade its quality management program.

METHODOLOGY

The Grand Jury used the following investigative methods:

- Researched internet-based scholarly literature pertaining to the use of tele-mental health practices with different clinical populations
- Reviewed Federal and State legislation concerning telehealth

- Reviewed BHS authorizations approving the use of tele-mental health services during the Covid-19 public health emergency
- Reviewed the Contra Costa County MHSA Three Year Program and Expenditure Plan for Fiscal Year 2020-2023
- Reviewed information provided by BHS administration in response to Requests for Information
- Conducted multiple interviews with behavioral health program administrators and clinical personnel
- Reviewed BHS clinical staff and network provider surveys

BACKGROUND

The Need

The demand for mental health services exceeds the supply of trained clinicians. In 2018, there were 115 million Americans living in an area with a shortage of professional service delivery providers. According to the National Survey on Drug Use and Health, almost one-quarter of adults with mental illness reported not receiving treatment. Between 1999 and 2017, the Centers for Disease Control and Prevention reported an increase of 33% in suicide rates with the highest increase in rural counties, which was double the rate of urban areas.[1] In 2016, 16.5% of children in the United States had at least one treatable mental health disorder. Half of the estimated 7.7 million children in the United States with a treatable mental health disorder did not receive treatment from a mental health professional.[2] In California there are only 13 practicing child and adolescent psychiatrists for every 100,000 children under 18.[3]

In addition to the limited availability of mental health clinicians, barriers to people receiving mental health intervention include geographic distances, transportation difficulties, insufficient financial resources to afford treatment costs, and time constraints, such as being unable to take time off from work or having caretaking responsibilities.

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[1]Michael L. Barnett and Haiden A. Huskamp, Telemedicine for mental health in the United States: Making progress, still a long way to go. A commentary, Psychiatric Services, 71 no. 2, (February 2020): 197-198.

[2] Daniel G. Whitney and Mark D. Peterson, US national and state-level prevalence of mental health disorder and disparities of mental health care use in children, JAMA Pediatric, 173 no. 4 (February 11, 2019): 389-391.

[3] American Academy of Child and Adolescent Psychiatry, Workforce Maps by State – Practicing child and adolescent psychiatrists (2021).

Access

Tele-mental health is the use of telecommunication or videoconferencing technology, rather than in-person services, to provide mental health services.[4] Tele-mental health is emerging as an alternative to in-person mental health services for addressing the limited accessibility to mental health services. Studies showed tele-mental health services to be comparable to in-person intervention in patient satisfaction, efficacy, and cost effectiveness.[5] Evidence indicated the strength of the patient-therapist relationship was comparable to in-person treatment.[6] Research showed tele-mental health was an effective treatment approach with diverse groups, including children and adolescents, rural residents, nursing home populations, college students, veterans, immigrants, and incarcerated individuals.[7] Additionally, psychotherapy services delivered by phone were shown to reduce symptoms of anxiety and depression.[8]

A Service Delivery Model

Identifying an expanded approach to providing behavioral health services to meet the needs of underserved populations, the American Psychological Association identified a four-level model of health care delivery [9] to provide access based on the diverse needs of patients:

1. In-person services
2. Traditional telehealth services provided at an originating site such as a clinic or health care facility
3. Telehealth service without originating site restrictions to allow for certain services to be delivered directly into a patient's home
4. Audio-only telehealth for a subset of services and/or particular populations

The California Telehealth Advancement Act of 2011

Recognizing the potential of telehealth to meet the needs of underserved populations the California legislature passed the California Telehealth Advancement Act of 2011 (AB 415). It states, in part,

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[4] National Institute of Mental Health, National Institute of Health Publication No. 21-MH-8155.

[5] Sam Hubley, Sarah B. Lynch, Christopher Schneck, Marshall Thomas, and Jay Shore, Review of key telepsychiatry outcomes, World Journal of Psychiatry, no. 2 (2016): 269-282.

[6] American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Telepsychiatry and AACAP Committee on Quality Issues, Clinical Update: Telepsychiatry with children and adolescents, American Academy of Child and Adolescent Psychiatry 56, no. 10 (2017): 875-893.

[7] Stacie Deslich, Bruce Stec, Shane Tomblin, and Alberto Coustasse, Telepsychiatry in the 21st Century: Transforming healthcare with technology, Perspectives in health information management (Summer 2013).

[8] Mental Health Liaison Group, Submission to the Subcommittee on Health of the House Committee on Energy & Commerce Hearing, The future of Telehealth: How Covid-19 is changing the delivery of virtual care, Recommendations for tele-behavioral health priorities (March 2, 2021).

[9] American Psychological Association, Submission to the Subcommittee on Health of the House Committee on Energy & Commerce Hearing, The future of Telehealth: How Covid-19 is changing the delivery of virtual care (March 2, 2021).

[The] lack of primary care providers, specialty providers, and transportation continue to be significant barriers to access to health services in medically underserved rural and urban areas [and] parts of California have difficulty attracting and retaining health professionals, as well as supporting local health facilities to provide a continuum of health care. . . . It is the intent of the legislature to create a parity of telehealth with other health care delivery modes. . . .Telehealth is a mode of delivering health care services and public health utilizing information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from health care providers. . . .The use of information and telecommunication technologies to deliver health services have the potential to reduce costs, improve quality, change the conditions of practice, and improve access to health care, particularly in rural and other medically underserved areas. Consumers of health care will benefit from telehealth in many ways, including expanded access to providers, faster and more convenient treatment, better continuity of care, reduction of lost work time and travel costs, and the ability to remain with support networks.

The Covid-19 Public Health Emergency

The Covid-19 pandemic prompted the temporary expansion of public and private telehealth services. The U.S. Department of Health and Human Services declared a public health emergency on January 31, 2020, followed by the President's declaration of a national emergency on March 13, 2020, allowing greater flexibility for Medicare providers' use of telehealth services. Consequently, the California Department of Managed Health Care (DMHC) issued temporary emergency orders[10] requiring Medi-Cal and other health plans regulated by the DMHC to reimburse providers at a parity rate for telehealth services typically delivered to patients in-person. Audio-only communication was an allowed service. Additionally, geographic-site constraints in providing telehealth services were suspended, enabling patients to receive services at-home.

Following this state directive, Contra Costa County authorized telehealth services on March 25, 2020.[11] BHS provided the following directive to be in effect during the Covid-19 public health emergency:

Telehealth is not a distinct service, but an allowable mechanism to provide clinical services. The standard of care is the same whether the patient is seen in-person, by telephone, or through telehealth. DHCS [The Department of Health Care Services] does not restrict the location of services via telehealth. Patients may receive services via telehealth in their home, and providers may deliver

[10] California Health and Human Services Agency, Department of Health Care Services, Medi-Cal payment for telehealth and virtual/telephonic communications relative to the 2019-Novel Coronavirus (Covid-19) (3/18/20).
[11] Contra Costa County BHS Memorandum (4/1/20).

services via telehealth from anywhere in the community, outside a clinic or other provider site.

The Future of Tele-Mental Health

Policies enabling temporary telehealth services during the public health emergency period will expire when the state of emergency ends, which has yet to be determined. There have been national and California legislative bills drafted to extend the expansion of telehealth services permanently. Congress recently passed the Consolidated Appropriations Act of 2021[12] to be enacted after the public health emergency regulations are no longer in effect, allowing Medicare providers to permanently receive reimbursement for tele-mental health services that are integrated with in-person sessions. As a result of this legislation, tele-mental health services will be accessible in one's home and extended to residents who do not live in rural locations. Audio-only services are not included in this legislation.

Contra Costa County Broadband Access

The 2018 U.S. Census Bureau estimated the population of Contra Costa County to be 1,150,215 with approximately 9% living in poverty and 30% of the noninstitutionalized residents receiving public health coverage.[13] Nonetheless, in 2021, the Federal Communications Commission (FCC) reported that 99.2 percent of Contra Costa County residents have fixed broadband access.[14] Therefore, most Contra Costa County residents will be able to access tele-mental health services by either computer or smartphone.

Investigation Purpose

Underserved people in the community with mental illness concerns who may have difficulty receiving in-person services, including rural residents and those with mobility and financial limitations, could benefit from tele-mental health services. The focus of this investigation is to ascertain Contra Costa County BHS' plan to maintain and expand tele-mental health services for the community following the termination of the Covid-19 state of emergency.

DISCUSSION

Contra Costa County BHS is staffed by dedicated and compassionate professionals who are invested in the wellbeing of county residents. Clinical staff at BHS clinics provides services to people with severe mental illness. BHS contracts with outside network providers to offer services to people with mild and moderate mental health

[12] Consolidated Appropriations Act (2021): 1775-1776.
[13] Contra Costa Mental Health Services Act Three Year Program and Expenditure Plan Fiscal year 2020-2023.
[14] Federal Communication Commission, Fourteenth Broadband Deployment Report (January 19, 2021): 81.

needs. Despite extensive programs to meet the needs of underserved populations with severe mental illness, the mental health needs of the community exceed the available resources.

The Contra Costa County Mental Health Services Act Three Year Program and Expenditure Plan[15] identifies "access" to service programs as a priority concern. "The cost of transportation and the County's geographical challenges make access to services a continuing priority." This was particularly pertinent for "homebound frail and elderly residents." The Contra Costa County MHSA Three Year Program identified several factors hindering residents receiving mental health services

- Transportation to clinics, especially for rural residents
- The need to provide services outside customary clinic hours
- The importance of clinicians who can offer cultural sensitivity and competent language skills for underserved ethnic groups

In addition, the MHSA plan notes a shortage of psychiatrists, which contributes to long waiting periods for an appointment and undermines the wellbeing of patients who do not have their medication regimens monitored in a timely manner.[16]

Notwithstanding this defined need to increase access to mental health services, the Contra Costa County MHSA Three Year Program did not include any initiatives to develop tele-mental health services.

In 2017, **the Mental Health Commission**[17] advocated offering telepsychiatry to increase the availability of psychiatrists and to reduce wait times for appointments.[18]

BHS Limited Implementation of Tele-Mental Health

BHS addressed the need for more psychiatrists by hiring telepsychiatrists, improving access to psychiatric care. However, BHS did not initiate programs to provide tele-mental health services in accordance with the California Telehealth Advancement Act of 2011.

As noted in Table 1, prior to the Covid-19 public health emergency, tele-mental and audio-only health services collectively represented approximately 7% and 8% of total outpatient services provided in 2018 and 2019, respectively. After the public health

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[15] In 2004, the Mental Health Services Act became California Law providing additional funding to the existing public mental health system.

[16] Contra Costa County Mental Health Services Act Three Year Program and Expenditure Plan Fiscal Year 2020 – 2023: 25-27.

[17] Contra Costa Mental Health Commission Amended Bylaws (September 16, 2014). The Mental Health Commission was established in 1993 to serve in an advisory capacity to the Contra Costa County Board of Supervisors on matters related to mental health.

[18] Mental Health Commission Annual Report 2018.

emergency in March 2020 allowing telehealth services to be reimbursed at parity with in-person services, telehealth services were 18% of services provided, fewer than the office sessions (30%) and services delivered by phone (52%).

Table 1: BHS Outpatient Modes of Service Delivery[19]

Year	Office	%	Audio-Only	%	Tele-mental health	%	Grand Total
2018	58,293	93%	3,263	5%	1,076	2%	62,632
2019	63,319	92%	3,162	4.5%	2,424	3.5%	68,905
2020	24,286	30%	42,495	52%	14,650	18%	81,431

When the public health emergency orders were implemented, BHS created a list of General Telehealth Logistical Guidelines[20] for providers, who were given Zoom accounts. There was no evidence that providers or clients were given further training to use a tele-mental health approach appropriately and maintaining confidentiality, which would be likely to increase familiarity and comfort with using this approach. Rather than use tele-mental health with video capabilities, the majority of providers used audio-only, which does not allow visual contact with clients. Reportedly, clients preferred audio-only services for the convenience or discomfort with video. Although the Federal Communication Commission (FCC) in 2021 reported 99.2% of Contra Costa residents had fixed broadband access,[21] BHS staff was concerned that a significant number of their clients did not have internet access.

Notwithstanding limited implementation, BHS clinical staff considered tele-mental health and audio-only services to be effective with clients who displayed symptoms of anxiety and depression. The clinical staff viewed clients who were more stable, verbal, insightful, and capable of managing technology benefited more from tele-mental health services. At the outset of the Covid-19 pandemic, BHS reported fewer missed appointments using telehealth and audio-only services in contrast to in-person services. However, as the pandemic persisted, some clients stopped seeking services.

Noteworthy, BHS clinical staff viewed tele-mental health to be inappropriate for the homeless and chronic schizophrenic patients with limited capacity to manage the tasks of daily life. A predominant method of service delivery, audio-only, was determined to be inadequate for patients prescribed controlled substances because of the absence of visual cues to assess the patient. Tele-mental health was also considered inappropriate for patients receiving medication injections.

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[19] Data provided by BHS.

[20] Contra Costa County BHS Memorandum (4/1/20).

[21] Federal Communication Commission, Fourteenth Broadband Deployment Report (January 19, 2021): 81.

Concerned for the adverse effects of clients' social isolation, BHS expressed the intention to resume in-person sessions as the public health emergency waned. As previously noted, Medicare expanded eligibility for tele-mental health services when the Covid-19 public health emergency ends.[22] BHS has not communicated plans to augment tele-mental health services in its mental health program.

Quality Management

BHS collects financial data on services provided and ensures documentation meets state standards. The BHS quality management program gathers information about the effectiveness of services provided by its clinical staff. The quality management information collected about tele-mental health services is limited to survey data about BHS clinicians' and network providers' perspectives.[23] The quality management program does not have access to electronic, email and texting forms of data collection.

Although BHS clinicians and network providers preferred in-person sessions, they conveyed confidence meeting client needs using tele-mental health services. Tele-mental health enabled clinicians to maintain connections with clients and facilitated family involvement, while reducing missed appointments. Another advantage acknowledged was the elimination of transportation difficulties to receive in-person treatment.

Network providers contract with the State of California, not Contra Costa County. BHS does not collect clinical information from network providers, who do not use the County electronic medical record system. Additionally, only one-third of clients use the Contra Costa County medical MyChart electronic records system, limiting the opportunity to collect information.

FINDINGS

F1. Prior to the Covid-19 pandemic, tele-mental health and audio-only services available through BHS were a small portion of the outpatient services provided (7% in 2018; 8% in 2019).

F2. During the Covid-19 pandemic, BHS did not offer training to prepare clinicians or clients for effective and confidential use of tele-mental health services.

F3. During the Covid-19 pandemic, BHS tele-mental health services continue to be underutilized. While audio-only increased to 52% of all outpatient services, tele-mental health was 18% of outpatient services delivered.

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[22] Consolidated Appropriations Act (2021): 1775-1776.

[23] CCBHS Remote Work Survey (September 2, 2020).
CCBHS Contract Providers Remote Work Survey (September 10, 2020).

F4. At the outset of the Covid-19 pandemic, tele-mental health and audio-only services decreased the number of missed appointments.

F5. Tele-mental health services are appropriate for clients who are more stable, verbal and insightful.

F6. Tele-mental health services are appropriate to use with clients displaying symptoms of anxiety and depression.

F7. The greater use of audio-only services has the limitation of not offering visual cues, which provide clinicians with important clinical information.

F8. Tele-mental health services are not appropriate for

a. Homeless populations
b. Patients presenting with chronic schizophrenia with a limited capacity to manage the tasks of daily life
c. Patients prescribed controlled substances or injectable medication.

F9. BHS has not incorporated tele-mental health into a comprehensive service delivery model to offer a broad range of opportunities for underserved populations to receive outpatient mental health services.

F10. Access to outpatient mental health services in Contra Costa County suffers from difficulties with transportation to clinics, long wait times for appointments, and insufficient availability of after-hours appointments.

F11. BHS has a limited number of clinicians who can provide culturally and linguistically sensitive services to diverse minority groups.

F12. Increasing access to mental health services is a priority for Contra Costa County BHS.

F13. The FCC reported 99.2% of Contra Costa County residents have access to internet broadband for greater use of tele-mental health services.

F14. BHS has not followed the directives of the California Telehealth Advancement Act of 2011 to develop telehealth services to better meet the needs of underserved populations in the community.

F15. The Congressional Consolidated Appropriations Act of 2021 expands Medicare services to allow tele-mental health services to be integrated with in-person sessions, and to be received by beneficiaries in their home without geographic limitations.

F16. BHS lacks an adequate electronic data system to evaluate the efficacy of outpatient mental health services provided.

F17. BHS does not collect clinical data from network providers, which limits accountability for the outpatient mental health services provided to county residents.

RECOMMENDATIONS

By June 30, 2022, it is recommended that Contra Costa Behavioral Health Services:

R1. Develop a hybrid plan to integrate tele-mental health services with in-person services in their clinics.

R2. Coordinate with network provider groups to integrate tele-mental health services with in-person services.

R3. Develop a training program for BHS clinicians, network providers, and support staff to facilitate the use of tele-mental health.

R4. Develop a training program for clients to facilitate and provide support for the use of tele-mental health.

R5. Collect outcome data from BHS providers and programs to provide feedback to improve mental health services delivered to the community.

R6. Collect outcome data from network providers to provide feedback to improve mental health services delivered to the community.

R7. Increase the use of the MyChart health care information system to make clinical information accessible to clients and providers.

R8. Modernize the electronic data collection capabilities of the quality management program to provide meaningful information about mental health services.

R9. Develop appropriate clinical metrics to evaluate outcomes that improve the effectiveness of mental health services provided.

R10. Seek grants and MHSA funding to upgrade the technological resources of the quality management program.

By June 30, 2022, it is recommended that Contra Costa Board of Supervisors:

R11. Allocate funds for BHS to upgrade its quality management program.

REQUIRED RESPONSES

	Findings	Recommendations
Contra Costa Behavioral Health Services	F1 through F17	R1 through R10
Contra Costa Board of Supervisors	F16	R11

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