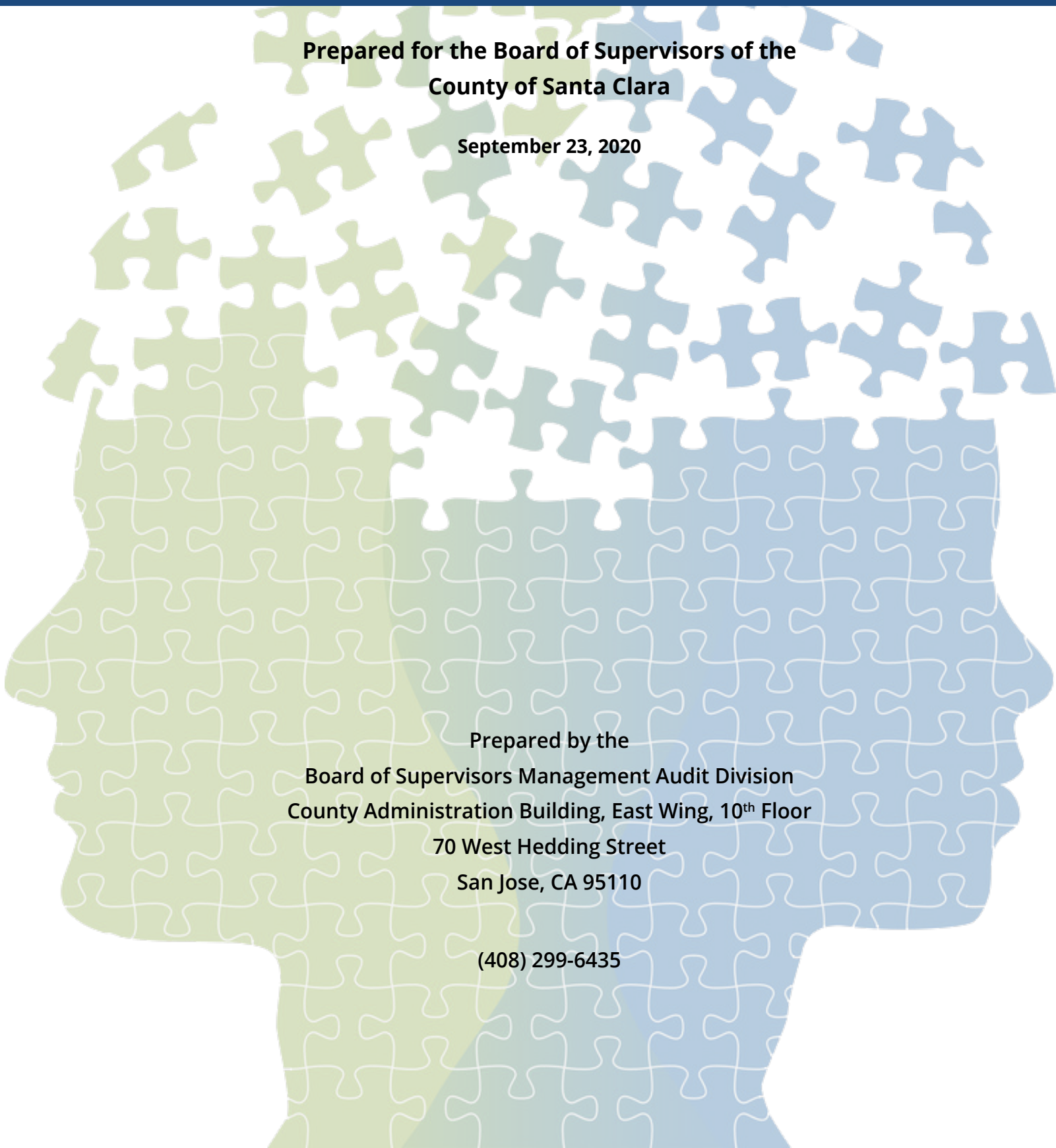
Management Audit of Mental Health Services Provided by Santa Clara County Behavioral Health Services

Prepared for the Board of Supervisors of the County of Santa Clara

September 23, 2020



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September 23, 2020

Supervisor Dave Cortese, Chair
Supervisor Cindy Chavez, Vice Chair
Board of Supervisors Finance and Government Operations Committee
70 West Hedding Street San Jose, CA 95110

Dear Supervisors Cortese and Chavez:

We have completed the Management Audit of mental health services provided by Behavioral Health Services. This audit was conducted in conformity with generally accepted government auditing standards as set forth in the 2011 revision of the "Yellow Book" of the U.S. Government Accountability Office. The purpose of this audit was to examine the operations, management practices, and finances of Behavioral Health Services to identify opportunities to increase the efficiency, effectiveness, and economy of the Department's provision of mental health services.

The report includes nine findings and 25 recommendations. The recommendations relate to Behavioral Health Services' pattern of under-spending its budget by nine to 12 percent; the Department's history of not always spending Mental Health Services Act (MHSA) funding within the required timeframe, which puts MHSA funding at risk of reversion to the State; the County's slow performance in reaching its target population and claiming of federal matching funds under the Whole Person Care pilot; the Department's slow ability to identify and standardize processes to measure the performance of three programs approved in the June 2018 MHSA plan to reduce the number of individuals with serious mental illness who only access emergency and crisis services; the Department's inability to consistently meet the State's timely access requirements for outpatient services for adults and older adults; the shortage of licensed residential care facilities and unlicensed board and care facilities and the lack of accurate County information on which licensed facilities accept clients with mental illness; the need to improve the living environments in some licensed residential care facilities and unlicensed board and care facilities to better support client wellness or recovery; the inadequate documenting, tracking, or reporting of the Department's procedures to identify and address reasons that individuals do not access outpatient care within seven days of discharge from Barbara Arons Pavilion or Emergency Psychiatric Services; and, the inability of County-run clinics' to assess their performance due to the Department's recent transition to a new electronic health record system.

In the attached response to this audit, Behavioral Health Services agrees with 14 of the 22 recommendations directed towards it and partially agrees with eight. Three of the recommendations are directed to the Board of Supervisors.

If implemented, the recommendations would:

- Encourage better planning for service needs and the hiring of key management positions;
- Enhance monitoring and reporting on spending levels for MHSA innovation projects;
- Provide for a formal review and presentation of performance and potential improvements following conclusion of the Whole Person Care pilot;
- Enhance tracking and reporting of service targets, performance indicators, and improvement objectives for the Intensive Full Service Partnership, Assertive Community Treatment, and In Home Outreach programs;
- Improve timely access to outpatient services;
- Provide for the creation of a resource for tracking all licensed residential care facilities and unlicensed board and care facilities;
- Prioritize planning and funding that would provide additional support for both residents and operators of licensed residential care facilities and unlicensed board and care facilities within the County's MHSA programming;
- Improve the Department's procedures and review of access to services upon discharge from emergency and acute inpatient care; and,
- Enhance performance monitoring of outpatient programs.

We would sincerely like to thank the Department of Behavioral Health Services and its staff, the Whole Person Care team, participants in our focus groups, and survey respondents for their thoughtful, patient, and professional cooperation and assistance throughout this audit.

Respectfully submitted,

Cheryl Solov
Management Audit Manager

CC: Supervisor Mike Wasserman
Supervisor Susan Ellenberg
Supervisor S. Joseph Simitian
James R. Williams, County Counsel

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Executive Summary

Finding 1: Department Spending and Outlook

The Department has under spent its budget in FY 2016-17 through FY 2018-19 from nine to 12 percent. The reasons for underspending, which came from Department salaries and contracts for services, could be due to a variety of factors, including County hiring and procurement practices, and delays in implementing programs. Underspending, however, could impact the Department's provision of behavioral health services, including leading to delays in accessing behavioral health services for County residents. The combination of the COVID-19 emergency, extended shelter-in-place orders, and resulting economic crisis and high unemployment means that State revenues to the counties and local county revenues will decline in FY 2020-21 compared to FY 2019-20. At the same time, behavioral health service needs are likely to increase due to economic stress and potential increase in homelessness.

The Director of the Department of Behavioral Health Services should work with the County Executive and the Board of Supervisors, including ongoing reporting to the Board's Health and Hospital Committee, to plan for service needs and setting priorities for service delivery. The Department Director should prioritize hiring of key managers and staff to ensure sufficient management oversight of existing programs, as well as planning for new service needs.

Finding 2: Slow Spending of Mental Health Services Act Funds

Historically, the County has not always spent MHSA funding within the required timeframe, which puts MHSA funding at risk of reversion to the State. The California Department of Health Care Services identified $14.6 million in MHSA funding that had been allocated to Santa Clara County between FY 2005-06 and FY 2014-15 that had not been spent within the required timeframe and was therefore subject to reversion as of July 1, 2017. The California Department of Health Care Services, subsequent to Assembly Bill (AB) 114, extended the County's deadline for spending this funding to July 2020. The Department of Behavioral Health services is particularly slow to spend MHSA innovation funds, which are funds for new approaches that may improve access, collaboration, or service outcomes for underserved populations, and has requested extensions on innovation projects from the Mental Health Services Oversight and Accountability Board. The County anticipates funding of approximately $5 million annually for innovation projects in FY 2020-21, FY 2021-22, and FY 2022-23. However, the County has never spent more than $3.8 million on innovation projects in a year since the MHSA became law. The slow spending of innovation funds draws the projects out longer and impedes the goals of innovation funding, which are to improve access, collaboration, or service outcomes for underserved populations.

The Department of Behavioral Health Services should continue to monitor and report on spending levels for MHSA innovation projects, and when evaluating new innovation project proposals as part of the MHSA Three-Year Plan review process, consider the timeliness of proposals and whether proposals would allow innovation funds to be spent immediately.

Finding 3: Whole Person Care Pilot

Although the WPC pilot has enabled the expansion of behavioral health services to high users of multiple systems, the County has been slow to reach its target population of 10,000 individuals and is behind its original schedule for claiming federal matching funds. Further, the County has made progress on some measures, but has missed performance targets under multiple categories. This raises the risk that some federal matching funds might eventually be forfeited. Health System staff notes that these numbers are relatively low due to significant challenges in reaching the target population. WPC eligible individuals often need more instances of engagement and outreach to authorize enrollment and engage them with health teams. As a result, many individuals in the target population continue to be unserved. Further, the County risks eventually forfeiting federal matching funds for WPC that have been rolled over from previous program years.

The County's WPC team should continue to monitor and track WPC performance metrics as required by DHCS. The WPC team should also report to the Board of Supervisors at the conclusion of the final program year on all performance metrics across all program years as well as lessons learned, and final expenditure amounts, including the amount of federal matching funds that were forfeited.

Finding 4: Programs to Reduce Emergency and Crisis Services Use

As of Spring 2020, the Behavioral Health Services Department was only beginning to identify and standardize processes to measure the performance of the three programs (Assertive Community Treatment; Intensive Full Service Partnerships; and, In Home Outreach) approved in the June 2018 Mental Health Services Act Plan to reduce the number of individuals with serious mental illness who only access emergency and crisis services; therefore, the ability of these programs to reduce visits to emergency and crisis services and increase access to ongoing community-based mental health services is not yet known. The Department will need to track, measure, and report these programs' services, enrollment, and outcomes to ensure efficient use of Mental Health Services Act resources and success in connecting seriously mentally ill individuals to ongoing mental health services.

The Behavioral Health Services Director should report quarterly on the Intensive Full Service Partnership, Assertive Community Treatment, and In Home Outreach programs' achievement of service targets, performance indicators and improvement objectives, and plans for improvement if these service targets, performance indicators, and improvement objectives are not met. The quarterly reporting should be included in the Department's Quality Improvement Work Plan and Program reports, and reported to the Board of Supervisors Health and Hospital Committee.

Finding 5: Timely Access to Outpatient Services

The Behavioral Health Services Department is not able to consistently meet the State's time and distance, or timely access requirements for adults and older adults. The County did not meet the State requirement in FY 2018-19 that services be provided within 10 miles or 30 minutes from the client's residence. In response, the Department created a new mental health outpatient team in Gilroy to serve 250 clients in 2019, but did so by reassigning existing staff from Narvaez Mental Health Center in East San Jose so that outpatient services did not increase overall. The Department also did not meet the State's requirement in FY 2018-19 that clients receive an outpatient appointment within 10 business days of the request, reporting an average of 12.6 days prior to the first appointment. The Behavioral Health Services Department submitted a corrective action plan in October 2019, outlining the steps to meet the State's requirements, which was cleared by the California Department of Health Care Services in January 2020.

The Behavioral Health Services Department Director should: (1) evaluate how MHSA funding in the draft MHSA Three Year Program and Expenditure Plan for FY 2020-21 through FY 2022-23 can be used to expand South County mental health services and restore staff to Narvaez Mental Health Center; and (2) develop outpatient procedures to increase staff productivity and direct services to clients. The Department Director should also include in the quarterly Quality Improvement Work Plan and Program reports data on staff productivity and the implementation of new outpatient programs, including the increase in the number of slots and ability to meet the California Department of Health Care Network Adequacy requirements.

Finding 6: Shortage of Residential Care and Board and Care Facilities

Behavioral Health Services Department staff state that licensed residential care facilities and unlicensed board and care facilities are closing and that there is a shortage of facility space to house clients with mental illness. State data shows that licensed facilities are closing at a higher rate in Santa Clara County than in California overall. However, not all licensed residential care facilities accept clients with behavioral health needs, and the lack of accurate information about facilities that do accept these clients impairs the Department's ability to assess the need for additional residential care space. The most apparent cause of facility closures are high costs to run the facilities and low facility revenues. The shortage and closures of residential care facilities impairs the continuum of care and patient recovery and generates costs for the County, because individuals who are unable to find appropriate residential care or housing when discharged from treatment programs may return to crisis programs, jails, or homelessness. When there is no space available for clients at a residential care facility, the Department may use County General Fund dollars to pay for an individual's extended stay in an inpatient or residential treatment setting.

The Behavioral Health Services Department should develop and maintain a resource for tracking all licensed residential care facilities and unlicensed board and care facilities that accept clients with mental illness, and report regularly to the Board of Supervisors on facility capacity and costs incurred to the County General Fund as a result of shortages. The Board of Supervisors should consider adopting a resolution that imposes additional requirements on residential care facilities proposing changes of use and consider allocating funding to the Department of Behavioral Health Services to pay for subsidies to licensed residential care facilities that house clients with behavioral health needs.

Finding 7: Quality and Oversight of Board and Care Facilities

Survey and focus group results show that the living environments in some licensed residential care facilities and unlicensed board and care facilities could be improved to better support client wellness or recovery. The Behavioral Health Services Department has been aware of quality concerns at some licensed and unlicensed facilities since at least 2014 but continues to refer clients to these facilities because there is a lack of available alternatives. Licensed residential care facilities are overseen and monitored by the Community Care Licensing Division, but there is no oversight body for unlicensed board and care facilities to establish minimum operating standards or to receive complaints from residents.

Santa Clara County's MHSA Three-Year Program and Expenditure Plan FY 2021-23 includes $990,000 for the Independent Living Facilities project, which is a new project that is planned to address some of the concerns related to facility quality, oversight, and support. The Behavioral Health Services Department should prioritize the release of the RFP for contract services to develop and manage this project. The Department should also consider funding proposals that would provide additional support for both residents and operators of licensed residential care facilities and unlicensed board and care facilities in future Mental Health Services Act spending plans.

Finding 8: Access to Services on Discharge from Emergency and Acute Inpatient Care

The Behavioral Health Services Department's discharge procedures are not sufficiently documented, tracked, or reported to identify and address reasons that individuals do not access outpatient care within seven days of discharge from Barbara Arons Pavilion or Emergency Psychiatric Services. The Department's draft Inpatient Discharge Manual ("Manual") outlines steps for referring individuals who are new to Behavioral Health Services to outpatient services on discharge from Emergency Psychiatric Services or Barbara Arons Pavilion, but these steps do not reflect the Department's actual practice. For example, the draft Manual does not address the role of the 24-Hour Care Team, which participates in discharge planning and placement for both Emergency Psychiatric Services and Barbara Arons Pavilion. The draft Inpatient Discharge Manual also does not address the role of Mental Health Urgent Care when individuals are discharged from Emergency Psychiatric Services, nor detail procedures for individuals who are discharged from Emergency Psychiatric Services between 10 p.m. and 8 a.m. when Mental Health Urgent Care is closed.

The Behavioral Health Services Department Director should finalize and formally adopt the Inpatient Discharge Manual, including ensuring that the manual reflects the Department's practices and includes all circumstances for individuals discharged from Barbara Arons Pavilion or Emergency Psychiatric Services. The Director should also develop written procedures for random audits of Barbara Arons Pavilion and Emergency Psychiatric Services charts to identify discharge referrals to outpatient services and notification of case managers on discharge. Data on individuals' access to outpatient services after discharge and chart audit results should be included in the Quality Improvement Reports.

Finding 9: Performance Monitoring of Outpatient Programs

In February 2018, the Behavioral Health Services Department began a transition to a new electronic health record system. The transition was unsuccessful, and as a result, the performance measurement data in the Performance Learning Measures for County-run clinics are considered incomplete and unreliable since February 2018, which impairs the County-run clinics' ability to assess their performance. The Department plans to complete a transition to a new electronic health record system by July 2020, but until the transition is complete, clinical and billing information for outpatient behavioral health services is spread out across three major information systems. Separately, in November 2018, the Department decided to suspend the use of Performance Learning Measures in contracted program monitoring in favor of a new contract monitoring tool. This contract monitoring tool relies exclusively on output and does not measure or give insight into client wellness and recovery, quality of life, or other outcomes of behavioral health services. Overall, the Department's ability to monitor the performance of outpatient programs, both contracted and County-run, has been impaired by the County's unsuccessful electronic health record system transition and the switch to a new contract monitoring tool that focuses exclusively on program outputs.

The Behavioral Health Services Department should: (1) revise the new contract monitoring tool for community-based organizations to include client outcome measures that were previously tracked in the Performance Learning Measures dashboard, and/or other outcome measures identified by the Department in a performance monitoring pilot; and (2) ensure that the new electronic health record system provided by NetSmart will be able to aggregate performance data for County-run outpatient programs. The Board of Supervisors should request that the Department provide a breakdown of the causes of the unsuccessful HealthLink transition after the transition to the new NetSmart electronic health record system is complete.

INTRODUCTION

This Management Audit of the Santa Clara Behavioral Health Services Department was added to the Management Audit Division's Fiscal Year (FY) 2018-19 work plan by the Board of Supervisors, pursuant to the Board's power of inquiry specified in Article III, Section 302(c) of the County of Santa Clara Charter. The Board added this audit after considering the annual County-wide audit risk assessment conducted by the Management Audit Division in accordance with Board policy.

PURPOSE, SCOPE, AND OBJECTIVES

The purpose of the audit was to examine the administration, finances, and management practices of the Santa Clara County Behavioral Health Services Department, and to identify opportunities to increase the efficiency, effectiveness and economy of the Department. Work on this audit began with an entrance conference on August 22, 2018, and a draft report was submitted to the Executive Director of the Santa Clara County Behavioral Health Services Department and the Office of the County Counsel on June 5, 2020.

An Exit Conference was held with the Santa Clara County Behavioral Health Services Department on June 26, 2020.

A Revised Report incorporating feedback from the exit conferences was issued to the Santa Clara County Behavioral Health Services Department on July 22, 2020.

The audit's main objectives were to assess the Department's administrative, financial, and management practices for mental health services, including to:

- Determine whether the Department's mission of providing a range of mental health services to Santa Clara County community members is achieved;
- Assess the Department's compliance with operating policies and procedures as stipulated in federal, State, and County laws and regulatory requirements; and,
- Evaluate the Department's performance in terms of its operating activities in relation to its specific objectives.

AUDIT METHODOLOGY

In the initial phase of the management audit, we interviewed key Department staff and collected documents detailing: (i) Department organization, (ii) federal, state, licensing, and other regulations governing the Department's operations, (iii) applicable County and Department written policies and procedures, (iv) licensing and training requirements for Department staff, (v) strategic, disaster, business continuity and other plans, (vi) performance and financial reports, (vii) lists of contracts, grants, and memoranda of understanding, (viii) inventory of fixed assets, (ix) financial plans, and (x) other documents detailing Department functions and operations.

At the end to the initial phase, we conducted a risk assessment and identified the main areas requiring further evaluation. We conducted follow up interviews with Department staff to gain a more in-depth understanding of the Department's policies and practices. We collected additional documentation on Department performance, program services and utilization, and outcomes.

Compliance with Generally Accepted Government Auditing Standards

This management audit was conducted under the requirements of the Board of Supervisors Policy Number 3.35 as amended on May 25, 2010. That policy states that management audits are to be conducted under generally accepted government auditing standards (GAGAS) issued by the U.S. Government Accountability Office. We conducted this performance audit in accordance with GAGAS as set forth in the 2011 revision of the "Yellow Book" of the U.S. Government Accountability Office. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. In accordance with these auditing standards, we performed the following procedures:

Audit Planning - The task plan for this audit was developed after reviewing available documentation on statutes governing the Behavioral Health Services Department; the mission and purpose of the Department; the Department's programs and funding sources; and other available information.

Entrance Conference – We held an entrance conference with the Department Director and managers to introduce the audit team, describe the audit program and scope of review, and to respond to questions. We provided a letter of introduction from the Board of Supervisors, the audit work plan and a request for background information at the entrance conference.

Pre-Audit Survey - Audit staff reviewed documentation and other materials to obtain an overall understanding of the District's operations, and to isolate audit areas that warranted more detailed assessments.

Field Work – We conducted detailed field work after completion of the pre-audit survey, which included interviews with Department executive management and program staff and other stakeholders, and analysis of financial and performance indicators

Draft Report – On June 5, 2020, we provided a draft report on our audit findings and recommendations to the Behavioral Health Services Department Director. We also provided the draft report to County Counsel.

Exit Conference – We held an exit conference with the Behavioral Health Services Department Director and executive staff on June 26, 2020 to discuss the report findings, conclusions and recommendations, and to make fact-based corrections and clarifications as appropriate. Following these meetings, we provided a revised draft to the Behavioral Health Services Department Acting Director on July 22, 2020 for use in preparing their formal written responses.

Final Report - We issued the final report on September 23, 2020. The Department's written response is attached to the final report.

Behavioral Health Services Department

The Santa Clara County Behavioral Health Services Department is a department within the County's Health and Hospital System. In 2014, the County's Mental Health Department and Department of Drug and Alcohol Services merged to form the Behavioral Health Services Department, serving approximately 21,000 County residents each year with an annual budget of more than $500 million, shown in Figure I.1 below.

Figure I.1: *Behavioral Health Services Department Budget FY 2017-18 to FY 2019-20*

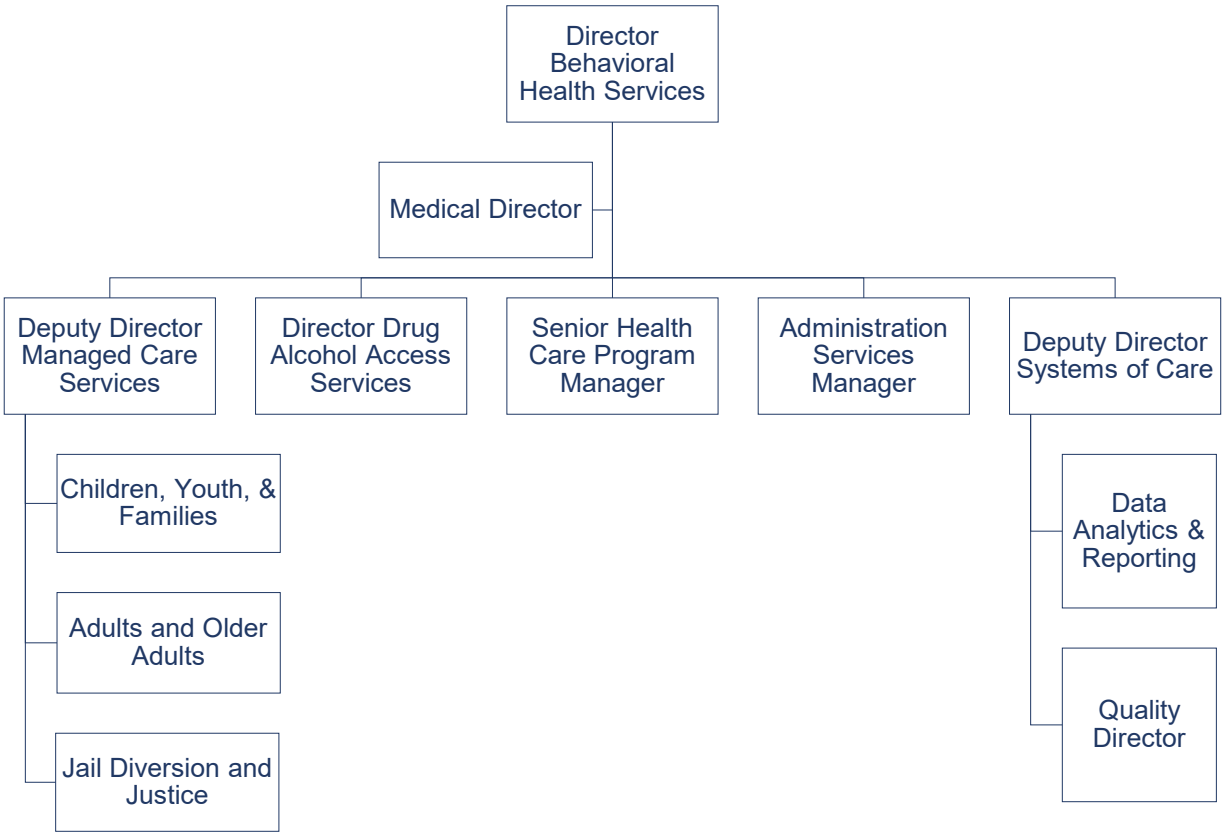
	Actual		Budget		
	FY 2016-17	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Percent Increase**
Sources					
Revenues	$353,433,503	$388,237,356	$376,209,398	$406,882,379	15%
Reimbursements	9,437,250	11,836,652	12,608,546	19,159,585	103%
Transfers	149,035,537	192,463,529	239,536,202	302,317,198	103%
Subtotal	511,906,290	592,537,537	628,354,146	728,359,162	42%
Net County Cost	85,901,861	86,119,265	147,111,138	171,036,594	99%
Total Sources	**$597,808,151**	**$678,656,802**	**$775,465,284**	**$899,395,756**	**50%**
Uses					
Salaries and Benefits	84,269,609	88,304,244	93,342,342	121,563,530	44%
Other Expenses	353,770,700	385,773,503	436,455,923	473,420,857	34%
Transfers and Other	159,767,841	204,579,055	245,667,018	304,411,369	91%
Total Uses	**$597,808,151**	**$678,656,802**	**$775,465,284**	**$899,395,756**	**50%**

Source: County Financial System.

The Department's budget increased by 50 percent from approximately $600 million in actual revenues and expenditures in FY 2016-17 to approximately $900 million in budgeted revenues and expenditures in FY 2017-18. Department sources increased by approximately 40 percent while the Net County Cost doubled. Increases in Department sources were largely due to Medi-Cal Short-Doyle/Mental Heatlh Services Act, other Medi-Cal revenues, and State grants.

The Department is headed by a Director who reports to the Deputy County Executive for the Health and Hospital Systems. Budget and financial support is provided by staff from the Health and Hospital Systems. The Department organization is shown Figure I.2 on page 10.

Figure I.2: *Behavioral Health Services Department Organization*



Source: Behavioral Health Services Department.

The Behavioral Health Services Call Center is the entry point for access to behavioral health services. Behavioral health services include prevention and early intervention, outpatient, intensive outpatient and full service partnership, and crisis services. Department services are provided through two systems: (1) Children, Youth, and Families, and (2) Adults and Older Adults. Our audit report focuses on the Adults and Older Adults system of care, summarized in Figure I.3 on page 11.

Figure I.3: *Behavioral Health Services Department Programs and Services*

	Program	Services	Hours
Behavioral Health Services Call Center	Mental Health Call Center	Centralized entry point for individuals seeking behavioral health services	24 hours/7 days
	Substance Use Services Call Center	Centralized entry point for individuals seeking alcohol or drug treatment services	8 am - 5 pm/weekdays
Emergency Services	Emergency Psychiatric Service	Psychiatric emergency room * Crisis Intervention * Medication & stabilization * Medication and hospitalization	24 hours/7 days
	Mental Health Urgent Care	Walk-in, outpatient crisis services	8 am - 10 pm/7 days
	Suicide & Crisis Hot Line	Phone-in crisis services	24 hours/7 days
Inpatient Services	Barbara Arons Pavilion, Valley Medical Center	Acute hospitalization	Inpatient/residential
	Institution for Mental Disease	Locked skilled nursing	Inpatient/residential
	Mental Health Rehabilitation Center	Locked facility for Lanterman-Petris-Short conservatorship	Inpatient/residential
	Licensed Residential Care	Residential care in the community, with payments supplemented by the County	Inpatient/residential
Outpatient Services	County and Community-Based Providers	Range of outpatient behavioral health programs throughout the County, including treatment, medication support, case management	Outpatient

Source: Behavioral Health Services Department.

Initiatives and Policies

In the past four years, the Behavioral Health Services Department has implemented program and policy changes to improve services and access. Two major technology changes were:

- Implementation of HealthLink, the Health and Hospital System care management system, which went live in February 2018; and
- Call Center system enhancements to provide real-time access to service provider capacity, facilitating access to services by individuals seeking services through the Call Center.

State Programs and Initiatives

Santa Clara County implemented several new State programs in FY 2016-17 and FY 2017-18 to increase access and improve outcomes for behavioral health services.

Drug Medi-Cal Organized Delivery System Waiver Program

The Drug Medi-Cal Organized Delivery System allows counties more local control over substance use treatment programs. Drug Medi-Cal Organized Delivery is a Medicaid 1115 Waiver pilot project approved for the State of California by the Centers for Medicare and Medicaid Services in 2015. The pilot program provides a new treatment model for substance use treatment and allows counties to bill Medi-Cal for additional services, including residential care and case management. Santa Clara County implemented the multi-year pilot program in FY 2017-18.

Whole Person Care Pilot Project

The Whole Person Care pilot project targets high users of multiple services. Whole Person Care is a Medicaid 1115 Waiver pilot project implemented by the State of California in 2016. Beginning in FY 2017-18, Valley Medical Center and the Behavioral Health Services Department participate jointly in designing and implementing programs to provide physical and behavioral health services to the target population, and to track and report outcomes.

Medi-Cal Managed Care Final Rule

The Medi-Cal Managed Care Final Rule sets network adequacy standards for Medi-Cal managed care programs, including county mental health plans and Drug Medi-Cal Organized Delivery System pilot projects. The Centers for Medicare and Medicaid Services established the Final Rule in 2016 to align Medicaid (including Medi-Cal) managed care plans with other health insurance plans. The network adequacy standards define an individual's access to provider services, including the number of days from the individual's request for services to the first appointment and the distance of services from the individual's residence. Implementation of the Final Rule began for the Behavioral Health Services Department and providers in FY 2017-18.

Section 1: Department Spending and Outlook

Background
The Behavioral Health Services Department budget consists of Department revenues, mostly Medi-Cal revenues and State grants, supplemented by the County General Fund. In FY 2016-17 and FY 2017-18, Medi-Cal and other State revenues came in over budget, reducing the General Fund contribution, but came in under budget in FY 2018-19, resulting in a revenue shortfall. However, the impact to the General Fund was minimal due to the Department's underspending in salaries and contracted services.

Problem, Cause, and Adverse Effect
The Department has underspent its budget in FY 2016-17 through FY 2018-19 from 9 to 12 percent. The reasons for underspending, which came from Department salaries and contracts for services, could be due to a variety of factors, including County hiring and procurement practices, and delays in implementing programs. Underspending, however, could impact the Department's provision of behavioral health services, including leading to delays in accessing behavioral health services for County residents.

The combination of the COVID-19 emergency, extended shelter-in-place orders, and resulting economic crisis and high unemployment means that State revenues to the counties and local county revenues will decline in FY 2020-21 compared to FY 2019-20. At the same time, behavioral health service needs are likely to increase due to economic stress and potential increase in homelessness. Potentially, direct contact between providers and clients, and outreach to schools and other congregate settings, will be limited for an extended period of time even after strict shelter-in-place orders area lifted. The Department may need to increase telephonic and telehealth access to services for clients, and identify other forms of outreach to schools, homeless shelters and encampments, and other areas of outreach. The Department also needs to ensure that State funds are fully utilized to maximize service delivery.

Recommendations
The Director of the Department of Behavioral Health Services should work with the County Executive and the Board of Supervisors, including ongoing reporting to the Board's Health and Hospital Committee, to plan for service needs and setting priorities for service delivery. The Department Director should prioritize hiring of key managers and staff to ensure sufficient management oversight of existing programs, as well as planning for new service needs.

Savings, Benefits, and Costs
Planning for revenue reductions and increases in services, as well as changes in how services are delivered will mitigate the impacts of reduced revenues an increased need. Prioritizing the hiring of executive management staff is within the Department's base budget and necessary to plan, implement and oversee the Department's core programs.

FINDING

Background

Santa Clara County's behavioral health services consists of two major systems of care: Adults and Older Adults, and Children, Youth, and Families. The system is set up so that clients can access the system through any portal – emergency room, acute inpatient, outpatient clinic, other – for immediate treatment, and then referred to the appropriate level of care.

The most recent, comprehensive behavioral health needs assessment and planning was conducted from 2016 to 2018, with a report completed in June 2018. Much of the source data for the needs assessment was from FY 2015-16, when the County's Behavioral Health Services Department served approximately 21,000 residents. The needs assessment identified underserved and unserved populations and recommended new or enhanced services to reach this population. Many of these services – such as Assertive Community Treatment and Intensive Full Service Partnership – are intensive and require increased resources. As noted in Figure I.1 on page 9 in the Introduction to this report, the Department's budget increased by 36 percent between 2016 and 2020, from $438.1 million actual expenditures in FY 2016-17 to $595.4 million in budget expenditures in FY 2019-20, in part due to new or enhanced programs.

The Behavioral Health Services Department budget consists of Department revenues, mostly Medi-Cal revenues and State grants, supplemented by the County General Fund. In FY 2016-17 and FY 2017-18, actual Department revenues exceeded the revised budget by 4 percent; in FY 2018-19 actual Department revenues fell short of the budget by 9 percent, as shown in Figure 1.1 below.

Figure 1.1: *Behavioral Health Services Department Revenues FY 2016-17 to FY 2018-19*

	FY 2016-17	FY 2017-18	FY 2018-19
Revised Budget	$350,108,498	$386,495,756	$413,223,875
Actual Revenues	$362,870,753	$400,074,009	$376,209,398
Surplus/(Deficit)	$12,762,255	$13,578,253	($37,014,477)
Percent	4%	4%	-9%

Source: County Financial System SAP.

In all three fiscal years, State Mental Health Realignment revenues came in over budget, offset by changes in Medi-Cal Short-Doyle and other revenues. In FY 2018-19, decreases in Medi-Cal Administration revenues offset increases in State Mental Health Realignment revenues, contributing to the $37.0 million shortfall shown in Figure 1.1 above.

Behavioral Health Services Department expenditures consist of salaries and other expenses, most of which are allocations to contracted services. In FY 2016-17 through FY 2018-19, actual Department expenditures were less than budget ranging from 9 to 12 percent, as shown in Figure 1.2 on page 15.

Figure 1.2: *Behavioral Health Services Department Expenditures FY 2016-17 to FY 2018-19 **

	FY 2016-17	FY 2017-18	FY 2018-19
Revised Budget	$499,279,614	$521,864,423	$596,689,201
Actual Expenditures	$438,090,643	$474,092,294	$529,798,265
Surplus/(Deficit)	$61,188,971	$47,772,129	$66,890,936
Percent	12%	9%	11%

Source: County Financial System SAP.

** The difference between revenues shown in Figure 1.1 on page 14 and expenditures shown in Figure 1.2 above is made up by the County General Fund.*

The expenditure surpluses in FY 2016-17 through FY 2017-18 come largely from salary savings and underspending from professional and contractual services.

Contracts for professional and provider services make up approximately 70 percent of the Behavioral Health Services Department expenditures. Actual contractual expenditures were 13 percent to 9 percent less than budgeted expenditures in FY 2016-17 to FY 2018-19, as shown in Figure 1.3 below.

Figure 1.3: *Behavioral Health Services Department Expenditures for Professional and Contractual Services FY 2016-17 to FY 2018-19*

	FY 2016-17	FY 2017-18	FY 2018-19
Revised Budget	$360,787,684	$368,131,931	$415,095,811
Actual Expenditures	$315,567,112	$337,819,681	$376,192,206
Surplus/(Deficit)	$45,220,572	$30,312,250	$38,903,605
Percent	13%	8%	9%

Source: County Financial System SAP.

Salaries and benefits make up approximately 18 to 19 percent of the Behavioral Health Services Department expenditures. Actual expenditures for staff salaries and benefits ranged from 7 percent below budget in FY 2016-17 to 13 percent below budget in FY 2018-19, as shown in Figure 1.4 below.

Figure 1.4: *Behavioral Health Services Department Expenditures for Salaries and Benefits FY 2016-17 to FY 2018-19*

	FY 2016-17	FY 2017-18	FY 2018-19
Revised Budget	$90,725,068	$99,378,101	$107,539,708
Actual Expenditures	$84,269,609	$88,304,244	$93,342,342
Surplus/(Deficit)	$6,455,459	$11,073,857	$14,197,366
Percent	7%	11%	13%

Source: County Financial System SAP.

The reasons for underspending for contractual services and Department staff salaries and benefits could be due to a variety of factors, including County hiring and procurement practices, and delays in implementing programs. The impact of underspending could lead to delays in accessing behavioral health services for County residents.

Vacancies in Key Management Positions

The Department has had vacancies in key management positions, which could contribute to delays in planning, implementing, and evaluating Department programs. As of June 2020, the Department Director position was filled as an interim position, and the Department had vacancies in the director positions for the Adult and Older Adult, and Children, Youth, and Families systems of care, for which the Department was in the process of filling at the time of this audit report, and in the director position for the Jail Diversion and Justice program.

The Need for Behavioral Health Services Will Increase at a Time When State and Local Revenues May Be Reduced, Requiring the Department to Plan for Service Demands With a Smaller Budget

Program Funding

The combination of the COVID-19 emergency, extended shelter-in-place orders, and resulting economic crisis and high unemployment means that State revenues to the counties and local county revenues will decline in FY 2020-21 compared to FY 2019-20. At the same time, behavioral health service needs are likely to increase due to economic stress and potential increase in homelessness.

State Revenues

Major State revenues to the Behavioral Health Services Department are Medi-Cal, Mental Health Realignment, and Mental Health Services. According to May 2020 California Department of Health Care Services documents, Medi-Cal funding, which makes up nearly 50 percent of Department revenues, increases statewide in FY 2020-21 compared to FY 2019-20 for Medi-Cal Local Assistance/Specialty Mental Health Services and Drug Med-Cal Organized Delivery. Mental Health Realignment is funded by sales tax and vehicle license fee revenues, projected by the Governor's Office to decrease by 13 percent in FY 2019-20 and grow slightly in FY 2020-21. Funding in FY 2020-21 for the Mental Health Services Act, which is funded by a one percent tax on income over $1 million, is not clear.

The County Executive's presentation to the May 29, 2020 Board of Supervisors meeting identified several reductions to behavioral health services in the Governor's proposed May 2020 budget, including cancellation of the Behavioral Health Quality Improvement Program, funding for behavioral health counselors, and funding for Medi-Cal enrollment navigators.

Local Funding

The County Executive's presentation identified potential solutions to close the projected County General Fund shortfall in FY 2020-21 and FY 2021-22. Among Board of Supervisors priorities that would continue to receive funding in FY 2020-21 were mental health diversion and new inpatient psychiatric facilities.

Assessment of Service Needs

The Behavioral Health Services Department does not have updated assessments of the need for behavioral health services subsequent to the June 2018 comprehensive needs assessment. The Department is still in the process of ramping up programs in response to the needs identified in that assessment, and evaluating the effectiveness of these programs.

The Department's website acknowledges the mental health problems that may be triggered by the COVID-19 crisis. According to discussions with the Department's interim director, current services will need to be addressed going forward. This includes not only the need for mental health services in response to COVID-19, but also changes in service delivery due to the shelter-in-place order. Potentially, direct contact between providers and clients, and outreach to schools and other congregate settings, will be limited for an extended period of time even after strict shelter-in-place orders area lifted. The Department may need to increase telephonic and telehealth access to services for clients, and identify other forms of outreach to schools, homeless shelters and encampments, and other areas of outreach.

The June 2018 comprehensive needs assessment used data for FY 2015-16 in large part to identify populations and service needs. The Behavioral Health Services Department needs to develop a plan to address potential increases in demand for services in response to the COVID-19 emergency and potential changes in service delivery due to COVID-19 and shelter-in-place.

Staff Vacancies and Hiring

The vacancies in key management positions impact the Department's service delivery and evaluation. As an example, the prior vacancy in the Quality Management Director position resulted in delays in finalizing discharge planning protocols and producing Quality Improvement Work Plan and Program reports. The Department needs to make hiring of key staff a priority to ensure sufficient management oversight of existing programs, as well as planning for prioritizing service needs.

CONCLUSION

The COVID-19 emergency, and resulting economic downturn reduces funding for behavioral health services at the same time that service needs are increasing and ways to delivery services are changing. The Department will need to actively plan for these changes to stay ahead of emerging behavioral health needs.

RECOMMENDATIONS

The Director of the Department of Behavioral Health Services should:

1.1 Work with the County Executive and the Board of Supervisors, including ongoing reporting to the Board's Health and Hospital Committee, to plan for service needs and setting priorities for service delivery. (Priority 1)

1.2 Work with the County Executive to prioritize hiring of key management positions as needed. (Priority 2)

SAVINGS, BENEFITS, AND COSTS

Planning for revenue reductions and potential increases in the need for services, as well as changes in how services are delivered will mitigate the impacts of reduced revenues and behavioral health needs triggered by the COVID-19 emergency and economic crisis. Prioritizing the hiring of key management positions is within the Department's base budget and necessary to plan, implement and oversee the Department's core programs.

Section 2: Slow Spending of Mental Health Services Act Funds

Background
The Mental Health Services Act (MHSA) was passed by California voters in November 2004 to increase funding for mental health services. The MHSA imposes a 1 percent tax on taxable personal income over $1 million and distributes tax revenues to California counties through the California Department of Health Care Services. In FY 2018-19, Santa Clara County received approximately $90.9 million in MHSA funding. Any MHSA funds that are not spent for their authorized purpose within a specified timeframe of three or ten years, depending on the funding category of allocation, must revert to the state.

Problem, Cause, and Adverse Effect
Historically, the County has not always spent MHSA funding within the required timeframe, which puts MHSA funding at risk of reversion to the state. The California Department of Health Care Services identified $14.6 million in MHSA funding that had been allocated to Santa Clara County between FY 2005-06 and FY 2014-15 that had not been spent within the required timeframe and was therefore subject to reversion as of July 1, 2017. The California Department of Health Care Services, subsequent to Assembly Bill (AB) 114, extended the County's deadline for spending this funding to July 2020.

The Department of Behavioral Health services is particularly slow to spend MHSA innovation funds, which are funds for new approaches that may improve access, collaboration, or service outcomes for underserved populations, and has requested extensions on innovation projects from the Mental Health Services Oversight and Accountability Board.

The County anticipates funding of approximately $5 million annually for innovation projects in FY 2020-21, FY 2021-22, and FY 2022-23. However, the County has never spent more than $3.8 million on innovation projects in a year since the MHSA became law. The slow spending of innovation funds draws the projects out longer and impedes the goals of innovation funding, which are to improve access, collaboration, or service outcomes for underserved populations.

Recommendations
The Department of Behavioral Health Services should continue to monitor and report on spending levels for MHSA innovation projects, and when evaluating new innovation project proposals as part of the MHSA Three-Year Plan review process, consider the timeliness of proposals and whether proposals would allow innovation funds to be spent immediately.

Savings, Benefits, and Costs
Timely spending of MHSA innovation funds will eliminate the risk of fund reversion and allow the County to realize the benefits of the innovation projects more quickly.

FINDING

Background

The Mental Health Services Act (MHSA) was passed by California voters in November 2004 to increase funding for mental health services. The MHSA imposes a 1 percent tax on taxable personal income over $1 million and distributes tax revenues to California counties through the California Department of Health Care Services (DHCS). Counties can use MHSA revenues for projects and services in the following funding categories:

- **Community services and supports**
  - Direct services and outreach for children, youth, adults, and older adults with mental health needs
- **Prevention and early intervention**
  - Services and programs that promote wellness, prevent the development of mental health problems, and identify and address early signs of mental health concerns
- **Innovation**
  - New approaches that may improve access, collaboration, or service outcomes for underserved populations
- **Workforce education and training**
  - Support to build, retain, and train mental health care providers
- **Capital facilities and technology needs**
  - Infrastructure development to support the implementation of an electronic health record and appropriate facilities for mental health services

Each county must prepare a Three-Year Program and Expenditure Plan and annual plan updates that must be approved by the county's Board of Supervisors and submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC).[1] The Three-Year Program and Expenditure Plans and plan updates detail the planned use of MHSA funds by category. In FY 2018-19, Santa Clara County received approximately $90.9 million in MHSA funds and has received $67.7 million to date in FY 2019-20 through May 15, 2020. The Department of Behavioral Health Services anticipates receiving between $102 and $105 million each year in FY 2020-21, FY 2021-22, and FY 2022-23.

1 The Mental Health Services Oversight and Accountability Commission was established as part of the Mental Health Services Act. The Commission oversees the implementation of the MHSA and is responsible for approving county plans for spending funds allocated for Innovation projects.

Under California Welfare and Institutions Code § 5892(h), funds allocated to community services and supports, prevention and early intervention, or innovation must be spent within three years. Funds allocated to capital facilities and technology needs or workforce education and training must be spent within ten years.[2] Any MHSA funds that are not spent for their authorized purpose within the specified timeframe must revert to the state. These reverted funds are to be deposited in the state Reversion Account and made available to other counties for future years.

Santa Clara County Has Not Always Spent MHSA Funds Within the Required Timeframe

In October 2018, DHCS identified $14.6 million in MHSA funding that had been allocated to Santa Clara County between FY 2005-06 and FY 2014-15 that had not been spent within the required timeframe and was therefore subject to reversion as of July 1, 2017. However, California Assembly Bill (AB) 114 (Chapter 38, Statues of 2017) amended provisions in the California Welfare and Institutions Code related to the reversion of MHSA funds. Under AB 114, all funds subject to reversion as of July 1, 2017 were deemed to have been reverted and reallocated to the county of origin for the purposes for which they were originally allocated (California Welfare and Institutions Code § 5892.1(a)). In effect, any MHSA funding that Santa Clara County would have been required to return to the state as of July 1, 2017 was re-allocated back to Santa Clara County.

The breakdown of unspent funds that were allocated between FY 2005-06 and FY 2014-15 and were subject to reversion are shown by category in Figure 2.1 on page 22. These funds were reallocated to Santa Clara County and must be spent by July 1, 2020, except for funds allocated in the Innovation category, which under California Welfare and Institutions Code § 5892.1(e) must be spent by July 1, 2020 or by the end of the project plan approved by the Mental Health Services Oversight and Accountability Commission, whichever is later.

2 The three- or ten-year window includes the fiscal year in which the funding was made available. For example, community services and supports funds made available in FY 2005-06 must be expended in FY 2005-06, FY 2006-07, or FY 2007-08. Workforce education and training funds made available in FY 2006-07 must be expended by FY 2015-16.

Figure 2.1: *Santa Clara County MHSA Funds Subject to Reversion as of July 1, 2017*

Fiscal Year of Allocation	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technology	Total
2007-08					$3,423,132	$3,423,132
2008-09			$2,609,677			$2,609,677
2009-10		$2,854,964	$710,660			$3,565,624
2010-11			$1,763,381			$1,763,381
2011-12						
2012-13						
2013-14			$280,357			$280,357
2014-15			$2,988,364			$2,988,364
Total	**$0**	**$2,854,964**	**$8,352,439**	**$0**	**$3,423,132**	**$14,630,535**

Source: California Department of Health Care Services, Mental Health Services Act Amounts Subject to Reversion before July 1, 2017, dated October 1, 2018.

DHCS required counties to prepare by July 1, 2018 a plan to spend the reverted funds by July 1, 2020. The Board of Supervisors approved Santa Clara County's Three-Year FY 2017-18 to FY 2019-20 MHSA Program and Expenditure Plan, which includes the spending plan for the $14.6 million in reverted funding under AB 114, on June 19, 2018. The spending plan for the funds, is summarized in Figure 2.2 below.

Figure 2.2: *Spending Plan for MHSA Funds Subject to Reversion as of 7/1/2017*

	Total Reverted Funds	Spending Plan			
		FY 2017-18	FY 2018-19	FY 2019-20	Total
Prevention and Early Intervention	$2,854,964	$2,854,964			$2,854,964
Innovation	$8,352,439	$572,273	$5,038,005	$2,742,161	$8,352,439
Capital Facilities and Technology	$3,423,132		$1,711,566	$1,711,566	$3,423,132
Total	**$14,630,535**	**$3,427,237**	**$6,749,571**	**$4,453,727**	**$14,630,535**

Source: FY 2017-18 – FY 2019-20 MHSA Program and Expenditure Plan.

The County Has Been Particularly Slow to Spend Funds Allocated for Innovation Projects

DHCS uses the "first-in first-out" method when applying MHSA expenditures to annual funding distributions, meaning that reported expenditures are applied to the earliest fiscal year fund distribution with a remaining balance. In other words, if Santa Clara County reported spending $4 million on prevention and early intervention in FY 2017-18, the $4 million expenditure would apply first to the $2,854,964 that was distributed to the County in FY 2009-10, and the remaining $1.2 million in expenditures would be applied to funds allocated in more recent fiscal years. Reviews of the County's MHSA

expenditures in the Annual Mental Health Services Act Revenue and Expenditure Reports for FY 2017-18 and FY 2018-19 show that as of July 1, 2019 the County has spent more than the reverted fund balance in the prevention and early intervention and capital facilities and technology funding categories, and has therefore expended all the reverted funds in those categories. However, the County has $6.7 million in outstanding unspent reverted funds in the innovation funding category as of July 1, 2019. Figure 2.3 below summarizes these expenditures and outstanding balances.

Figure 2.3: *Spending Progress for MHSA Funds Subject to Reversion as of July 1, 2017*

	Total Reverted Funds as of July 1, 2017	Total MHSA Fund Expenditures			Remaining Balance on Reverted Funds as of July 1, 2019
		FY 2017-18	FY 2018-19	Total	
Prevention and Early Intervention	$2,854,964	$15,317,033	$12,267,984	$27,585,017	$0
Innovation	$8,352,439	$615,479	$1,055,847	$1,671,326	$6,681,113
Capital Facilities and Technology	$3,423,132	$1,928,849	$1,557,866	$3,486,715	$0

Source: Santa Clara County Annual Mental Health Services Act Revenue and Expenditure Reports, FY 2017-18 and FY 2018-19.

According to the approved spending plan for reverted funds, the County has until June 30, 2020 to spend the remaining $6.7 million in the Innovation funding category. However, as noted in Figure 2.3, California Welfare and Institutions Code § 5892.1(e) states that reverted funds allocated in the Innovation category must be spent by July 1, 2020 or by the end of the project plan approved by the Mental Health Service Oversight and Accountability Commission, whichever is later. In February of 2020, Santa Clara County received extensions on three Innovation projects from the Mental Health Services Oversight and Accountability Commission until 2022 or 2023. Due to these extensions, the County's unspent innovation funds are not subject to reversion until 2022 or 2023. Figure 2.4 on page 24 displays the County's approved innovation plans, amounts, and project end dates.

Figure 2.4: *Approved Innovation Projects and Expenditures*

Project	MHSOAC[3] Approved Date	Approved Budget Amount	Spent in FY 2017-18	Spent in FY 2018-19	Amount Still to Spend	Approved Project End Date
Faith-Based Training and Supports	11/16/2017	$608,964		$25,926	$583,038	10/1/2022
Client and Consumer Employment	11/16/2017	$2,525,148		$205,551	$2,319,597	2/1/2023
Psychiatric Emergency Response Team/Peer Linkage	11/16/2017	$3,688,511		$25,927	$3,662,584	6/1/2022
Allcove Ramp-Up	11/16/2017	$572,273	$170,106		$402,167	11/5/2020
Allcove Implementation	8/23/2018	$14,960,943		$676,996	$14,283,947	6/30/2023
Administration/ Annual Planning Costs			$445,373	$121,447		
Total			**$615,479**	**$1,055,847**	**$21,251,332**	

Source: Annual Mental Health Services Act Revenue and Expenditure Reports, FY 2017-18 and FY 2018-19; MHSOAC Innovation Approved Projects Lists, FY 2017-18 and FY 2018-19.

Although the County's innovation funds will not be subject to reversion until 2022 or 2023, the historical slow spending on innovation projects in general puts the County's future MHSA allocations for innovation at risk of reversion. The MSHA requires that 5 percent of a county's allocated funding be spent on innovation projects,[4] and the County anticipates funding of approximately $5 million annually for innovation projects in FY 2020-21, FY 2021-22, and FY 2022-23. However, the County has never spent more than $3.8 million on innovation projects in a year. The County will need to increase its spending on projects in this funding category in order to ensure that no MHSA funds are reverted to the state and to maximize the benefit of the projects in this category.

CONCLUSION

Historically, the County has not always spent MHSA funding within the required timeframe, which puts MHSA funding at risk of reversion to the state. Innovation projects in particular have low spending levels and often take longer than the timeline originally proposed to the MHSOAC. While these projects have been granted extensions to 2022 or 2023, the slow spending of innovation funds draws the projects out longer and impedes the goals of innovation funding, which are to improve access, collaboration, or service outcomes for underserved populations.

3 Mental Health Services Oversight and Accountability Commission.
4 California Welfare and Institutions Code § 5892(a)(6).

RECOMMENDATIONS

The Department of Behavioral Health Services should:

2.1 Continue to monitor and report on spending levels for MHSA innovation projects, and when evaluating new innovation project proposals as part of the MHSA Three-Year Plan review process, consider the timeliness of proposals and whether proposals would allow innovation funds to be spent immediately. (Priority 2)

SAVINGS, BENEFITS, AND COSTS

Timely spending of MHSA innovation funds will eliminate the risk of fund reversion and allow the County to realize the benefits of the innovation projects more quickly.

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Section 3: Whole Person Care Pilot Program

Background
The Whole Person Care (WPC) pilot program was designed by the California Department of Health Care Services (DHCS) to address the health, behavioral health, and social needs of high-need, high-cost Medi-Cal beneficiaries. The WPC pilots were set up to test whether local initiatives coordinating physical health, behavioral health, and social services (e.g. housing supports, food assistance, General Assistance, Supplemental Security Income, etc.) can improve health outcomes and reduce medical costs. A total of $3 billion is budgeted statewide for the WPC pilot with up to $1.5 billion funded through federal Medicaid matching funds and up to $1.5 billion matched with local funds provided through intergovernmental transfers. The total five-year budget for the Santa Clara County WPC pilot is $250,191,859, 50 percent of which is funded with local dollars.

Problem, Cause, and Adverse Effect
Although the WPC pilot has enabled the expansion of behavioral health services to high users of multiple systems, the County has been slow to reach its target population of 10,000 individuals and behind its original schedule for claiming federal matching funds. Further, the County has made progress on some measures, but has missed performance targets under multiple categories. This raises the risk that some federal matching funds might eventually be forfeited. Health System staff notes that these numbers are relatively low due to significant challenges in reaching the target population. WPC eligible individuals often need more instances of engagement and outreach to authorize enrollment and engage them with health teams. As a result, many individuals in the target population continue to be un-served. Further, the County risks eventually forfeiting federal matching funds for WPC that have been rolled over from previous program years.

Recommendations
The County's WPC team should continue to monitor and track WPC performance metrics as required by DHCS. The WPC team should also report to the Board of Supervisors at the conclusion of the final program year on all performance metrics across all program years as well as lessons learned, and final expenditure amounts, including the amount of federal matching funds that were forfeited.

Savings, Benefits, and Costs
Reporting to the Board on lessoned learned and final expenditure amounts will help inform future programming and could result in more efficient and effective use of County funds to provide services to the population of residents who are high users of behavioral health services.

FINDING

Background

The Whole Person Care (WPC) pilot program was designed by the California Department of Health Care Services (DHCS) to address the health, behavioral health, and social needs of high-need, high-cost Medi-Cal beneficiaries. The WPC pilots were set up to test whether local initiatives coordinating physical health, behavioral health, and social services (e.g. housing supports, food assistance, General Assistance, Supplemental Security Income, etc.) can improve health outcomes and reduce medical costs. The program is part of the State's Medi-Cal 2020 Section 1115 waiver renewal[5] with the federal Centers for Medicare and Medicaid Services (CMS). A total of $3 billion is budgeted statewide for the WPC pilot with up to $1.5 billion funded through federal Medicaid matching funds and up to $1.5 billion matched with local funds provided through intergovernmental transfers. Reimbursement from federal dollars is not provided for services already covered by Medi-Cal.

Application Process

The application process designed by DHCS for local agencies interested in participating in WPC pilots required lead entities to outline: (1) their identified target populations; (2) the unmet need for services in their geographical areas; (3) proposed services that are not otherwise provided by Medi-Cal; (4) community partners (including participating health plans, providers, and social service providers); (5) a set of metrics that they would track and report in addition to the required universal metrics; and, (6) a detailed budget outlining predicted expenditures based on how they would deliver services or achieve outcomes. Santa Clara County, led by the County of Santa Clara Health System, was one of 18 pilots approved in November 2016 for an implementation date of January 1, 2017 (an additional seven pilots were approved in June 2017 for an implementation date of July 1, 2017).

In January 2017, DHCS announced that it would accept applications from the lead entities approved in November 2016 for expansion of their WPC pilots. Health System subsequently submitted an application for an expanded WPC pilot in June 2017, which was approved by DHCS. The total (expanded) five-year budget for the Santa Clara County WPC pilot is $250,191,859, 50 percent of which would be funded with local dollars.

5 Although federal law sets Medicaid minimum standards related to eligible groups and required benefits, states have significant latitude to make decisions about program eligibility, optional benefits, premiums and cost sharing, delivery system, and provider payments. A Medicaid waiver is a written approval from the federal government (reviewed and determined by the Centers for Medicare and Medicaid Services) that allows states to differ from the rules of the standard federal program. This allows states to test and develop how to deliver services in their state-based program in a way that differs from federal guidelines.

WPC Pilot Timeline and Payments

The WPC pilot is a five-year program running through December 31, 2020.The WPC timeline is broken down into program years (PYs) for funding and outcome measurement purposes as follows:

PY 1: January 1- June 30, 2017
PY 2: July 1- December 31, 2017
PY 3: January 1- December 31, 2018
PY 4: January 1- December 31, 2019
PY 5: January 1- December 31, 2020

Pilots receive payments from DHCS based on their approved budgets, assuming they achieve the WPC goals and metrics outlined in their approved application. In the first year, the WPC pilots focused on infrastructure development and received payments for submitting their applications and reporting baseline data. In years two through five, the pilots are focused on providing services, implementing interventions, achieving metrics, and providing incentive payments. Pilots are required to submit mid-year and annual reports to DHCS to receive payments, which are based on achieving the metrics outlined in their application.

WPC funding is divided into seven categories as follows:

- Administrative Infrastructure
- Delivery Infrastructure
- Fee for Services (FFS)
- Per Member Per Month (PMPM) Bundles
- Incentive Payments
- Pay for Reporting
- Pay for Outcomes

WPC is a federal financial participation program, with a 50 percent match. The County match is sent via intergovernmental transfer from the County of Santa Clara to DHCS and the State in turn returns twice the dollar amount upon their review and acceptance of the County's data, plans, and reports submitted.

T*arget Population*

The County's WPC target population is approximately 10,000 individuals and includes high utilizers of multiple systems (HUMS) who are Medi-Cal enrolled, engaging in two or more systems of care (e.g. mental health services, substance use services, physical health services) and in the top five percent of utilizers in the population with Health System encounters in 2015 (the most recent year of data that the Center for Population Health Improvement had when Health System was preparing its WPC application). According to the County's WPC application, a significant percentage of this group is characterized by co-occurring medical and behavioral health conditions and members are more likely to experience health disparities related to social determinants and psychosocial stressors, such as poverty, homelessness, few social supports, and cultural group membership. Some may also experience cognitive impairment, chronic homelessness, or criminal justice involvement.

As shown in Figure 3.1, the top five percent of the HUMS population includes a roughly equal distribution of male and female adults, primarily between the ages of 26-54. They are racially diverse, and most likely to be single and speak English as their preferred language.

Figure 3.1: ***Demographic Characteristics of Top Five Percent of HUMS Population (2015)***

Gender		**Marital Status**	
Male	53%	Single	62%
Female	47%	Married/Partnered	22%
Age		Divorced/Separated	12%
18-25	11%		
26-54	58%		
55+	31%		
Preferred Language		**Race/Ethnicity**	
English	79%	Hispanic/Latino	45%
Spanish	15%	White (Non-Hispanic)	32%
Asian language	3%	Asian/Pacific Islander	12%
Other/Unknown	3%	Black/African American	9%
		Other	2%

Source: DHCS Whole Person Care Application dated June 5, 2017.

According to the Center for Population Health Improvement (CPHI), a large portion of the target population has multiple chronic medical conditions and mental health/ substance use disorders. Approximately 37 percent of the target population has serious mental illness; 23 percent has serious mental illness and substance use disorder; and, 16 percent has a chronic medical condition, serious mental illness, and substance use disorder. Among the population that experiences serious mental illness, 30 percent experienced schizophrenia and other psychotic disorders; 20 percent experienced bipolar and depressive disorders; and, 15 percent experienced anxiety.

CPHI also found that the majority of the target population (60 percent) has at least one chronic medical condition, including hypertension (42 percent), Type I and II diabetes (23 percent), hyperlipidemia (24 percent), arthritis (18 percent), asthma (18 percent), and chronic kidney disease (15 percent). The County's WPC application noted that many of these conditions are associated with unhealthy lifestyles, inactivity, smoking, and long-term use of psychotropic medication.

Outcomes Measurement

Starting in the second program year, which began in July 2017, pilots began submitting reports detailing spending and outcomes metrics. All WPC pilots are required to report universal metrics and self-selected variant metrics in annual and mid-year reports. The list of all universal metrics is shown in Figure 3.2 on page 31.

Figure 3.2: *List of Whole Person Care Universal Metrics*

Health Outcomes Measures
Ambulatory Care- Emergency Department Visits (number of visits per 1,000 member months)
Inpatient Utilization- General Hospital/Acute Care
Follow-up After Hospitalization for Mental Illness[6] (within seven days and 30 days)
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*
Administrative Measures
Proportion of participating beneficiaries with a comprehensive care plan, accessible by the entire care team, within 30 days of: • Enrollment into the WPC Pilot • The beneficiary's anniversary of participation
Care coordination, case management, and referral infrastructure
Data and information sharing infrastructure

Source: DHCS Whole Person Care Application Attachment MM: Whole Person Care Pilot Requirements and Metrics; SCC Health System Whole Person Care application, June 5, 2017.

**Specific to Substance Use Disorder.*

WPC Lead Entities are also required to select (subject to approval by DHCS) and report in annual and mid-year reports on a set of variant metrics. The variant metrics selected by Santa Clara County are shown in Figure 3.3 below.

Figure 3.3: *List of Whole Person Care Variant Metrics*

Variant Metric Number[7]	Target Population	Description
Variant Metric 1	All	New participants enrolled and patient assessments completed within 60 days
Variant Metric 2	All target populations across all program years	30 day all cause inpatient readmissions
Variant Metric 3	PHQ-9/depression[8]	Depression remission at 12 months
Variant Metric 4	Severe Mental Illness population	Suicide risk assessment
Variant Metric 5	Homeless/at-risk for homelessness	Percent of homeless referred for supportive housing who receive supportive housing

Source: DHCS Whole Person Care Application Attachment MM: Whole Person Care Pilot Requirements and Metrics; SCC Health System Whole Person Care application, June 5, 2017.

6 This metric was originally defined as consumers with a minimum of four outpatient visits after discharge from hospital, but was amended to "follow up after hospitalization" "7 days" and "30 days."
7 As listed in the County's Whole Person Care Pilot Application dated June 5, 2017.
8 The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring, and measuring the severity of depression.

County Has Expanded Behavioral Health Services Through WPC, but Has Been Slow in Implementation and Reaching Target Population Benchmark

Expansion and Integration of Services

The Behavioral Health Services Department (Department) has focused its involvement in the WPC program on creating new programs and infrastructure to better serve people in the County who need behavioral health (mental health and/or substance use disorder) assistance. According to Department management, these initiatives include:

- The Restoration Center/Sobering Center (Mission Street Sobering Center);[9]
- Peer Respite Program (Blackbird House);
- Social Services Agency (SSA) Integration project; and,
- Provision of behavioral health services while in supportive housing

According to Department management, all four of these programs serve the County population generally and were unfunded prior to the WPC program. Of these four programs, only the Sobering Center does not include the provision of mental health services. The three mental health WPC initiatives are summarized below.

The Peer Respite program provides a home-like, peer-staffed environment for those experiencing mental health crises. The program provides services to manage crises, learn healthier boundaries, and develop safety planning. Further, the program provides an alternative to inpatient psychiatric treatment when the individual is not a danger to themselves or others, but requires a supportive environment. Department staff reports that this initiative included the opening of the Blackbird House in December 2018, which currently has a six-bed capacity and will eventually be able to accommodate 10 beds.

The goal of the SSA Integration Project is to better integrate the BHS and SSA infrastructure to allow for timely and comprehensive assessment of SSA General Assistance clients' behavioral health needs onsite, and to refer such clients to appropriate services. This project has included the establishment of a workflow, additional staffing, development of screening tools, training, communications, and rollout.

BHS and the Office of Supportive Housing (OSH) have collaborated to provide case management and care navigation to individuals experiencing severe mental illness and homelessness. BHS, OSH, and the WPC pilot team were able to work with a current contracted agency to cross match the list of eligible individuals for permanent supportive housing with WPC eligibility and found that 70 individuals met both criteria. This WPC initiative contributed funds toward the contract to be used toward case management and supportive services. The contractor provides behavioral health case management to support the most vulnerable chronically homeless individuals in the process of getting permanent supportive housing, which continues once they have been successfully housed.

9 Focused on substance use disorder services (not mental health services).

Claims Submitted vs. Total WPC Funds Available

The County's claims for matched federal WPC funding has been slower than originally envisioned in its WPC application. This raises the risk that some federal matching funds might eventually be forfeited. Health System staff have noted that the State allows the County to rollover most of the unspent funds to the following year and to make adjustments to the categories that were not meeting the targets as planned. The exception to this rollover allowance is the administrative infrastructure category, which is cost based. Health System staff have stated that $166,438 has been forfeited under this category due to staff vacancies and challenges in recruitment and retention of staff by BHS. It is unclear whether the State will allow unclaimed funds in other categories to continue to rollover after the pilot period is complete at the end of 2020.

Although the County has been able to claim 94 percent or more of each program year's adjusted budget through 2019, about $36 million, or nearly 29 percent, of the total five-year program budget for matched federal funding has been left to the fifth (final) year of the pilot program. This remaining amount is 45 percent higher than the most claimed in a single year (about $25 million in 2019) and 62 percent higher than the average amount claimed over the first four program years ($22.3 million). Figure 3.4 below shows the original budget (from the County's WPC application to DHCS), the adjusted budget (after rollover from previous program years), the budget for federal matching funds, and total funds received. Note that the figures in Figure 3.4 below include all WPC program funds, including mental health, physical health, and substance use treatment services.

Figure 3.4: *SCC WPC Original Budget vs. Funds Received by Program Year 2016 to 2020*

Program Year	Total Budget (original from WPC application)	Original Budget for Matching Funds	Total Adjusted Budget (after rollover)	Adjusted Budget for Matching Funds (after rollover)	Total Matching Funds Received	Percent of Original PY Budget for Matching Funds	Percent of Adjusted PY Budget
PY 1 (2016)	$45,143,059.00	$22,571,529.50	$45,143,059.00	$22,571,529.50	$22,571,530.00	100.0%	100.0%
PY 2 (2017)	$48,639,711.00	$24,319,855.50	$36,221,569.75	$18,110,784.87	$18,015,696.54	74.1%	99.5%
PY 3 (2018)	$52,136,363.00	$26,068,181.50	$47,069,058.15	$23,534,529.08	$22,201,501.79	85.2%	94.3%
PY 4 (2019)	$52,136,363.00	$26,068,181.50	$49,750,662.12	$24,875,331.06	$24,277,200.48	93.1%	97.6%
PY 5 (2020)	$52,136,363.00	$26,068,181.50	$72,007,509.98	$36,003,754.99	N/A		
Total	**$250,191,859.00**	**$125,095,929.50**	**$250,191,859.00**	**$125,095,929.50**			

Source: SCC Health System.

WPC has Served Relatively Few Targeted Individuals with Mental Health Services

Although the County's target population for the WPC pilot is 10,000 individuals, the WPC pilot has reached relatively few WPC eligible persons with mental health services through WPC. As shown in Figure 3.5 below, through Program Year 4 (2019) BHS has provided 98 WPC eligible persons with peer respite services, and 112 WPC eligible persons with referrals via the Social Services Agency integration initiative. Although not shown below because it is not considered mental health services, BHS provided 211 WPC eligible persons with services at the Restoration Center/Sobering Station (Mission Street Sobering Center).

Health System staff notes that these numbers are relatively low due to significant challenges in reaching the target population. Health System staff have stated that WPC eligible individuals often need more instances of engagement and outreach to authorize enrollment and engage them with health teams. Santa Clara County's WPC approved applications target the High Utilizers of Multiple Systems (HUMS). The HUMS population targeted is historically difficult to reach and not accustomed to having outreach or support in the model of WPC. DHCS allowed the County to add an additional Fee for Service (FFS) category for Outreach and Engagement due to associated uncompensated work by WPC teams. The new approved category was added as part of the PY3 and PY4 budget rollover request.

Figure 3.5: *WPC Eligible Persons Receiving BHS Mental Health Related Services 2016 to 2019*

Program Year(s)	Calendar Year(s)	Peer Respite	SSA Referral Integration
PY 1	2016	0	0
PY 2	2017	0	0
PY 3	2018	2	5
PY 4	2019	96	107
Subtotal PY 1-4	**2016-2019**	**98**	**112**

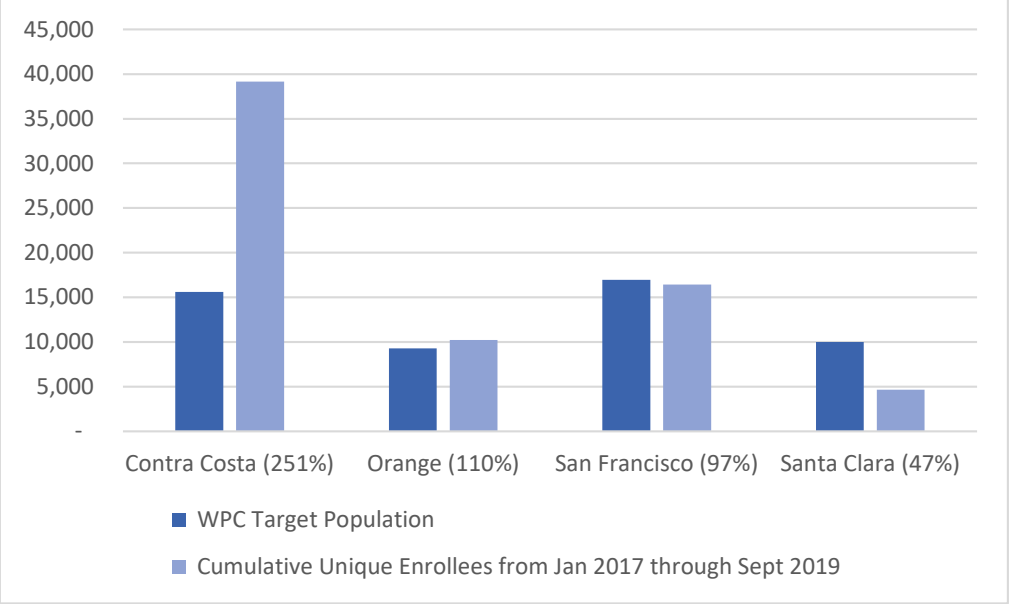
Source: SCC Health System.

County Not on Track to Meet Target Population Benchmark Within Pilot Period

As mentioned in Figure 3.5 above, the County of Santa Clara Health System established a target population of approximately 10,000 high utilizers of multiple systems (HUMS) as one of its variant metrics for its application to DHCS for participation in the WPC program. However, two measures of enrollment show that the SCC WPC has been slow to reach its target population: (1) monthly cumulative unique enrollees from January 1, 2017 through September 30, 2019 and (2) total monthly point in time enrollment as of September 2019.

As shown in Figure 3.6 below, Santa Clara County had 4,651 cumulative unique enrollees, or 46.5 percent of the 10,000-person target population, as of September 2019. Three other counties with similar target population sizes have achieved a much higher level of cumulative unique enrollees. Contra Costa County had 39,156 unique enrollees (251 percent of its 15,600 target beneficiary count); Orange County had 10,245 unique enrollees (110 percent of its 9,303 target beneficiary count); and, the City and County of San Francisco had 16,427 unique enrollees (96.9 percent of its 16,954 target beneficiary count).

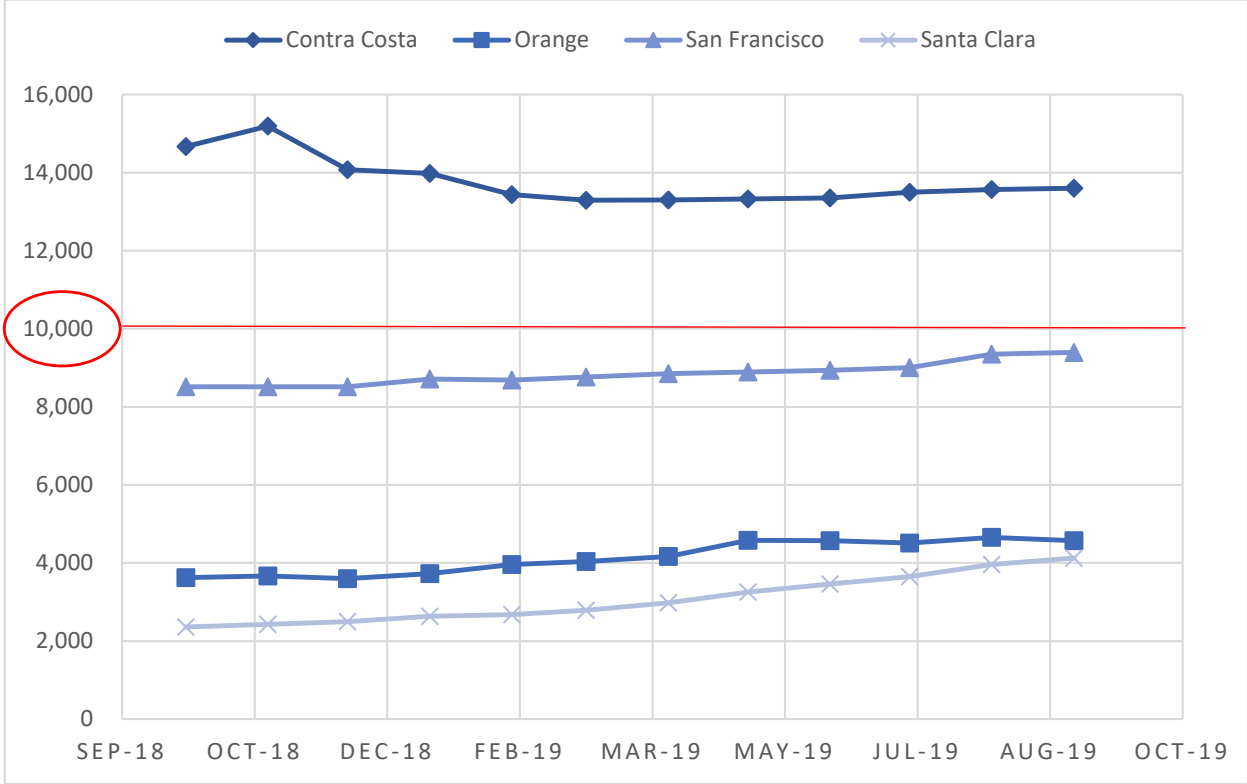
Figure 3.6: *SCC WPC Cumulative Unique Enrollees vs. Population Target Compared to Counties with Similar Target January 2017 to September 2019*



Source: DHCS Whole Person Care Monthly Cumulative Unique Enrollees Report by Lead Entity January 2017 to September 2019 (Report date: December 18, 2019).

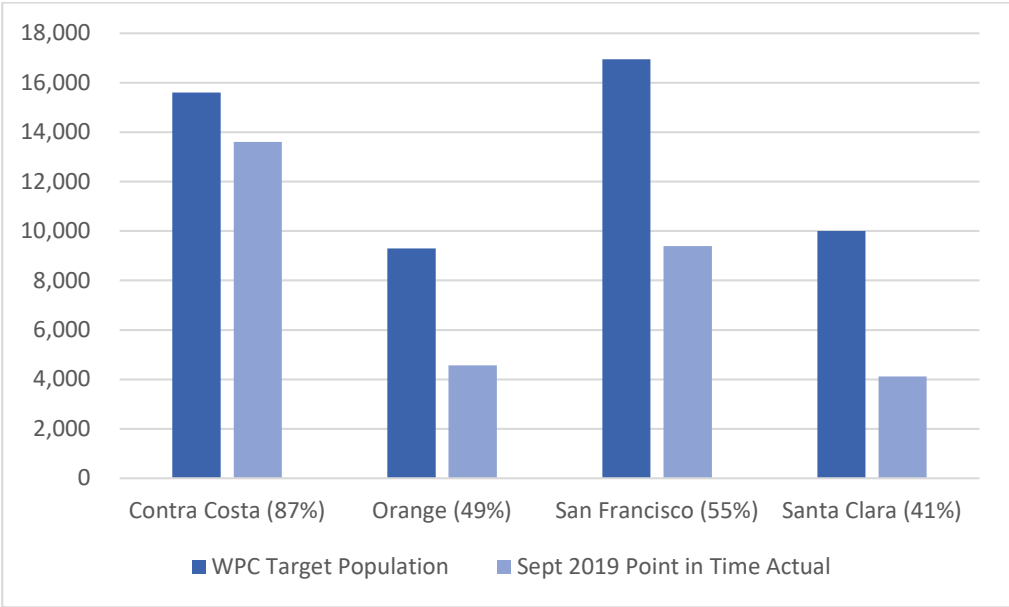
As shown in Figure 3.7 and Figure 3.8 on page 36, Santa Clara County appears to be closer in line with these same counties when comparing total monthly point in time enrollment for September 2019, but is still well below its five year target population of approximately 10,000 persons. Santa Clara County had 4,125 enrollees as of September 2019, or 41.3 percent of the 10,000 person-target population. This compares to Contra Costa County, which had 13,603 enrollees (87.2 percent of the target beneficiary count); Orange County, which had 4,573 enrollees (49.2 percent of the target beneficiary count); and the City and County of San Francisco, which had 9,394 enrollees (55.4 percent of the target beneficiary count).

Figure 3.7: *SCC WPC Monthly Point in Time Enrollment vs. Counties with Similar Targets October 2018 to September 2019*



Source: DHCS Whole Person Care Monthly Point in Time Enrollment Report October 2018 to September 2019 (Report date: December 18, 2019).

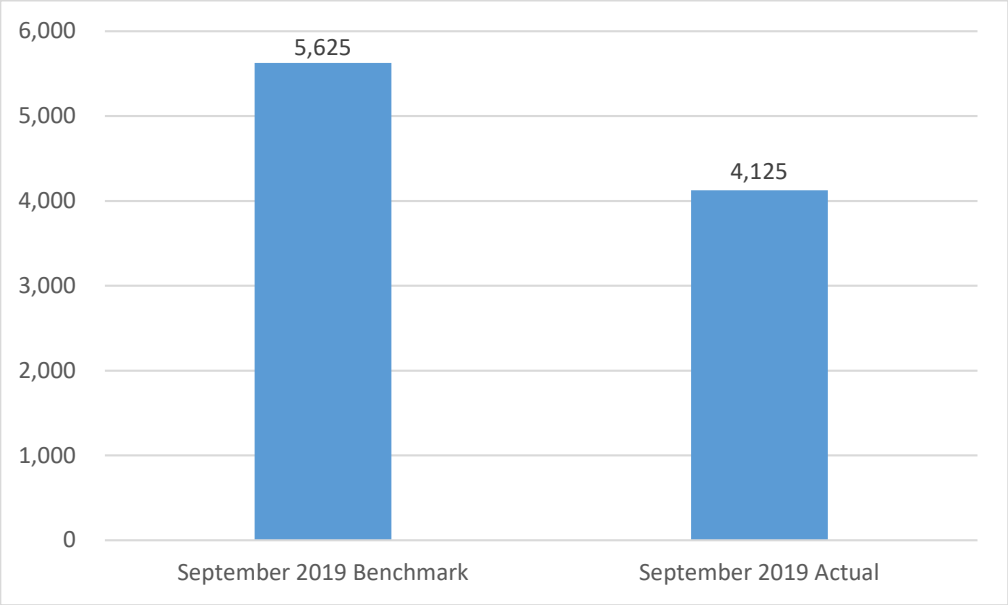
Figure 3.8: *CC WPC Monthly Point in Time Enrollment vs. Counties with Similar Targets October 2018 to September 2019*



Source: DHCS Whole Person Care Monthly Point in Time Enrollment Report October 2018 to September 2019 (Report date: December 18, 2019).

Neither SCC Health System staff nor DHCS would have expected the County to reach its 10,000 beneficiary target until the end of the five-year program. However, based on the benchmark set in its application, SCC Health System had targeted an estimated 5,625 beneficiaries through September 2019. Based on the projected temporal enrollment from the County's WPC application, enrollment appears to be approximately 73 percent of the anticipated enrollment for September 2019 (approximately 4,125 enrolled vs. 5,625 anticipated beneficiaries). These figures are shown in Figure 3.9 below.

Figure 3.9: *WPC Monthly Point in Time Enrollment vs. Beneficiary Enrollment Benchmark*



Source: SCC Health System June 2017 WPC application and DHCS WPC Total Monthly Point in Time Enrollment Report.

Note: September 2019 benchmark calculated by auditor using Variant Metric 1 program year benchmarks in the County's 2017 WPC application.

Whole Person Care Performance Measure Benchmarks Show Mixed Results in Pilot Outcomes

The County has had mixed results on universal and variant metrics over the first three program years (January 2017 through December 2018). The County has made progress on some measures, but has missed several performance targets.

Universal Metrics

The County consistently exceeded its performance targets for two of the four universal metrics pertaining to mental health services. Specifically, the County exceeded its targets for follow-up after hospitalization for mental illness within seven days and 30 days. The County's target was to maintain its baseline[10] for follow-up after hospitalization in Program Year two (2017) and then achieve a five percent absolute increase from 2017 in the number of consumers who have such follow-up after discharge from the hospital in Program Year three (2018). These performance metrics were far surpassed as shown in Figure 3.10 below.

Figure 3.10: *Santa Clara County Universal Performance Metrics vs. Actual Performance- Follow Up After Hospitalization*

Definition		Updated Baseline[11] (2016 Data)			Program Year 2 (Calendar Year 2017)			Program Year 3 (Calendar Year 2018)			Desired Trend
		Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Direction
Follow Up After Hospitalization for Mental Illness- 7 Days	Target	N/A	N/A	N/A	812	1,205	67.4%	853	1,738	49.1%	
	Actual	611	906	67.4%	887 (up 45.2%)	1,205	73.6%	1,222 (up 37.8%)	1,738	70.3%	↑
Follow Up After Hospitalization for Mental Illness- 30 Days	Target	N/A	N/A	N/A	497	1,204	74.1%	522	1,738	30.0%	
	Actual	671	906	74.1%	1,009 (up 50.4%)	1,204	83.8%	1,417 (up 40.4%)	1,738	81.5%	↑

Source: SCC Health System WPC Universal & Variant Metrics- included in the PY3 Annual Report (2018) updated May 8, 2019.

10 Baseline data is from 2016.
11 For enrollments from January 2017 to June 2018.

Although the County's trend on the two other universal metrics pertaining to mental health (emergency department visits and inpatient utilization of General Hospital acute care) in Program Year three (2018) indicates a slight improvement from the 2016 baseline, performance deteriorated in Program Year two (2017). As shown in Figure 3.11 on page 39, the number of emergency department visits increased from 285 per 1,000 member months in 2016 to 290 in 2017 before dropping to 279 in 2018, which was just short of the County's target of 278 or lower for Program Year three. Similarly, the acute inpatient hospitalization rate increased from a baseline rate of 4.99 percent (1,996 per 39,990 member months) to 5.38 percent (1,784 per 33,180 member months) in 2017 before dropping to 4.94 percent (1,542 per 31,212 member months) in 2018, which is above the target of 4.83 percent.[12]

Figure 3.11: *Santa Clara County Universal Performance Metrics vs. Actual Performance- Emergency Department Visits and Inpatient Utilization*

Definition		Updated Baseline[13] (2016 Data)			Program Year 2 (Calendar Year 2017)			Program Year 3 (Calendar Year 2018)			Desired Trend
		Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Direction
ED Visits (number of visits per 1,000 member months)	Target	N/A	N/A	N/A	9,456	33,180	285	8,677	31,212	278	↓
	Actual	11,413	39,990	285	9,640	33,180	290	8,719	31,212	279	
Inpatient Utilization	Target	N/A	N/A	N/A	1,659	33,180	5.0%	1,508	31,212	4.8%	↓
	Actual	1,996	39,990	5.0%	1,784	33,180	5.4%	1,542	31,212	4.9%	

Source: SCC Health System WPC Universal & Variant Metrics- included in the PY3 Annual Report (2018) updated May 8, 2019.

12 The County's inpatient utilization target metric for program year 3 (2018) was to reduce utilization by 10 percent relative from program year 2 (2017). A 10 percent reduction from the 2017 rate of 5.38 percent would equate to 4.83 percent.

13 For enrollments from January 2017 to June 2018.

Variant Metrics

The County has not met its performance targets for four of the five WPC variant metrics. As mentioned in Figure 3.11 above, the County has been slow to reach its population enrollment target, which is one of its five variant metrics. In addition, as shown in Figure 3.10 on page 38, the County has fallen short in meeting its targets for the following three variant metrics:

- Lowering all cause hospital stay readmissions within 30 days[14];
- Raising the proportion of adults who achieved remission at 12 months after diagnosis of major depression or dysthymia[15]; and,
- Raising the proportion of suicide risk assessments among adult patients who have been newly diagnosed with, or had a recurrent episode of, major depressive disorder.

As shown in Figure 3.12 on page 41, the County has not met its variant metric target for decreasing the prevalence of hospital readmissions (for any cause other than for the initial admission) within 30 days of hospital stays for all participants. The County's target for this metric is to report baseline data in the first program year (baseline data is from 2016), maintain the baseline in program year two (2017), and achieve successive five percent decreases in each of the following three years. Rather than decreasing, all cause hospital readmissions went up from 21.2 percent of initial hospitalizations in 2016 to 23.1 percent in 2017, and up again to 24.4 percent in 2018.

As shown in Figure 3.12 below, the County has not met its variant metric target for increasing the proportion of adults who achieved remission[16] at 12 months after diagnosis of major depression or persistent depressive disorder. The County's target for this metric is to report baseline data in the first program year (baseline data is from 2016), maintain the baseline in program year two (2017), and achieve successive five percent increases in each of the following three years. Rather than increasing, the depression remission at 12 months went down from 7.3 percent in 2016 to 6.6 percent in 2017, and down again to 1.0 percent in 2018.

As shown in Figure 3.12 below, the County has not met its variant metric target for increasing the proportion of adult patients with a newly diagnosed or recurrent episode of major depressive disorder who received a suicide risk assessment completed at each visit. The County's target for this metric is to report baseline data in the first program year (baseline data is from 2016), maintain the baseline in program year two (2017), and achieve successive five percent increases in each of the following three years. Rather than increasing, the proportion of such patients who received a suicide risk assessment went down from 1.6 percent in 2016 to 0.9 percent in 2017, and down again to 0.3 percent in 2018.

14 All cause readmissions (i.e. related to physical health, mental health, substance use disorder) that was not already a reason for the initial admission to the hospital.
15 Also known as persistent depressive disorder.
16 Remission is demonstrated by a 12 months (+/- 30 days) PHQ-9 score (a patient health questionnaire used for measuring the severity of depression) of less than five.

Figure 3.12: *Santa Clara County Variant Performance Metrics vs. Actual Performance- 30-Day All Cause Hospital Readmissions/ Depression Remission at 12 Months/ Suicide Risk Assessments for Adults with Major Depressive Disorder*

Definition		Updated Baseline[17] (2016 Data)			Program Year 2 (Calendar Year 2017)			Program Year 3 (Calendar Year 2018)			Desired Trend
		Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Direction
All Cause Readmissions (# of 30-day hospital readmissions)	Target	N/A	N/A	N/A	186	875	21.2%	157	780	20.1%	↓
	Actual	204	961	21.2%	202	875	23.1%	190	780	24.4%	
PHQ-9/Depression Remission at 12 Months	Target	N/A	N/A	N/A	7	91	7.3%	8	103	7.7%	↑
	Actual	9	123	7.3%	6	91	6.6%	1	103	1.0%	
Suicide Risk Assessments (patients who had suicide risk assessment completed at each visit)	Target	N/A	N/A	N/A	10	644	1.6%	11	668	1.68%	↑
	Actual	8	490	1.6%	6	644	0.9%	2	668	0.3%	

Source: SCC Health System WPC Universal & Variant Metrics- included in the PY3 Annual Report (2018) updated May 8, 2019.

The County has had more success meeting its WPC target for the fifth WPC variant metric, which is the number of participants referred for supportive housing who receive supportive housing even though the County did not report baseline data in the first program year. The County's target for this metric is to maintain baseline data in program year two (2017), then increase the proportion by five percent in program year three (2018), increase by another five percent in program year four (2019), and increase by 10 percent in program year five (2020). Although the County did not report baseline data, it was able to increase the proportion of participants referred to supportive housing who received supportive housing from 63.6 percent in 2017 to 69 percent in 2018 (or an increase of 6.4 percent).

17 For enrollments from January 2017 to June 2018.

CONCLUSION

Although the WPC pilot has enabled the expansion of behavioral health services to high users of multiple systems, the County is behind its original schedule for reaching its target population of 10,000 individuals and for claiming federal matching funds. Further, the County has made progress on some measures, but has missed performance targets under multiple categories. This raises the risk that some federal matching funds might eventually be forfeited. Health System staff notes that the proportion of the target population reached is relatively low due to significant challenges in reaching the target population. WPC eligible individuals often need more instances of engagement and outreach to authorize enrollment and engage them with health teams. As a result, many individuals in the target population continue to be un-served. Further, the County risks eventually forfeiting federal matching funds that have been rolled over from previous program years.

RECOMMENDATIONS

The Whole Person Care team and Director of Behavioral Health Services should:

3.1 Continue to monitor and track WPC performance metrics as required by DHCS. The WPC team should also report to the Board of Supervisors at the conclusion of the final program year on all performance metrics across all program years as well as lessons learned, and final expenditure amounts, including the amount of federal matching funds that were forfeited. (Priority 3)

3.2 Report to the Board of Supervisors at the conclusion of the final program year on all performance metrics across all program years as well as lessons learned, and final expenditure amounts, including the amount of federal matching funds that were forfeited. (Priority 2)

SAVINGS, BENEFITS, AND COSTS

Recommendation 3.1 would not require any additional staff time or resources other than what would already be required under the Whole Person Care program and would ensure that the County fully complies with DHCS requirements for federal matching funds. Recommendation 3.2 would require a relatively minimal amount of staff time to prepare and present to the Board of Supervisors on the lessons learned and final expenditure amounts. The presentation would help inform future programming and how County behavioral health funds can be used more efficiently and effectively to provide a higher level of services to high utilizers of multiple systems.

Section 4: Programs to Reduce Emergency and Crisis Services Use

Background
According to the June 2018 Mental Health Services Act Three-Year Program and Expenditure Plan ("Plan"), 25 percent of adults and older adults receiving mental health services through the Adult and Older Adult Services Division only received services in emergency and crisis settings, and never connected to ongoing mental health services.

Problem, Cause, and Adverse Effect
The Behavioral Health Services Department implemented three programs in FY 2019-20, funded by the Mental Health Services Act and intended to increase access to ongoing mental health services for individuals with a serious mental illness who only access emergency/crisis services. Assertive Community Treatment and Intensive Full Service Partnerships are intensive, community-based programs, providing ongoing treatment to individuals. In Home Outreach consists of three teams to reach individuals with serious mental illness who do not currently access care with the goal of connecting these individuals to ongoing community-based mental health services.

As of Spring 2020, the Behavioral Health Services Department was only beginning to identify and standardize processes to measure the performance of the three programs approved in the June 2018 Mental Health Services Act Plan to reduce the number of individuals with serious mental illness who only access emergency and crisis services; therefore, the ability of these programs to reduce visits to emergency and crisis services and increase access to ongoing community-based mental health services is not yet known. The Department will need to track, measure, and report these programs' services, enrollment, and outcomes to ensure efficient use of Mental Health Services Act resources and success in connecting seriously mentally ill individuals to ongoing mental health services.

Recommendations
The Behavioral Health Services Director should report quarterly on the Intensive Full Service Partnership, Assertive Community Treatment, and In Home Outreach programs' achievement of service targets, performance indicators and improvement objectives, and plans for improvement if these service targets, performance indicators, and improvement objectives are not met. The quarterly reporting should be included in the Department's Quality Improvement Work Plan and Program reports, and reported to the Board of Supervisors Health and Hospital Committee,

Savings, Benefits, and Costs
These recommendations address the Behavioral Health Services Department's oversight of new programs funded by the Mental Health Services Act. The Department has existing resources to track, measure, and report on the programs' performance; tracking, measuring, and measure program performance will help to ensure successful program implementation and efficient use of Mental Health Services Act funds.

FINDING

Background

The Adult and Older Adult Services Division of the Department serves individuals 18 years of age and older who have a serious mental illness. Mental health services include emergency and crisis services, residential services, and outpatient services. According to the Mental Health Services Act Three-Year Program and Expenditure Plan for FY 18 through FY 20 ("Plan"), 25 percent of adults and older adults receiving mental health services through the Adult and Older Adult Services Division only received services in emergency and crisis settings, and never connected to ongoing mental health services.

Programs to Reduce Use of Emergency and Crisis Services Have Not Yet Been Evaluated

New and Expanded Programs

As of Spring 2020, the Behavioral Health Department was only beginning to identify and standardize processes to measure the performance of three programs approved in the June 2018 Mental Health Services Act Three Year Program and Expenditure Plan to reduce the number of individuals with serious mental illness who only access emergency and crisis services. The Plan identified three programs to increase access to outpatient services in lieu of emergency and crisis services for adults and older adults with serious mental illness, including two new programs and one program with added capacity. The programs, which are funded by the Mental Health Services Act, include Assertive Community Treatment, Intensive Full Service Partnership, and In Home Outreach, as shown in Figure 4.1 below.

Figure 4.1: *New and Expanded Programs to Address Access to Services*

Program	Description	New or Added Capacity
Full Service Partnership for Adults and Older Adults		
Assertive Community Treatment	Two multidisciplinary teams to conduct assertive outreach in the community to provide "whatever it takes" services in the community to serve individuals with the most severe mental health needs.	New program: 200 slots
Intensive Full Service Partnerships for Adults and Older Adults	Full range of community and clinical services providing a higher per person funding allocation than previously available. These services represent new intensive service slots for individuals.	Added capacity and increased per person spending: 400 slots for adults; as needed increase for older adults.
Outreach and Engagement		
In Home Outreach	Targeted outreach and engagement teams to identify and connect individuals to mental health services.	New program

Source: June 2018 Mental Health Services Act Three-Year Program and Expenditure Plan.

Intensive Full Service Partnership

The Intensive Full Service Partnership Program for Adults and Older Adults is an ongoing program funded by the Mental Health Services Act to provide intensive case management and services to individuals with serious mental illness. According to the Mental Health Services Act Three-Year Program and Expenditure Plan for FY 18 through FY 20, the Intensive Full Service Partnership Program in Santa Clara County was not funded or designed to provide the level of service seen in Intensive Full Service Partnership programs in other California Counties; program funding in Santa Clara County averaged $15,000 per client, compared to funding in other counties of $30,000 to $35,000 per client. The Plan provided for adding 400 slots for adults and older adults and increasing the per-person allocation

The Behavioral Health Services Department awarded four contracts for Intensive Full Service Partnerships to four providers – Gardner, Telecare, Momentum for Mental Health, and Community Solutions – which were approved by the Board of Supervisors on October 8, 2019. The contracts provide for intensive case management and other services to 400 adults and older adults with severe mental illness, funded by Short-Doyle/Medi-Cal and the Mental Health Services Act with an average allocation per person of $49,557, as shown in Figure 4.2 below.

Figure 4.2: ***Intensive Full Partnership Contract Funding in FY 2019-20***

	Annual Caseload	FY 2019-20 Funding	Per Client
Community Solutions	99	$4,940,875	$49,908
Momentum for Mental Health	103	$5,038,272	$48,915
Gardner	109	$5,201,091	$47,716
Telecare	89	$4,642,480	$52,163
Total	**400**	**$19,822,718**	**$49,557**

Source: Respective Contracts

Note: Intensive Full Partnership funding in FY 2019-20 of $19,822,718 consists of Medi-Cal ($4,432,716) and Mental Health Services Act ($15,390,002). Average Mental Health Services Act funding per individual is $38,475.

Assertive Community Treatment

Assertive Community Treatment is a new program funded by the Mental Health Services Act to provide services to individuals who are otherwise at risk to be placed in institutional settings or experience homelessness. Assertive Community Treatment consists of an interdisciplinary team, intensive community-based services, longer periods of outreach prior to accessing treatment, crisis response, and time-unlimited services.

The Behavioral Health Services Department awarded contracts for Assertive Community Treatment to two providers – Mental Health Systems and Telecare - which were approved by the Board of Supervisors on October 8, 2019. The contracts provide for services to 200 adults and older adults with severe mental illness, funded by Short-Doyle/Medi-Cal and the Mental Health Services Act with an average allocation per person of $57,963, as shown in Figure 4.3 on page 46.

Figure 4.3: *Assertive Community Treatment Contract Funding in FY 2019-20*

	Annual Caseload	FY 2019-20 Funding	Per Client
Mental Health Systems	100	$5,756,779	$57,568
Telecare	100	$5,835,721	$58,356
Total	**200**	**$11,592,500**	**$57,963**

Source: Respective Contracts.

Note: Assertive Community Treatment funding in FY 2019-20 of $11,592,500 consists of Medi-Cal ($2,553,124) and Mental Health Services Act ($9,039,376). Average Mental Health Services Act funding per individual is $45,197.

In Home Outreach

In Home Outreach Teams are a new program in FY 2019-20 to follow up with individuals with severe mental illness, who do not have an existing provider and access mental health services through Emergency Psychiatric Services and other crisis services. The goal of the program is to identify, reach out, and engage with individuals not currently served by the mental health system, including individuals experiencing homelessness. Once the individual has agreed to receive services, the team staff ensure that the individual is assigned a provider through the Call Center and attends the first appointment. After the individual is successfully connected to an outpatient provider, the individual is assigned a case manager for ongoing care coordination.

Santa Clara County has three teams, one County team and two providers – Bill Wilson Center and Starlight Community Services – which were implemented for the first time in FY 2019-20. The In Home Outreach Teams are funded by the Mental Health Services Act, with a budget of $2.26 million in FY 2019-20, shown in Figure 4.4 below. The teams are to serve approximately 360 unduplicated clients each year, at an estimated cost per client of approximately $6,200 per year.

Figure 4.4: *In Home Outreach Team Funding in FY 2019-20*

	FY 2019-20 Funding
Nonprofit Providers	
Bill Wilson Center	$710,655
Starlight Community Services	$653,865
Subtotal Nonprofit Providers	$1,364,520
County Team	$895,480
Total	**$2,260,000**

Source: Respective contracts and Behavioral Health Services Department.

Program Performance Goals and Measure

The contracts for the Intensive Full Partnership Program and Assertive Community Treatment set performance goals and measures, shown in Figure 4.5 below.

Figure 4.5: *Intensive Full Partnership Program and Assertive Community Treatment Performance Goals and Measures*

Performance Indicator	Assertive Community Treatment Improvement Objective	Intensive Full Service Partnership Improvement Objective
Access for New Clients	Reduce the number of clients accessing services more than 10 business days from initial request to no more than 20% of total new clients	N/A
Engagement in Services	Increase the number of clients who are engaged in the recovery process to 75%	Increase the number of clients who are engaged in the recovery process to 75%
Successful Discharges	Reduce the percentage of clients receiving inpatient hospital services who are readmitted within 30 days to no more than 7%	Increase the percentage of clients who are successfully discharges to at least 35%

Source: Respective Contracts.

In Home Outreach

The contracts for the In Home Outreach Teams set program set program goals, objectives, and outcomes. Program goals include increased access to services and reduced impacts of untreated mental illness on individuals and their families. Program objectives included identifying the root causes of psychiatric hospitalization, assisting individuals to remain in their communities, and connecting clients to supportive services, such as housing and public benefits. Program outcomes included successfully connecting 50 percent of individuals to outpatient and other services within 12 months of referral, and 25 percent reduction in individuals' visits to emergency services or hospitalization.

Department's Measurement of Program Performance

The Behavioral Health Services Department was in the early stage of implementing the Intensive Full Service Partnership, Assertive Community Treatment, and In Home Outreach programs at the time of the audit. The Assertive Community Treatment and In Home Outreach programs are new to the County, and one contractor for the Assertive Community Treatment program – Mental Health Systems – is new to the County. The Department began assigning clients to the Assertive Community Treatment program in December 2019, but data collection and measurement was not yet in place as of March 2020. The Department was also beginning the process of defining and standardizing data collection for the In Home Outreach program and developing a program evaluation plan as of March 2020.

Because the Intensive Full Service Partnership, Assertive Community Treatment, and In Home Outreach programs are only just being implemented, the programs' success in reducing the number of individuals who access only emergency and crisis services, and increasing these individuals' access to ongoing mental health services, is not yet known. Before achieving the performance improvement objectives, these programs need to show successful enrollment and service provision for the targeted number of clients, and the sufficiency of data systems to track and measure program performance and outcomes.

The Behavioral Health Services Department's Quality Improvement Program reports quarterly on the quality improvement work plan and improvement objectives. The most recent quarterly Quality Improvement Work Plan and Program report was in June 2019, which was in draft form at the time of the audit report. The Department should finalize and distribute the Quality Improvement Work Plan and Program reports in a timely manner each quarter. Performance of the Intensive Full Service Partnership, Assertive Community Treatment, and In Home Outreach programs' initial enrollment, service levels, and data tracking and reporting, and by the end of the first year of the programs' implementation, the performance indicators and achievement of improvement objectives should be included in the quarterly Quality Improvement Work Plan and Program reports. The Behavioral Health Services Department should quarterly report to the Board of Supervisors Health and Hospital Committee on the Intensive Full Service Partnership, Assertive Community Treatment, and In Home Outreach programs' achievement of service targets, performance indicators and improvement objectives, and plans for improvement if these service targets, performance indicators, and improvement objectives are not met.

CONCLUSION

The Behavioral Health Services Department identified in the June 2018 Mental Health Services Act Three Year Program and Expenditure Plan the high number of individuals with serious mental illness who only access care through emergency/crisis services. The Plan provided for implementation of three programs – Assertive Community Treatment, Intensive Full Service Partnership, and In Home Outreach – to increase seriously mentally ill individuals' access to ongoing mental health services. Because these programs were in the early stages of implementation at the time of the audit in Spring 2020, the success of these programs in reducing the number of individuals who only access mental health services through emergency/crisis services is not yet known. The Department will need to track, measure, and report these programs' services, enrollment, and outcomes to ensure efficient use of Mental Health Services Act resources and success in connecting seriously mentally ill individuals to ongoing mental health services.

RECOMMENDATIONS

The Director of the Behavioral Health Services Department should:

4.1 Finalize and distribute the Quality Improvement Work Plan and Program reports in a timely manner each quarter. (Priority 1)

4.2 Include in the quarterly Quality Improvement Work Plan and Program reports initial enrollment, service levels, and data tracking and reporting for the Intensive Full Service Partnership, Assertive Community Treatment, and In Home Outreach programs, and by the end of the first year of the programs' implementation, the performance indicators and achievement of improvement objectives. (Priority 2)

4.3 Report twice per year to the Board of Supervisors Health and Hospital Committee on the Intensive Full Service Partnership, Assertive Community Treatment, and In Home Outreach programs' achievement of service targets, performance indicators and improvement objectives, and plans for improvement if these service targets, performance indicators, and improvement objectives are not met. (Priority 2)

The Board of Supervisors Health and Hospital Committee Chair should:

4.4 Calendar twice per year reports from the Director of the Behavioral Health Services Department on the Intensive Full Service Partnership, Assertive Community Treatment, and In Home Outreach programs on the regular agenda for discussion. (Priority 2)

SAVINGS, BENEFITS, AND COSTS

These recommendations address the Behavioral Health Services Department's oversight of new programs funded by the Mental Health Services Act. The Department has existing resources to track, measure, and report on the programs' performance; tracking, measuring, and measure program performance will help to ensure successful program implementation and efficient use of Mental Health Services Act funds.

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Section 5: Timely Access to Outpatient Services

Background
The California Department of Health Care Services set Network Adequacy Standards in March 2018, setting requirements for access to outpatient mental health services.

Problem, Cause, and Adverse Effect
The Behavioral Health Services Department is not able to consistently meet the State's time and distance, or timely access requirements for adults and older adults. The County did not meet the State requirement in FY 2018-19 that services be provided within 10 miles or 30 minutes from the client's residence. In response, the Department created a new mental health outpatient team in Gilroy to serve 250 clients in 2019, but did so by reassigning existing staff from Narvaez Mental Health Center in East San Jose so that outpatient services did not increase overall. The Department also did not meet the State's requirement in FY 2018-19 that clients receive an outpatient appointment within 10 business days of the request, reporting an average of 12.6 days prior to the first appointment. The Behavioral Health Services Department submitted a corrective action plan in October 2019, outlining the steps to meet the State's requirements, which was cleared by the California Department of Health Care Services in January 2020.

In order to increase the number of outpatient slots, the Department issued a Request for Proposals in November 2019, soliciting for approximately eight providers for outpatient services for approximately 2,084 adults. Approval of contract awards were not expected until July 2020 with services not expected to begin until the fall of 2020 In order to increase the timeliness of outpatient visits, the Department also needs to increase staff productivity in the County's outpatient clinics, which averaged 45 percent over a nine-month period, 20 points below the staff productivity target of 65 percent.

Recommendations
The Behavioral Health Services Department Director should (1) evaluate how MHSA funding in the draft MHSA Three Year Program and Expenditure Plan for FY 2020-21 through FY 2022-23 can be used to expand South County mental health services and restore staff to Narvaez Mental Health Center; and (2) develop outpatient procedures to increase staff productivity and direct services to clients. The Department Director should also include in the quarterly Quality Improvement Work Plan and Program reports data on staff productivity and the implementation of new outpatient programs, including the increase in the number of slots and ability to meet the California Department of Health Care Network Adequacy requirements.

Savings, Benefits, and Costs
The Behavioral Health Services Department has already identified programs to help meet Network Adequacy requirements. Monitoring and reporting on the meeting of requirements would not result in new budgetary costs, but could improve outpatient services by increasing visibility of the Department's program implementation. The Department could also increase reimbursements for outpatient services by improving outpatient staff productivity.

FINDING

Background

The Behavioral Health Services Department Adult and Older Adult Division serves more than 12,000 outpatient clients per year, of whom approximately 87 percent access non-intensive outpatient services and 13 percent access intensive outpatient services. Outpatient services are provided through contracts with community-based providers and by County providers.

The Behavioral Health Services Department Does Not Consistently Meet California Department of Health Care Services Standards

Department of Health Care Services' Network Adequacy Standards

The California Department of Health Care Services set Network Adequacy Standards in March 2018, setting requirements for access to primary care, including outpatient mental health services. These standards were the subject of debate among a number of counties as to their legality. The Network Adequacy Standards were revised in April 2020, to allow outpatient services to be within 15 miles of a client's residence, rather than 10 miles as previously required.

Figure 5.1: *Network Adequacy Standards*

	March 2018 to March 2020	As of April 2020
Time and Distance	10 miles or 30 minutes from client's residence	15 miles or 30 minutes from client's residence
Timely Access	Within 10 business days from request to appointment	Within 15 business days from request to appointment
		Within 10 business days from request to non-physician mental health provider appointment

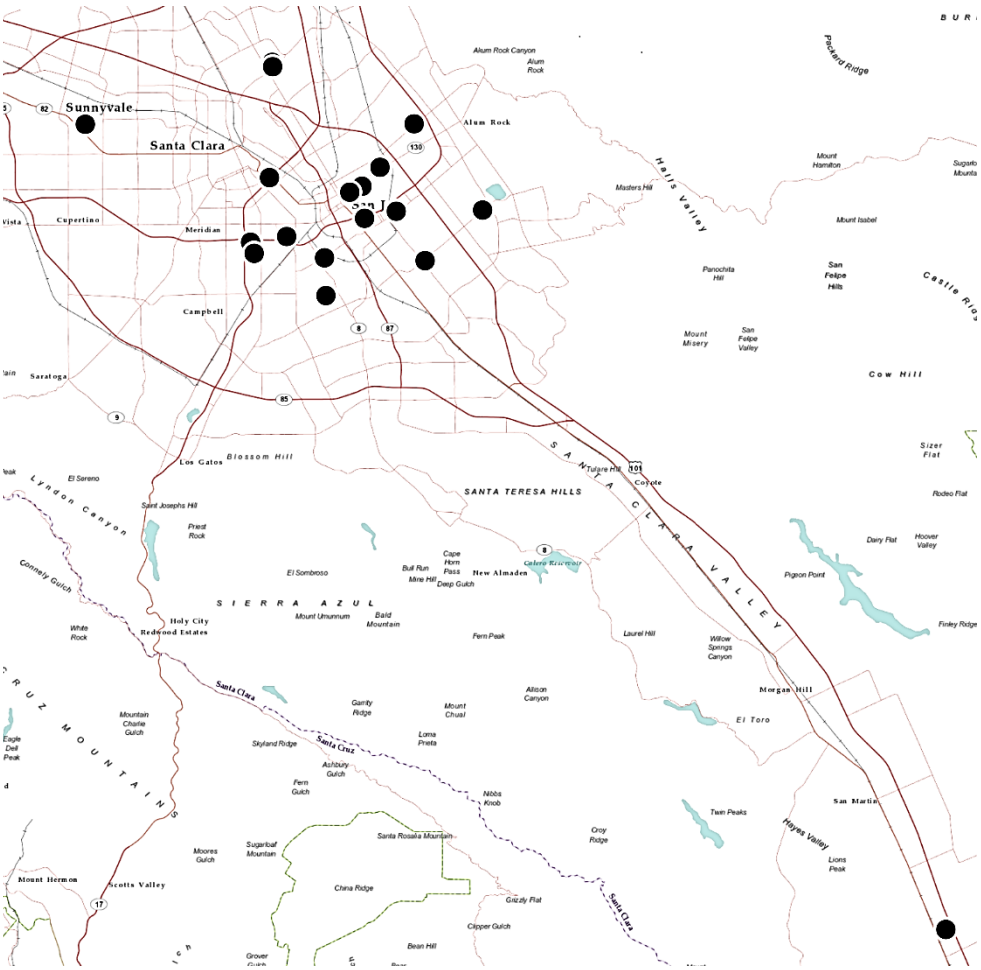
Source: California Department of Health Care Services Network Adequacy Standards.

Behavioral Health Services Department staff have identified the ongoing need to improve outpatient mental health services, and meet the California Department of Health Care Services standards. However, the Behavioral Health Services Department is not able to consistently meet the State's time and distance, or timely access requirements for adults and older adults.

Time and Distance

The Behavioral Health Services Department website lists 15 community-based providers for adult and older adult mental health services, of which 13 are in the city of San Jose, one is in the North County (Sunnyvale), and one is in the South County (Morgan Hill), as shown in Figure 5.2 on page 53. According to interviews with Department staff, the County needs to add additional South County providers to meet the 15-mile/ 30-minute standard, noted in Figure 5.1.

Figure 5.2: *Adult and Older Adult Community Based Outpatient Mental Health Providers*

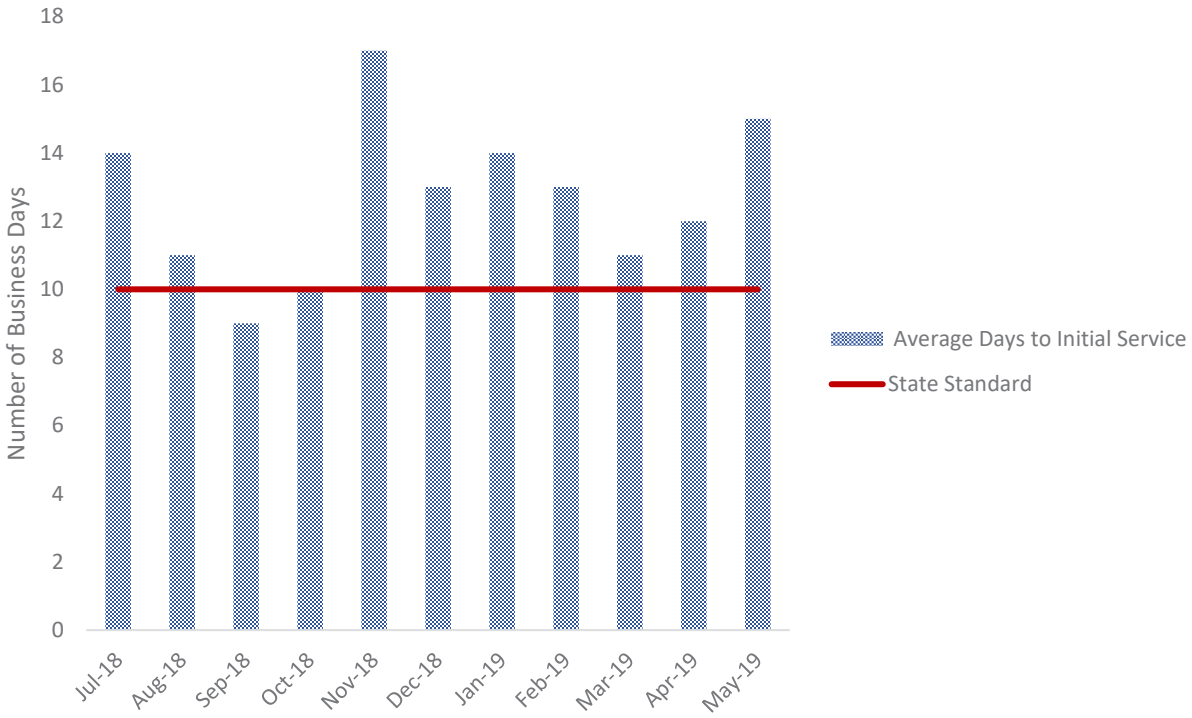


Source: Behavioral Health Services Department website.

Timely Access

In 2018 and 2019, the California Department of Health Care Services required that Medi-Cal beneficiaries receive their first assessment appointment for non-urgent/non-psychiatry services within 10 business days of his or her request, and revised the requirement in April 2020 for the first appointment to be within 15 business days of the request. The Behavioral Health Services Department set a new performance standard in FY 2018-19 that 80 percent of beneficiaries will receive mental health assessment appointments within 10 business days, consistent with State requirements at that time. According to the Department's draft 2020 Mental Health Services QI Work Plan & QI Program, the Department was below this goal at the time of the draft report in June 2019, with the most recent rate of performance at 61 percent. In FY 2018-19, the average number of days before the first appointment varies from 9 to 17 days, with an average of 12.6 days over an 11-month period, as shown in Figure 5.3 on page 54.

Figure 5.3: *Average Number of Days Before First Outpatient Appointment FY 2018-19*



Source: Draft 2020 Mental Health Services QI Work Plan & Q1 Program.

Note: The California Department of Health Care Services revised Network Adequacy standards in April 2020 to provide for the first referral to non-psychiatrist providers within 15 business days.

Corrective Action Plan

The Behavioral Health Services Department submitted a corrective action plan in October 2019 to the California Department of Health Care Services, outlining the steps to achieve 70 percent of referrals to initial outpatient appointment within 10 business days. These steps included increased training for Mental Health Call Center staff, information to Behavioral Health Services clients on their right to access out-of-network providers, and increase in provider capacity. In January 2020, the California Department of Health Care Services cleared the Behavioral Health Services Department's corrective actions.

New Initiatives to Increase Access

The Behavioral Health Services Department presented proposed initiatives in January 2019 to increase access to outpatient mental health services, including creating:

- A new outpatient clinic in south Santa Clara County to serve 250 seriously mentally ill adults;
- Procedures to facilitate same-day access to Mental Health Urgent Care for seriously mentally ill adults; and
- A referral path for new outpatient programs, including an additional 2,000 outpatient slots.

Increase in South County Outpatient Services

The Department created a new mental health outpatient team in Gilroy to serve 250 clients in 2019, including receiving Medi-Cal certification for these outpatient services, as part of the Department's 2019 initiatives. Because existing staff from Narvaez Mental Health Center in East San Jose were reassigned to the new South County mental health outpatient team, rather than hiring new positions to serve South County, the Department's outpatient services did not increase overall.

The South County outpatient mental health team is funded by the County's General Fund. Because these services were not included in the Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan for FY 18 through FY 20, MHSA funds cannot be used to fund the South County outpatient mental health team. The Department has drafted the new MHSA Three Year Program and Expenditure Plan for FY 21 through FY 23, which provides for MHSA funding beginning on July 1, 2020. The Department evaluated how MHSA funding for 2,300 outpatient slots in the MHSA Three Year Program and Expenditure Plan for FY 2020-21 through FY 2022-23 (an increase from 2,000 slots in the prior plan) can be used to expand South County outpatient services and restore staff to Narvaez Mental Health Center.

Same Day Access and Referrals for New Patients

The Department's January 2019 mental health initiatives provided for implementing same-day access to Mental Health Urgent Care and creating a referral path for new outpatient programs, including increasing outpatient slots by 2,000.

Same-day access to Mental Health Urgent Care for seriously mentally ill individuals was not implemented. Rather, the Department's January 2020 mental health initiatives provide for redesigning the downtown Central Wellness and Benefit Center to operate as an outpatient team, providing some level of outpatient services to meet the State's requirement to provide initial access to services within 10 days. The plan was to implement the outpatient team in April 2020.

The referral path for outpatient programs was documented in a "continuum of care" policy developed in September 2019. The continuum of care policy details service components, program goals, staffing requirements, admission criteria, access to care, discharge criteria, and transportation requirements for community-based programs, including In-Home Outreach, Assertive Community Treatment, regular and intensive Full Service Partnerships, outpatient services, and medication support. The transportation component of the continuum of care for outpatient services is intended to meet the State requirement that services are available within 15 miles or 30 minutes.

In order to increase the number of outpatient slots, the Department issued a Request for Proposals in November 2019, soliciting for approximately eight providers for outpatient services for approximately 2,084 adults.[18] Approval of contract awards were expected in July 2020 with services to begin in the fall of 2020.

18 The Request for Proposal also solicited for outpatient services for special communities, including dual diagnosis, older adult, and ethnic specific.

Outpatient Staff Productivity

Behavioral Health Services Department policy is for outpatient services staff to spend at least 65 percent of their time in direct patient services. However, County outpatient clinics averaged only 45 percent of hours spent in direct patient services between July 2017 and March 2018, or 14,468 direct service hours out of 32,242 total staff hours according to management reports provided by the Decision Support Team. Because only direct patient services are reimbursable by Medi-Cal, the missed 20 percent represents a revenue loss to the County.

The Behavioral Health Services Department's plans for increasing access to outpatient services do not specifically address staff productivity, although the Adult and Older Adult Division's initiatives for 2020 include creating unit-based teams (which could include front-line staff, managers, and providers) to review outpatient processes. The Department should incorporate outpatient clinic staff, including use of unit-based teams, in evaluating staff productivity and developing processes to increase productivity.

CONCLUSION

The Behavioral Health Services Department has proposed initiatives to address the shortfall in meeting California Department of Health Care Services Network Adequacy requirements and increasing access to outpatient services. More could be accomplished, including accessing Mental Health Services Act funds for expanded outpatient services, ensuring that contracts for outpatient services are fully implemented, and improving staff productivity in County clinics.

RECOMMENDATIONS

The Behavioral Health Services Department Director should:

5.1 Evaluate how MHSA funding for 2,300 outpatient slots in the draft MHSA Three Year Program and Expenditure Plan for FY 2020-21 through FY 2022-23 can be used to expand South County mental health services and restore staff to Narvaez Mental Health Center. (Priority 1)

5.2 Review outpatient services functions, including incorporating outpatient staff in the review, and identify processes and develop formal procedures to increase staff productivity. (Priority 2)

5.3 Include in the quarterly Quality Improvement Work Plan and Program reports data on staff productivity and the implementation of new outpatient programs, including the increase in the number of slots and ability to meet the California Department of Health Care Network Adequacy requirements. (Priority 2)

SAVINGS, BENEFITS, AND COSTS

The Behavioral Health Services Department has already identified programs and processes to increase access to outpatient services and meet Network Adequacy requirements. Monitoring and reporting on the achievement of program goals and meeting of requirements would not result in new budgetary costs, but could improve outpatient services by increasing visibility of the Department's program implementation. The Department could also increase reimbursements for outpatient services by improving outpatient staff productivity.

Section 6: Shortage of Residential Care and Board and Care Facilities

Background
In Santa Clara County, licensed residential care facilities and unlicensed board and care facilities are a step-down placement option for clients with mental illness who are returning to the community from higher levels of care or locked facilities. Placement in these facilities provides at minimum room and board, with additional services provided at licensed facilities, and helps clients remain stable in an unrestricted homelike environment. Behavioral Health Services Department staff and community-based organizations rely on these facilities to house clients with mental illness who no longer qualify for a higher level of care but who are not able to live independently.

Problem, Cause, and Adverse Effect
Behavioral Health Services Department staff state that licensed residential care facilities and unlicensed board and care facilities are closing and that there is a shortage of facility space to house clients with mental illness. State data shows that licensed facilities are closing at a higher rate in Santa Clara County than in California overall. However, not all licensed residential care facilities accept clients with behavioral health needs, and the lack of accurate information about facilities that do accept these clients impairs the Department's ability to assess the need for additional residential care space. The most apparent cause of facility closures are high costs to run the facilities and low facility revenues.

The shortage and closures of residential care facilities impairs the continuum of care and patient recovery and generates costs for the County, because individuals who are unable to find appropriate residential care or housing when discharged from treatment programs may return to crisis programs, jails, or homelessness. When there is no space available for clients at a residential care facility, the Department may use County General Fund dollars to pay for an individual's extended stay in an inpatient or residential treatment setting.

Recommendations
The Behavioral Health Services Department should develop and maintain a resource for tracking all licensed residential care facilities and unlicensed board and care facilities that accept clients with mental illness, and report regularly to the Board of Supervisors on facility capacity and costs incurred to the County General Fund as a result of shortages. The Board of Supervisors should consider adopting a resolution that imposes additional requirements on residential care facilities proposing changes of use and consider allocating funding to the Department of Behavioral Health Services to pay for subsidies to licensed residential care facilities that house clients with behavioral health needs.

Savings, Benefits, and Costs
Depending on the amount allocated, subsidies for licensed residential care facilities could incur significant costs to the County, although the costs may be partially offset by a reduction in General Fund expenditures to keep clients in inpatient or residential treatment programs if an increase in capacity results from the implementation of a subsidy. The other recommendations will incur no costs to the County.

FINDING

Background

The Behavioral Health Services Department's residential continuum of care covers facilities and programs that provide 24-hour care and supervision for clients with behavioral health needs at a variety of intensity levels. These facilities and programs include locked facilities, skilled nursing facilities with special treatment programs, neurobehavioral programs, and supplemental behavioral health services provided at licensed residential care facilities. In addition to these services, which formally fall under the purview of the Behavioral Health Services Department's 24-Hour Care Unit, the continuum of available 24-hour residential care services also includes licensed residential care facilities and unlicensed board and care facilities.[19]

In Santa Clara County, there are three types of privately-owned and operated residential care and board and care facilities, which are defined in detail below: (1) licensed residential care facilities, (2) licensed residential care facilities with supplemental services, and (3) unlicensed board and care facilities. These facilities act as a step-down placement for clients returning to the community from locked facilities and as a stabilization opportunity for clients who are referred from the community. Placement in these facilities helps clients remain stable in an unrestricted homelike environment.

Licensed Residential Care Facilities

The California Department of Social Services, Community Care Licensing Division licenses and monitors residential care facilities in California. These facilities are required to provide room and board, including meals and laundry services, 24-hour supervision of residents, assistance with medical and psychiatric needs and appointments, and medication dispensation. The Community Care Licensing Division monitors licensed facilities to ensure that minimum standards for operations, including requirements for the physical environment, staff-client ratios, supervision, and admission and eviction procedures, are met.

Santa Clara County does not contract directly with licensed residential care facilities unless the facilities are part of the supplemental services program, which is described below. However, Behavioral Health Services Department staff and community-based organizations refer clients to these facilities as a step-down housing placement option in the 24-hour residential continuum of care for clients who no longer qualify for a higher level of care but who are not able to live independently.

Licensed residential care facilities with supplemental patch: Through the Supplemental Services Program, Santa Clara County contracts with some licensed residential care facilities to provide enhanced client services in addition to the standard residential care facility services. These contracted facilities provide supplemental services and/or additional supervision to seriously mentally ill clients whose level of functioning, symptoms, and psychiatric history necessitate service interventions in order for them to remain in community settings, and whose

19 Throughout this section, the term "licensed residential care facilities" refers to facilities licensed by the California Department of Social Services, Community Care Licensing Division to provide residential care, which are formally typically licensed as Adult Residential Facilities or Residential Care Facilities for the Elderly. "Unlicensed board and care facilities" refers to room and board or independent living facilities that are not licensed or overseen by the state.

conditions prevent them from being placed in a regular residential care facility. Depending on the type of supplemental service provided, the County pays between $39 per day (for clients requiring basic supplemental services at a standard facility) and $150 per day (for clients diagnosed with severe mental illness and traumatic brain injury) for each day a client is placed at licensed residential care facilities that are part of the Supplemental Services Program.

The Number of Licensed Residential Care Facilities

The California Department of Social Services maintains information on the total number of licensed residential care facilities in California. However, not all licensed facilities accept clients with mental illness (some accept only clients with a physical or developmental disability). As a result, the Department and clinicians must rely on informal lists of residential care facilities that do accept clients with mental illness. Figure 6.1 displays information from these informal lists maintained by the County and the National Alliance on Mental Illness (NAMI) Santa Clara County.[20] As shown in Figure 6.1 below, only between 31 and 63 licensed residential care facilities in Santa Clara County, with an estimated bed capacity between 600 and 650, accept clients with mental illness. These figures include licensed residential care facilities in the Supplemental Services program.

Figure 6.1: ***Licensed Residential Care Facilities Accepting Clients With Mental Illness***

Source	Number of Facilities	Capacity	Date
County Internal List #1	63	N/A	2018
County Internal List #2	34	598	2019
NAMI Santa Clara	31	658	12/2/2019

Source: Santa Clara Behavioral Health Services Department; NAMI Santa Clara.

Unlicensed Board and Care Facilities

Board and care facilities are not required to be licensed, and many facilities operate in Santa Clara County without a license. Unlicensed board and care facilities may be either "room and board" homes that offer meals, laundry, transportation, and other services, or "independent living" homes that do not provide meals or other daily living needs. These homes are not licensed and do not provide 24-hour supervision, medication management, or other services that licensed residential care facilities are required to provide. These facilities are not overseen by either the state or Santa Clara County.

20 NAMI Santa Clara County is the Santa Clara County affiliate of the National Alliance on Mental Illness, a non-profit organization founded in 1975 as a grassroots self-help, support, and advocacy organization of consumers, families, and friends of people with severe mental illnesses.

The Number of Unlicensed Board and Care Facilities

Because these facilities are unlicensed, no entity is responsible for monitoring or tracking the number or capacity of unlicensed board and care facilities. However, like the licensed residential care facilities, NAMI Santa Clara and the County maintain informal lists of unlicensed board and care facilities that accept clients with mental illness. As shown in Figure 6.2 below, as estimated in 2018 and 2019, there were between 30 and 40 unlicensed board and care facilities in Santa Clara County accepting clients with mental illness.

Figure 6.2: ***Unlicensed Board and Care Facilities Accepting Clients With Mental Illness***

Source	Number of Facilities	Capacity	Date
County Internal List #1	40	N/A	2018
County Internal List #2	32	N/A	2019
NAMI Santa Clara	36	N/A	12/2/2019

Source: County of Santa Clara Behavioral Health Services; NAMI Santa Clara.

The Number of Residential Care Facilities in Santa Clara County is Decreasing

Shortages of residential care facilities have been documented throughout California and have drawn state-wide attention. The California Behavioral Health Planning Council, which is under federal and state mandate to advocate on behalf of adults with serious mental illness,[21] issued an issue paper in March 2018 that highlights "the lack of adult residential facilities as housing options for individuals with serious mental illness in California" as a significant public health concern. The issue paper emphasizes the need for increasing access to appropriately staffed and maintained residential care facilities for adults and seniors with mental illness throughout California. In addition to the California Behavioral Health Council, the Los Angeles County Mental Health Commission, the California Association of Local Behavioral Health Boards & Commissions, the San Francisco Long-Term Care Coordinating Council, and other governmental entities in California have all identified the shortage of residential care facilities and/or unlicensed board and care facilities as a critical gap in the system of care, and expressed concern about the public health implications of facility shortages and closures.

Interviews with multiple individuals at the Behavioral Health Services Department in Santa Clara County identified the shortage and closures of residential care facilities for clients with mental illness as a critical challenge facing the Department, echoing the state-wide concerns. As mentioned above, Santa Clara County maintains informal lists of licensed and unlicensed residential facilities that accept clients with mental illness, but there is no formal tracking system that allows for an analysis of changes in capacity over time to support these anecdotal accounts of facility closures and unmet need. As a result, the County does not know how many licensed residential care facilities and unlicensed board and care facilities have closed in recent years. However, state data does show overall trends in licensed adult residential facility capacity and closures.

21 California Welfare and Institutions Code § 5772 outlines the powers and authority of the California Behavioral Health Planning Council.

According to data from the California Department of Social Services Community Care Licensing Division, as of November 2018 (the most recent available data) there were 230 licensed Adult Residential Facilities in Santa Clara with a capacity of 1,770 beds, in addition to 10 facilities pending license. As shown in Figure 6.3 below, in the five years between calendar year 2014 and 2018, the annual number of facility closures outpaced the annual number of new facilities licensed by between 1 and 15 facilities annually. Between 2014 and 2018, Santa Clara County experienced a net loss of 30 licensed adult residential care facilities, representing a decrease in open licensed facilities of 11.5 percent. This net facility loss accounted for a net decrease of 262 beds between 2014 and 2018, representing a decrease in bed capacity of 12.9 percent in the County. As mentioned above, not all licensed facilities accept clients with mental illness, so the figures in Figure 6.3 do not fully represent capacity for this population.

Figure 6.3: ***Licensed Adult Residential Facilities in Santa Clara County, 2014-2018***

	Number of Facilities			Facility Capacity		
Calendar Year	**Total New Licensees**	**Total Closures**	**Net Gain/ Loss**	**Total New Licensed Capacity (Beds)**	**Total Closures (Beds)**	**Net Gain/ Loss (Beds)**
2014	12	(27)	(15)	71	(204)	(133)
2015	15	(22)	(7)	198	(233)	(35)
2016	8	(9)	(1)	84	(120)	(36)
2017	15	(19)	(4)	157	(190)	(33)
2018*	9	(12)	(3)	51	(76)	(25)
Total	**59**	**(89)**	**(30)**	**561**	**(823)**	**(262)**

Source: California Department of Social Services Community Care Licensing Division, Adult Residential Facilities; last updated November 2018. As noted above, not all licensed adult residential facilities accept clients with mental illness; this Figure shows trends in Santa Clara County but does not represent actual capacity for clients with mental illness.

**2018 figures are a partial year through November 2018 only and do not reflect any new licenses or closures from December 2018.*

The state data shows that the loss of licensed Adult Residential Facilities is particularly pronounced in Santa Clara County. As shown in Figure 6.4 on page 62, Santa Clara County is experiencing a higher percentage decrease in licensed adult residential facilities (-11.5 percent) and facility capacity (-12.9 percent) than California as a whole (-4.7 percent and -9.4 percent, respectively).

Figure 6.4: *Decreases in Licensed Adult Residential Facilities, Santa Clara County and California*

	California		Santa Clara County	
	No. of Facilities	**Facility Capacity**	**No. of Facilities**	**Facility Capacity**
Percentage Decrease in Licensed Adult Residential Facilities Between 2014 and 2018*	-4.7%	-9.4%	-11.5%	-12.9%

Source: California Department of Social Services Community Care Licensing Division, Adult Residential Facilities; last updated November 2018.

*As noted above, not all licensed adult residential facilities accept clients with mental illness; this Figure shows trends in Santa Clara County but does not represent actual capacity for clients with mental illness. *2018 figures are a partial year through November 2018 only and do not reflect any new licenses or closures from December 2018.*

Lack of Data Impairs the Department's Ability to Assess Need for Residential Care Facilities

As mentioned above, the Department does not contract with most licensed residential care facilities (only those part of the Supplemental Services Program) or any unlicensed board and care homes, but does refer clients to these facilities as part of the 24-hour continuum of care. The Department does not formally track the number of facilities available in the County or the capacity of each facility, and as a result the total capacity of residential care facilities for clients with behavioral health needs in Santa Clara County is unknown. Similarly, the Department does not know how many of its outpatient clients are living in unlicensed board and care homes or licensed residential care facilities (unless that facility is part of the Supplemental Services Program under contract with the Department).

As a result, the Department's ability to assess the need for residential care facilities is impaired. As demonstrated above, while data from the Community Care Licensing Division shows that the total number of licensed adult residential care facilities is decreasing in Santa Clara County, we do not know how many of these facilities accept clients with behavioral health needs. As a result, the Department does not know (a) the true residential care capacity for in Santa Clara County clients with behavioral health needs, or (b) the recent loss in facility capacity in the County for these clients. Along those lines, the Department is unable to calculate the gap in capacity and need, and the total additional facility capacity that would be required to fully meet the needs of the County's 24-hour continuum of care is unknown.

Operation of Residential Care Facilities Is Not Financially Viable in Santa Clara County

Interviews with multiple individuals at Behavioral Health Services cite financial constraints as the main factor that drives closures of residential care facilities, especially given the high price of property in Santa Clara County. Anecdotal evidence suggests that many facilities are closing and the properties are being sold for commercial or housing development projects. These reports are supported by the California Behavioral Health Planning Council issue paper, which identifies financial constraints as the most apparent challenge to the viability of residential care facilities.[22] The issue paper presents a sample annual budget for a licensed 13-person adult residential facility, replicated in Figure 6.5 on page 64.

22 The other challenges identified in the issue paper are community resistance and opposition to these facilities (the "Not In My Backyard" reaction) and staffing.

Figure 6.5: *Estimated Annual Expenditures for 13-Bed Licensed Adult Residential Facility*

Line item	Amount	Comment
Personnel Expenses		
Line Staff	$182,000	4.5 FTE at $15/hour covers single coverage 7 days/week, plus 1.0 FTE at 40 hours/week for administration, transportation of clients, admissions, grocery shopping, etc. at $20/hour.
Landscaping	$2,400	$200/month.
Relief Staff	$15,600	Fill-in for sick/vacation employees at 20 hours/week.
Total Wages	$200,000	Presumes 9 sick days, 14 vacation days, and 8 holidays per employee per year.
Health/Dental/Life/Vision Insurance	$39,600	$600 per month per employee, prorated for part-time for 5.5 employees. Rate is for minimal insurance.
Unemployment Insurance	$1,482	
Worker's Compensation Insurance	$13,836	
FICA/Medicare	$15,116	
Total Benefits	$70,034	
Training	$2,000	
Total Personnel Expenses	***$272,034***	
Operating Expenses		
Legal and Other Consultation	$1,000	
Household Supplies	$10,000	Cleaning, paper supplies, non-food, any recreational supplies, linens, towels, paper goods.
Office Supplies	$2,250	
Computer/Office Furnishings	$1,000	
Utilities	$20,238	
Maintenance – Building and Equipment	$12,000	Presumes that this line item includes furniture and appliance replacement.
Vehicle Maintenance	$6,000	Presume one vehicle for use at $550/month.
Food	$40,880	$8 person/day plus one staff eating.
Insurance	$8,215	
Telephone/Internet/Cable	$3,000	
Printing and Postage	$500	
Licensing and Permits	$1,711	
Property Taxes	$6,000	
Advertising	$500	
Total Operating Expenses	***$113,294***	
Rent or Loan Payments	$30,396	$500,000 loan for 30 years at 4.5%, or $2,533/month rent.
Total Expenses	***$415,724***	

Source: California Behavioral Health Planning Council. Adult Residential Facilities: Highlighting the critical need for adult residential facilities for adults with serious mental illness in California, March 2018.

It is likely that some line items, particularly salaries, benefits, and rent/loan payments, will be higher in Santa Clara County than in this sample budget, for several reasons:

- **Salaries and benefits:** The sample budget assumes that line staff earn a minimum wage of $15 per hour. However, as of January 2020, Santa Clara County minimum wage is $15.40 per hour and will be adjusted annually based on the regional consumer price index. In addition, the California Behavioral Health Planning Council notes that many facilities are unable to hire properly trained and experienced staff at minimum wage.
- **Facility costs:** The California Behavioral Health Planning Council states that the ability to purchase or rent a facility that would accommodate 13 beds at a cost of either $600,000 or a monthly rent of approximately $2,500 in urban or higher cost areas is "highly questionable."

Residential care facilities are private businesses and their rates, income, and expenditures are not made public. However, the California Code of Regulations[23] requires licensed Adult Residential Facilities to provide basic services to Supplemental Security Income (SSI)/State Supplementary Payment (SSP)[24] recipients at the basic SSI/SSP payment rate, with no additional charge to the resident. As shown in Figure 6.6 below, as of January 2020 these payment rates total $1,206.37 per month for an individual receiving Non-Medical Out-of-Home Care.[25] Of this amount, $137 is classified as an allowance for personal and incidental needs and must be retained by the recipient, leaving $1,069.37 that licensed Adult Residential Facilities may charge SSI/SSP residents for room and board and care and supervision.

Figure 6.6: ***Monthly SSI and SSP Payment Standard for Non-Medical Out-of-Home Care***

Supplemental Security Income (SSI)	$783.00
State Supplementary Payment (SSP)	$423.37
Total SSI/SSP income	$1,206.37
Personal and incidental needs allowance	$137.00
Amount payable for basic services (room and board + care and supervision)	$1,069.37

Source: California Assisted Living Association, as of January 2020.

23 22 C.C.R. § 85060.

24 Supplemental Security Income (SSI) is a federal income supplement (cash assistance) program for individuals who are age 65 or older, blind, or disabled. The national benefit amount (Federal Benefit Rate) is established by the Social Security Administration. State Supplementary Payment (SSP) is the California program that augments SSI by providing additional cash assistance for individuals who are eligible for the federal SSI income supplement.

25 SSI/SSP payment levels vary depending on the living situation of the recipient (for example, recipients living in their own home or in the home of a relative receive lower supplements than individuals living in a licensed facility). The $1,206.37 amount is the payment standard for an individual living in a licensed facility or the household of relative without in-kind room and board, which is classified as Non-Medical Out-of-Home Care.

As shown in Figure 6.7 below, the SSI/SSP rate of $1,069.37 per resident per month is insufficient to fund the operating expenses of the sample 13-bed licensed adult residential facility shown in Figure 6.5 on page 64. Without additional revenue, the example facility faces an annual deficit of $257,243.37. The facility would require an additional $21,436.95 in revenue per month in order to break even, or an additional $23,169.13 in revenue per month in order to generate a 5 percent profit for the operator.

Figure 6.7: ***Estimated Revenue and Expenditures for a 13-Bed Licensed Adult Residential Facility***

Total annual facility revenue	$158,480.63	For a 13-person facility at 95% occupancy
Total annual operating expenses	$415,724.00	
Annual deficit	($257,243.37)	
Supplemental monthly revenue required for break even	$21,436.95	
Supplemental monthly revenue required to generate 5% profit	$23,169.13	

Source: (estimate of annual operating expenses): California Behavioral Health Planning Council. Adult Residential Facilities: Highlighting the critical need for adult residential facilities for adults with serious mental illness in California, March 2018.

A shortage of residential care facilities impairs the continuum of care and patient recovery and generates costs for the County.

The decline in licensed residential care facilities means that individuals with mental illness may not be able to obtain sustainable, supportive housing within the community following stays in acute in-patient treatment programs, hospitals, or correctional institutions. When individuals are discharged from these programs or facilities and are unable to find appropriate residential care or housing, they may return to high-level crisis programs, hospitals, jails, or homelessness.

This recidivism takes both a human and a financial toll. Department staff state that when there is no placement available for clients at a residential care facility, the Department will use County General Fund dollars to pay for an individual to stay in an inpatient setting or for an extension of residential treatment.

County Efforts to Address Facility Closures Are Not Always Effective

According to individuals in the Department, when a licensed residential care facility is planning to close down, the County will attempt to purchase the facility to keep the home as a residential care facility. The Department has also explored the possibility of purchasing other properties and contracting with a community-based organization to manage the facilities, and is collaborating with the Office of Supportive Housing to open additional residential care and/or supportive housing facilities. However, despite these efforts, individuals at the Department still report a significant need for additional capacity of residential care facilities.

Other counties in California are pursuing a variety of strategies to address the closure of residential care facilities. The Los Angeles County Mental Health Commission recommended that the County offer residential care facilities supplemental funding to incentivize operators to continue housing residents with mental illness, and that the infusion of resources must be substantial enough to prevent the closure of the facilities, the sale of the properties for residential or commercial development, and the conversion of the facilities into housing for populations that can charge higher daily rates. In San Francisco, elected officials released a plan to increase local subsidies for residential care facility operators and urged the City to buy and possibly expand facilities at risk of closing. San Francisco also passed legislation that temporarily makes it more difficult to convert facilities into a different use by imposing zoning controls to require a Conditional Use authorization for a proposed change of use from a residential care facility.

At the state level, AB-2377 "Adult residential facilities: closures and resident transfers" was introduced in February 2020. As of May 2020, the amended version legislation would require licensed Adult Residential Facilities to notify the county 180 days prior to closure and give the county the right of first refusal to purchase the property.

CONCLUSION

Licensed residential care facilities and unlicensed board and care facilities are an important component of 24-hour care services for behavioral health clients in Santa Clara County. State data shows that adult residential facilities are closing at a higher rate in Santa Clara than in California overall and that the County experienced a net decrease of 262 beds between 2014 and 2018. However, not all adult residential facilities accept clients with behavioral health needs, and the lack of accurate information about facilities that accept these clients impairs the Department's ability to calculate the need for additional facilities.

The most common and apparent cause of facility closures are high costs to run the facilities and low facility revenues, which are constrained by residents' SSI/SSP payment amounts. The shortage and closures of residential care facilities impairs the continuum of care and patient recovery and generates costs for the County, because individuals who are unable to find appropriate residential care or housing when discharged from treatment programs or correctional facilities may return to high-level crisis programs, hospitals, jails, or homelessness. When there is no placement available for clients at a residential care facility, the Department may use County General Fund dollars to pay for an individual to stay in an inpatient setting or for an extension of residential treatment. While the Department has tried to purchase facilities at risk of closure and has been collaborating with the Office of Supportive Housing, the shortage of residential care facilities remains a significant concern for the Department.

RECOMMENDATIONS

The Behavioral Health Services Department should:

6.1 Develop and maintain a resource for tracking all licensed residential care facilities and unlicensed board and care facilities that accept clients with behavioral health needs. The tracking resource should show real-time capacity, so County providers and community-based organizations can see which facilities have capacity to accept new residents at the time of referral. The tracking resource should also generate monthly capacity reports to allow for an analysis of change in capacity over time. (Priority 1)

6.2 Report regularly to the Board of Supervisors on residential care facility capacity and any costs incurred to the City's General Fund as a result of shortages of residential care facilities. (Priority 2)

The Board of Supervisors should:

6.3 Consider adopting a resolution that imposes additional zoning controls on residential care facilities proposing changes of use. (Priority 2)

6.4 Consider allocating funding to the Department of Behavioral Health Services to pay for subsidies to licensed residential care facilities housing clients with behavioral health needs. (Priority 1)

SAVINGS, BENEFITS, AND COSTS

The development and maintenance of a tracking system for licensed residential care facilities and unlicensed board and care facilities, as recommended in Recommendation 6.1, can be accomplished with existing resources allocated to the Department. Regular reporting to the Board of Supervisors on residential care facility capacity and any costs incurred to the City's General Fund as a result of shortages of residential care facilities, as recommended in Recommendation 6.2, can also be accomplished using existing resources allocated to the Department. Adoption of a resolution related to residential care facilities proposing changes of use, as recommended in Recommendation 6.3, will incur no costs to the County. These recommendations will all provide the Department and the Board of Supervisors with more accurate information about the state of facility capacity in the County and the financial effects of facility shortages.

Depending on the amount allocated, Recommendation 6.4 could incur significant costs to the County, although the costs may be partially offset by a reduction in General Fund expenditures to keep clients in inpatient or residential treatment programs if an increase in capacity results from the implementation of a subsidy. Two cost scenarios are outlined below:

- In San Francisco, the local subsidy to facility operators was increased to $35 per day as part of the City's efforts to address the issue of facility closures. Using NAMI's most recent estimation of licensed residential care facility bed capacity in Santa Clara County (658) and assuming 95 percent occupancy, a $35 daily subsidy would incur a cost of approximately $8 million per year. This subsidy would amount to an increase in revenue of $1,148 per month ($157,771 annually) for a 13-person facility or $6,068 per month ($72,817 annually) for a 6-person facility.

- In Figure 6.5 on page 64, the sample 13-person facility budget shows an annual deficit of $257,243.37, which would require a daily subsidy of $54 per day to close. A $54 daily subsidy to all licensed residential care facilities that accept clients with mental illness would incur a cost of approximately $12.3 million per year

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Section 7: Quality and Oversight of Board and Care Facilities

Background
In Santa Clara County, licensed residential care facilities and unlicensed board and care facilities are a step-down placement option for clients with mental illness who are returning to the community from higher levels of care or locked facilities. Placement in these facilities provides at minimum room and board, with additional services provided at licensed facilities, and helps clients remain stable in an unrestricted homelike environment. Behavioral Health Services Department staff and community-based organizations rely on these facilities to house clients with mental illness who no longer qualify for a higher level of care but who are not able to live independently.

Problem, Cause, and Adverse Effect
Survey and focus group results show that the living environments in some licensed residential care facilities and unlicensed board and care facilities could be improved to better support client wellness or recovery. The Behavioral Health Services Department has been aware of quality concerns at some licensed and unlicensed facilities since at least 2014 but continues to refer clients to these facilities because there is a lack of available alternatives.

Licensed residential care facilities are overseen and monitored by the Community Care Licensing Division, but there is no oversight body for unlicensed board and care facilities to establish minimum operating standards or to receive complaints from residents..

Recommendations
Santa Clara County's MHSA Three-Year Program and Expenditure Plan FY 2021-23 includes $990,000 for the Independent Living Facilities project, which is a new project that is planned to address some of the concerns related to facility quality, oversight, and support. The Behavioral Health Services Department should prioritize the release of the RFP for contract services to develop and manage this project. The Department should also consider funding proposals that would provide additional support for both residents and operators of licensed residential care facilities and unlicensed board and care facilities in future Mental Health Services Act spending plans.

Savings, Benefits, and Costs
The recommendations can be paid for using Mental Health Services Act funding rather than the County General Fund. The recommendations could result in improved conditions at both licensed and unlicensed facilities, which will benefit residents and operators, improve staff/resident relations, and contribute to client wellness and recovery.

FINDING

Background

The Behavioral Health Services Department's residential continuum of care provides 24-hour care and supervision for clients with behavioral health needs at a variety of intensity levels. Facilities and programs include locked facilities, skilled nursing facilities with special treatment programs, neurobehavioral programs, and supplemental behavioral health services provided at licensed residential care facilities. In addition to these services, which formally fall under the purview of the Behavioral Health Services Department's 24-Hour Care Unit, the continuum of available 24-hour residential care services also includes licensed residential care facilities and unlicensed board and care facilities.

There are three types of privately-owned and operated residential care/board and care facilities,[26] which are defined in detail below: (1) licensed residential care facilities, (2) licensed residential care facilities with supplemental services, and (3) unlicensed board and care facilities. These facilities act as a step-down placement for clients returning to the community from locked facilities and as a stabilization opportunity for clients who are referred from the community. Placement in these facilities helps clients remain stable in an unrestricted homelike environment.

Licensed Residential Care Facilities

The California Department of Social Services, Community Care Licensing Division licenses and monitors residential care facilities in California. These facilities are required to provide room and board, meals and laundry services, 24-hour supervision of residents, assistance with medical and psychiatric needs and appointments, and medication dispensation. The Community Care Licensing Division monitors licensed facilities to ensure that minimum standards for operations, including requirements for the physical environment, staff-client ratios, supervision, and admission and eviction procedures, are met.

Santa Clara County does not contract directly with licensed residential care facilities unless the facilities are part of the supplemental services program.[27]

26 Throughout this section, the term "licensed residential care facilities" refers to facilities licensed by the California Department of Social Services, Community Care Licensing Division to provide residential care, which are formally typically licensed as Adult Residential Facilities or Residential Care Facilities for the Elderly. "Unlicensed board and care facilities" refers to room and board or independent living facilities that are not licensed or overseen by the state.

27 Through the Supplemental Services Program, Santa Clara County contracts with some licensed residential care facilities to provide enhanced client services in addition to the standard residential care facility services. These contracted facilities provide supplemental services and/or additional supervision to seriously mentally ill clients. The County pays these facilities a per-day rate, which varies by the type of supplemental service provided, for each day a client is at a facility.

Unlicensed Board and Care Facilities

Board and care facilities are not required to be licensed, and many facilities operate without one. Unlicensed board and care facilities may be either "room and board" homes that offer meals, laundry, transportation, and other services, or "independent living" homes that do not provide meals or other daily living needs. These homes are not licensed and do not provide 24-hour supervision, medication management, or other services that licensed residential care facilities are required to provide. These facilities are not overseen by either the state or the County.

The Living Environments at Some Licensed Residential Care Facilities and Unlicensed Board and Care Facilities Could Be Improved to Better Support Client Recovery

2014 Community Care Licensing Division Report

In 2014, the Santa Clara County Community Living Coalition[28] conducted a survey of County personnel who make placements or referrals to licensed residential care facilities and unlicensed board and care homes. As part of the survey, respondents were asked to identify the top issues or problems reported by clients living in these facilities. Of the respondents, 75 percent reported that food quality was a top concern, followed by respect from staff (46 percent), overall comfort in the living environment (42 percent), lack of activities (42 percent), evictions (37 percent), and problems getting to healthcare appointments (37 percent). The Community Living Coalition reported the survey results to the Behavioral Health Services Department at the time in 2014.

2019 Focus Groups

In 2019, Management Audit Division staff held focus groups with 16 mental health professionals who are responsible for placing and monitoring clients in residential care facilities and/or board and care facilities, such as rehabilitation counselors, clinicians, and case managers.[29] According to the providers in the focus groups, case managers place their clients "wherever they can find space" in residential care or board and care facilities. Case managers stated that they prefer to place their clients in the licensed residential care facilities that contract with the County through the Supplemental Services Program and are therefore held to a higher standard than facilities that do not contract with the County. However, placement at facilities in the Supplemental Services Program is only available to seriously mentally ill clients whose level of functioning, symptoms, and psychiatric history necessitate service interventions in order for them to remain in community settings, and whose conditions prevent them from being placed in a regular residential care facility.

28 The Santa Clara County Community Living Coalition is a collaboration between independent living operators, peer providers, other behavioral health providers, residents, family members, and community stakeholders. The Community Living Coalition's goals are to develop standards for independent living homes, training and education for providers, and a list of independent living homes that ensure a minimum standard of housing.

29 Ten of the focus group participants were from community-based organizations and six were County employees. The results from the focus groups represent a sample of perspectives and not necessarily representative of all mental health professionals in Santa Clara County.

Providers in the focus groups stated that the second-best option for client placement is at licensed residential care facilities, where there is some level of operator accountability from the state, although not all licensed operators maintain decent standards. However, due to a shortage of licensed residential care facilities that accept clients with mental illness, case managers stated that they are often forced to place clients in the least desirable option, unlicensed board and care facilities, even though they know that the conditions may not support client wellness or recovery. The sentiment of the focus groups was that although living conditions at unlicensed facilities are substandard, these facilities are better than a shelter or returning to homelessness on the street.

There Is No Oversight Body to Establish Minimum Operating Standards for Unlicensed Board and Care Facilities or to Receive Complaints From Residents

As noted above, the California Department of Social Services, Community Care Licensing Division licenses and monitors residential care facilities but not unlicensed board and care facilities in California. To report suspected violations at licensed facilities, individuals can file complaints with the Community Care Licensing Division. The Community Care Licensing Division monitors licensed facilities' compliance with applicable laws and regulations through unannounced facility inspections, complaint investigations, the issuance of deficiency notices, consultations, and education and technical support. In Santa Clara County, the Behavioral Health Services Department does not conduct any additional oversight of either licensed residential care facilities or unlicensed board and care facilities, although these facilities are a critical component of client care and recovery and Behavioral Health Services Department staff and community-based organizations refer clients to these facilities as a step-down housing placement option for clients who no longer qualify for a higher level of care but who are not able to live independently.

Unlike licensed residential care facilities, unlicensed board and care facilities have no oversight body or organization to establish minimum operating standards or to receive and address complaints from residents. The National Alliance on Mental Illness (NAMI) Santa Clara County[30] lists resources that are available to assist with serious violations of residents' rights in unlicensed board and care facilities, including Disability Rights California, Adult Protective Services (for dependent elders and adults), the Long Term Care Ombudsman, Code Enforcement at the City of San Jose (for unsafe building conditions or bedbugs, cockroaches, or other vermin), and the Mental Health Advocacy Project, which provides legal assistance and specialized services for individuals with mental illness or developmental disabilities. However, residents may not be aware of these resources or may be unable to contact these resources due to their disability. None of these resources establish or maintain standards specifically for board and care facilities.

In 2018 the Santa Clara County Community Living Coalition prepared a proposal to establish a professional association for independent living facility operators. The program is modeled after the Independent Living Association in San Diego County, which as of April 2020 maintains a listing of 81 homes that have been peer reviewed and have pledged to meet a set of eight quality standards. As part of the association, participant operators are connected to supportive resources and being listed as

30 NAMI Santa Clara County is the Santa Clara County affiliate of the National Alliance on Mental Illness, a non-profit organization founded in 1975 as a grassroots self-help, support, and advocacy organization of consumers, families, and friends of people with severe mental illnesses.

an approved facility by the Independent Living Association San Diego in exchange for their commitment to meeting a set of quality living standards. The goals of the program are to create a system of oversight, support, coordination, and ongoing quality improvement for unlicensed facilities and to improve the quality of care provided at these facilities by establishing quality standards, providing peer support services, and preserving and improving the quality of homes.

Behavioral Health Services Department staff stated that due to the shortage of both licensed residential care facilities and unlicensed board and care facilities, which is discussed in depth in Section 6 of this report, they must tread lightly when interacting with unlicensed facilities and introducing the possibility of licensure and/or additional oversight. The operators of these facilities provide an extremely scarce and valuable resource, which gives the County little to no leverage in negotiations.

Mental Health Peer Support Workers Could Support and Educate Residents and Help Improve Quality of Life and Conditions at Residential Care and Board and Care Facilities

The Behavioral Health Services Department Office of Consumer Affairs is a consumer-run program that advocates on behalf of clients for changes to the mental health system and provides peer support and other services. In January of 2020, the Office of Consumer Affairs submitted a proposal for a Mental Health Services Act Innovation Project.[31] The project proposes to use mental health peer support workers to support and educate residents and to collaborate on initiatives to improve quality of life and conditions at licensed residential care facilities and unlicensed board and care facilities. The peer support workers are proposed to support and mentor individual clients, facilitate communication between clients and facility operators, provide residents with tenants' rights and code enforcement information, and provide independent living skills training. If successful, the mental health peer support workers could help improve quality of life and conditions at licensed residential care and unlicensed board and care facilities.

A New Proposal for Facility Oversight and Owner Assistance

Santa Clara County's MHSA Three-Year Program and Expenditure Plan FY 2021-23 includes $990,000 for the Independent Living Facilities project, which is a new project that is planned to address some of the concerns related to facility quality, oversight, and support described above. As outlined in the FY 2021-23 Plan, the Department will partner with the Community Living Coalition to create residential facility oversight for licensed and unlicensed facilities with voluntary membership. Participant operators will commit to meeting a set of eight quality living standards, and in exchange, the Independent Living Facilities Project will connect operators to supportive resources. The key components of the project are: (a) to create a system of oversight, support, coordination, and ongoing quality improvement for independent living facilities, and (b) to assess independent living facilities and offer owners assistance to improve the quality of the facility to meet evidence-based quality standards.

31 MHSA Innovation projects are projects that are expected to contribute to learning and that test out new approaches that can inform current and future practices. Project proposals can be submitted to the MHSA Innovations manager for evaluation for the upcoming FY 2021-2023 Mental Health Services Act Three-Year Program and Expenditure Plan.

CONCLUSION

Licensed residential care facilities and unlicensed board and care facilities are an important component of 24-hour care services for behavioral health clients in Santa Clara County. Survey and focus group results show that the living environments in some of these facilities could be improved to better support client wellness or recovery. The Behavioral Health Services Department has been aware of quality concerns at licensed and unlicensed facilities since at least 2014 but continues to refer clients to these facilities because there is a lack of available alternatives. Licensed residential care facilities are overseen and monitored by the Community Care Licensing Division, but there is no oversight body to establish minimum operating standards for unlicensed board and care facilities or to receive complaints from residents. The County's MHSA Three-Year Program and Expenditure Plan FY 2021-23 includes $990,000 for the Independent Living Facilities project, which is a new project that is planned to address some of the concerns related to facility quality, oversight, and support.

As discussed in Section 6 of this report, Santa Clara County is facing a shortage of both licensed residential care facilities and unlicensed board and care facilities that accept clients with mental illness. This shortage affects the quality of care provided because clients and care providers do not have alternatives to facilities that have received complaints or that are known to provide poor care, and because the County has little leverage when introducing the possibility of licensure and/or additional oversight to unlicensed facility operators. Measures to address and ameliorate the shortage of residential care and board and care facilities, as outlined in Section 6 of this report, will be required to supplement the recommendations below to improve quality of care at licensed and unlicensed facilities.

RECOMMENDATIONS

The Behavioral Health Services Department should:

7.1 Prioritize the release of the RFP for contract services to develop and manage the Independent Living Facilities Project, as included in the County's MHSA Three-Year Program and Expenditure Plan FY 2021-23. (Priority 1)

7.2 Continue to fund the Independent Living Facilities Project with MHSA funds in future years. (Priority 2)

7.3 Consider funding proposals that would provide additional support for both residents and operators of licensed residential care facilities and unlicensed board and care facilities in future updates to the County's MHSA spending plans. (Priority 2)

SAVINGS, BENEFITS, AND COSTS

Santa Clara County's MHSA Three-Year Program and Expenditure Plan FY 2021-23 included $990,000 in MHSA funds for the Independent Living Facilities Project as recommended in Recommendation 7.1. The Behavioral Health Services Department can allocate ongoing funding for the project in future years from MHSA funds, which amounted to approximately $90.9 million in FY 2018-19, and fund other proposals that would provide additional and/or ongoing support for both residents and operators of licensed residential care facilities and unlicensed board and care facilities, as recommended in Recommendation 7.2 and 7.3. All three of these recommendations could result in improved conditions at both licensed and unlicensed facilities, which will benefit residents and operators, improve staff/resident relations, and contribute to client wellness and recovery.

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Section 8: Access to Services on Discharge from Emergency and Acute Inpatient Care

Background
The Behavioral Health Services Department's policy is for individuals discharged from Emergency Psychiatric Services or Barbara Arons Pavilion to be scheduled for an appointment with an outpatient provider within seven calendar days. However, more than 20 percent of individuals discharged to outpatient services from Barbara Arons Pavilion and nearly 30 percent of individuals discharged to outpatient services from Emergency Psychiatric Services do not meet this goal.

Problem, Cause, and Adverse Effect
The Behavioral Health Services Department's discharge procedures are not sufficiently documented, tracked, or reported to identify and address reasons that individuals do not access outpatient care within seven days of discharge from Barbara Arons Pavilion or Emergency Psychiatric Services. The Department's draft Inpatient Discharge Manual ("Manual") outlines steps for referring individuals who are new to Behavioral Health Services to outpatient services on discharge from Emergency Psychiatric Services or Barbara Arons Pavilion, but these steps do not reflect the Department's actual practice. For example, the draft Manual does not address the role of the 24-Hour Care Team, which participates in discharge planning and placement for both Emergency Psychiatric Services and Barbara Arons Pavilion. The draft Inpatient Discharge Manual also does not address the role of Mental Health Urgent Care when individuals are discharged from Emergency Psychiatric Services, nor detail procedures for individuals who are discharged from Emergency Psychiatric Services between 10 p.m. and 8 a.m. when Mental Health Urgent Care is closed. The draft Inpatient Discharge Manual needs to be updated to reflect Department policies and procedures, and finalized, so that the Manual's procedures are available to and consistently followed by Department staff.

Recommendations
The Behavioral Health Services Department Director should finalize and formally adopt the Inpatient Discharge Manual, including ensuring that the manual reflects the Department's practices and includes all circumstances for individuals discharged from Barbara Arons Pavilion or Emergency Psychiatric Services. The Director should also develop written procedures for random audits of Barbara Arons Pavilion and Emergency Psychiatric Services charts to identify discharge referrals to outpatient services and notification of case managers on discharge. Data on individuals' access to outpatient services after discharge and chart audit results should be included in the Quality Improvement Reports.

Savings, Benefits, and Costs
Developing and adopting discharge policies and procedures are within the core responsibilities of the Behavioral Health Services Department and should be accomplished within existing resources. Adopting and implementing comprehensive and consistent discharge policies should facilitate the Department's stated goal of all discharges to outpatient services from Barbara Arons Pavilion and Emergency Psychiatric Services access services within seven days.

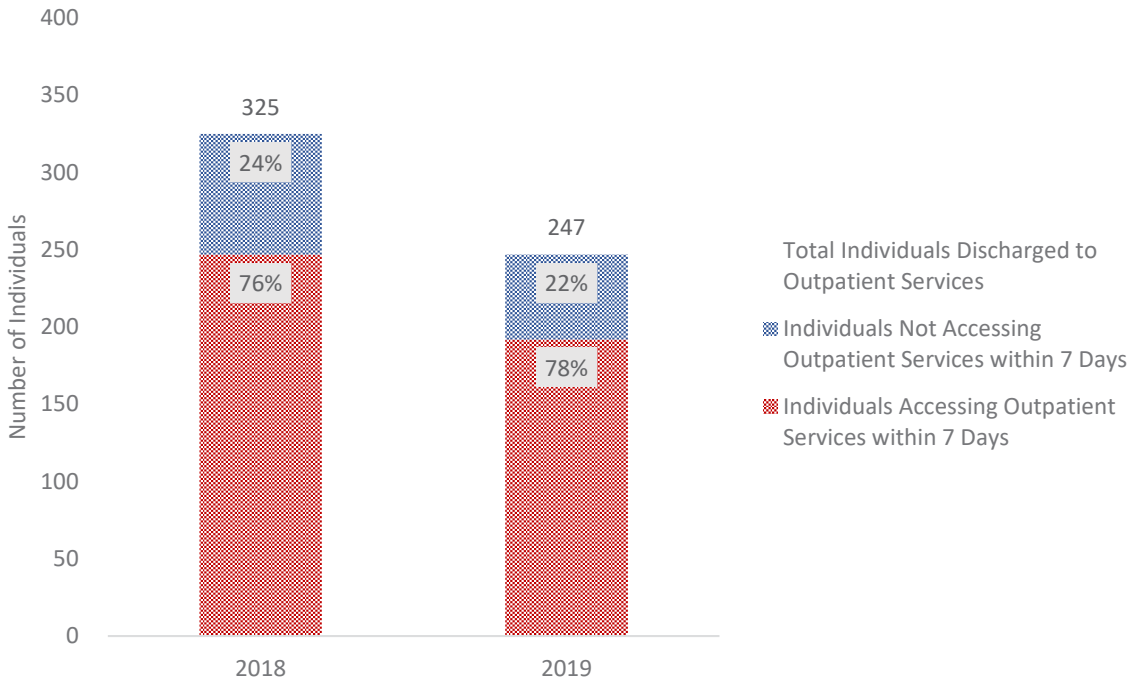
FINDING

Background

Santa Clara County's Mental Health Services Act Three-Year Program and Expenditure Plan for FY 18 through FY 20 provides for "ensuring smooth transitions for moving between levels of care". According to the Plan, once individuals are discharged from Emergency Psychiatric Services or acute inpatient care, little support is available to connect these individuals to services.

The Behavioral Health Services Department's policy is for individuals discharged from Emergency Psychiatric Services or Barbara Arons Pavilion to be scheduled for an appointment with an outpatient provider within seven calendar days. Approximately 50 percent of individuals admitted to Barbara Arons Pavilion are discharged to outpatient services. Of these individuals, more than 20 percent did not access outpatient services within seven calendar days in 2018 and 2019, as shown in Figure 8.1 below.

Figure 8.1: *Percent of Individuals Discharged from Barbara Arons Pavilion Accessing Outpatient Services within 7 Days*

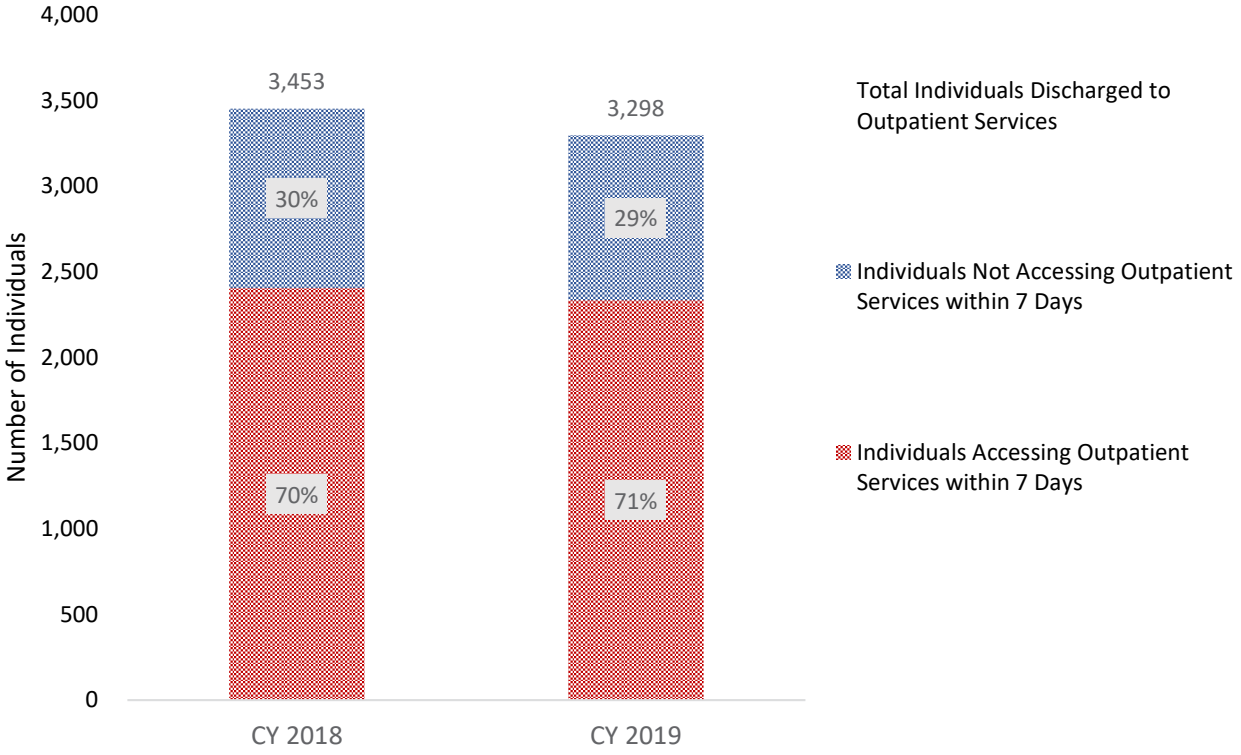


Source: Mental Health Division Decision Support.

Note: The individuals discharged from Barbara Arons Pavilion to outpatient services include individuals who had and individuals who did not have an outpatient provider. The reasons that individuals did not access an outpatient provider within seven calendar days, including those who refused services, are not identified in the information provided by the Mental Health Division Decision Support.

Approximately 70 percent of individuals discharged from Emergency Psychiatric Services are discharged to outpatient services. Of these individuals, approximately 30 percent did not access outpatient services within seven calendar days in 2018 and 2019, as shown in Figure 8.2 on page 81.

Figure 8.2: *Percent of Individuals Discharged from Emergency Psychiatric Services Accessing Outpatient Services within 7 Days*



Source: Mental Health Division Decision Support.

Note: The individuals discharged from Emergency Psychiatric Services to outpatient services include individuals who had and individuals who did not have an outpatient provider. The reasons that individuals did not access an outpatient provider within seven calendar days, including those who refused services, are not identified in the information provided by the Mental Health Division Decision Support.

The Behavioral Health Services Department's Discharge Procedures Are Not Sufficiently Documented, Tracked, or Reported to Identify and Address Reasons That Individuals Do Not Access Outpatient Care Within Seven Days of Discharge

Discharge Procedures

The Department's draft Inpatient Discharge Manual ("Manual") outlines steps for referring individuals who are new to Behavioral Health Services to outpatient services on discharge from Emergency Psychiatric Services or Barbara Arons Pavilion, but these steps do not reflect the Department's actual practice.

The draft Manual provides for staff at Barbara Arons Pavilion (or other acute psychiatric hospital) to notify the outpatient provider when an individual is admitted to the hospital, and to discuss the care provided on discharge with the individual's case manager. If individuals are new to Behavioral Health Services, Barbara Arons Pavilion staff are to work the Mental Health Call Center to assign an outpatient provider to the individual. On discharge, Barbara Arons Pavilion staff are to schedule an appointment with the outpatient provider within seven calendar days and provide the individual with the appointment information.

The draft Manual provides for staff at Emergency Psychiatric Services to notify outpatient providers within two hours of an individual's admission to Emergency Psychiatric Services. If the individual is new to Behavioral Health Services, Emergency Psychiatric Services staff are to work with the Mental Health Call Center to assign or refer the individual to appropriate resources. At the time of discharge, staff are to call the Call Center for an assignment to an outpatient clinic.

The draft Manual does not address the role of the 24-Hour Care Team, which participates in discharge planning and placement for both Emergency Psychiatric Services and Barbara Arons Pavilion. According to interviews, the 24-Hour Care Unit is responsible to ensure that individuals discharged from Barbara Arons Pavilion and Emergency Psychiatric Services are referred to and access outpatient services within seven business days.

The draft Inpatient Discharge Manual also does not address the role of Mental Health Urgent Care when individuals are discharged from Emergency Psychiatric Services. According to interviews, Emergency Psychiatric Services staff walk individuals to Mental Health Urgent Care, which works with the Call Center to assign an outpatient provider. Mental Health Urgent Care retains responsibility for the individual until contact is made with the new outpatient provider, who then assumes responsibility.

The draft Inpatient Discharge Manual needs to be updated to reflect Department policies and procedures, and finalized, so that the Manual's procedures are available to and consistently followed by Department staff. In addition to the procedures noted above, the Inpatient Discharge Manual needs to detail procedures for individuals who are discharged from Emergency Psychiatric Services between 10 p.m. and 8 a.m. when Mental Health Urgent Care is closed.

Auditing and Reporting Discharge Referrals

The 24-Hour Care Unit conducts quarterly random audits of 20 patient charts in two Barbara Arons Pavilion inpatient units to identify referrals to outpatient services and notification of case managers. No audits are currently conducted of discharges from Emergency Psychiatric Services for this purpose. The Department should also conduct quarterly audits of Emergency Psychiatric Services patient charts to identify referrals to outpatient services and notification of case managers.

According to the Barbara Arons Pavilion audit reports for July 2019 through December 2019 (80 audited charts), all but one individual was informed of the aftercare plan on discharge and given the date and time of the follow-up outpatient appointment. Only one individual refused services. All but seven of the individuals had a case manager. Of the individuals with case managers, according to the audit reports, only one case manager was not notified of the individual's discharge. While these audits show that nearly all individuals are referred to outpatient services on discharge and nearly all case managers are notified of discharges, the Department's goal should be that all individuals are referred to outpatient services and all case managers are notified of discharges.

The Behavioral Health Services Department's Quality Improvement Program reports quarterly on the quality improvement work plan. The most recent quarterly Quality Improvement Work Plan and Program report was in June 2019, which was in draft form at the time of the audit report. The report does not specifically track access to outpatient services after discharge from acute inpatient or emergency psychiatric services. The Department should include data on individuals' access to outpatient services after discharge from Barbara Arons Pavilion and Emergency Psychiatric Services and results from the random audits of Barbara Arons Pavilion and Emergency Psychiatric Services in the Quality Improvement Reports.

CONCLUSION

The Behavioral Health Services Department's policy is for individuals discharged from Emergency Psychiatric Services or Barbara Arons Pavilion to be scheduled for an appointment with an outpatient provider within seven days. However, the Department does not have sufficiently documented procedures, including an adopted Discharge Manual, to identify and address reasons that individuals to don consistently access outpatient services within seven days of discharge.

RECOMMENDATIONS

The Director of the Behavioral Health Services Department's Adult and Aging Adult Division should:

8.1 Revise, finalize, and formally adopt the Inpatient Discharge Manual, including detailing the Department's procedures for (1) planning for discharge and discharging individuals from Emergency Psychiatric Services and Barbara Arons Pavilion to outpatient services, including the role of the 24 Hour Care Team and Mental Health Urgent Care; and (2) procedures for discharges from Emergency Psychiatric Services between 10 p.m, and 8 a.m. when Mental Health Urgent Care is closed. (Priority 1)

8.2 Develop written procedures for quarterly audits of Barbara Arons Pavilion and Emergency Psychiatric Services patient charts to identify referrals to outpatient services and notification of case managers. (Priority 2)

8.3 Include data on individuals' access to outpatient services after discharge from and results from the random audits of Barbara Arons Pavilion and Emergency Psychiatric Services in the Quality Improvement Reports. (Priority 2)

SAVINGS, BENEFITS, AND COSTS

Developing, formalizing, and adopting discharge policies and procedures are within the core responsibilities of the Behavioral Health Services Department and should be accomplished within existing resources. Adopting and implementing comprehensive and consistent discharge policies should facilitate the Department's stated goal of all discharges to outpatient services from Barbara Arons Pavilion and Emergency Psychiatric Services access services within seven days.

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Section 9: Performance Monitoring of Outpatient Programs

Background
The Behavioral Health Services Department provides outpatient services primarily through contracted community-based organizations. One of the metrics used to monitor performance of these programs were Performance Learning Measures, which were program-level metrics collected from the electronic health records of outpatient programs run by community-based organizations and County-run programs. County-run programs also used the Performance Learning Measures to assess their performance. In November 2018, the Department decided to suspend the Performance Learning Measures review process in favor of a new contract monitoring tool for contracted outpatient programs.

Problem, Cause, and Adverse Effect
In February 2018, the Behavioral Health Services Department began a transition to a new electronic health record system. The transition was unsuccessful, and as a result, the performance measurement data in the Performance Learning Measures for County-run clinics are considered incomplete and unreliable since February 2018, which impairs the County-run clinics' ability to assess their performance. The Department plans to complete a transition to a new electronic health record system by July 2020, but until the transition is complete, clinical and billing information for outpatient behavioral health services is spread out across three major information systems. Separately, in November 2018, the Department decided to suspend the use of Performance Learning Measures in contracted program monitoring in favor of a new contract monitoring tool. This contract monitoring tool relies exclusively on output and does not measure or give insight into client wellness and recovery, quality of life, or other outcomes of behavioral health services. Overall, the Department's ability to monitor the performance of outpatient programs, both contracted and County-run, has been impaired by the County's unsuccessful electronic health record system transition and the switch to a new contract monitoring tool that focuses exclusively on program outputs.

Recommendations
The Behavioral Health Services department should: (1) revise the new contract monitoring tool for community-based organizations to include client outcome measures that were previously tracked in the Performance Learning Measures dashboard, and/or other outcome measures identified by the Department in a performance monitoring pilot; and (2) ensure that the new electronic health record system provided by NetSmart will be able to aggregate performance data for County-run outpatient programs. The Board of Supervisors should request that the Department provide a breakdown of the causes of the unsuccessful HealthLink transition after the transition to the new NetSmart electronic health record system is complete.

Savings, Benefits, and Costs
These recommendations will improve the County's ability to monitor the performance of both County-run and contracted outpatient programs and provide insight into the causes of the unsuccessful previous electronic health record transition.

FINDING

Background

The Behavioral Health Services Department provides outpatient services primarily through contracted community-based organizations. In FY 2018-19, 88 percent of mental health outpatient programs in the Adult and Older Adult Division and 95 of outpatient programs in the Family and Children Division were administered by contracted providers. The contractual agreements with these providers include a section or figure that summarizes the program, the volume of services to be delivered, the number of clients to be served, and the costs of the care to be provided. Each program is assigned a contract monitor, whose role is to (1) ensure that clients are connected to the appropriate level of care and receive the amount of services needed, and (2) ensure contracted agencies deliver the volume of services they are contracted to deliver and do not exceed their contract budgets.

In 2016, the Behavioral Health Services Department developed two Tableau-based dashboards, one for the Adult and Older Adult Division and one for the Family and Children Division, to track Performance Learning Measures, which are program-level metrics collected from the electronic health records of outpatient programs run by community-based organizations and County-run programs. The Tableau dashboards were used regularly by contract monitors, program managers, and Quality Improvement staff to track program- and agency-level progress and performance.

The 2016 dashboards tracked and reported 13 Performance Learning Measures for the Adult and Older Adult Division and 10 Performance Learning Measures for the Family and Children Division. In November 2018, the Department decided to suspend the Performance Learning Measures review process in favor of a new contract monitoring tool to streamline the workflow of contract service providers and avoid duplication with other reporting tools, although the Performance Learning Measures dashboards would continue to be updated for providers' and contract monitors' usage.

Recent Changes to the County's Electronic Health Record System Have Impaired Performance Measure Data Reliability

In February 2018, the Behavioral Health Services Department began a transition from Unicare, the County's previous electronic health record provider, to a new electronic health record system. The transition required two new systems that were implemented in parallel: one system (HealthLink) to record and store clinical information that supports client care and allows for billing and reporting, and one system (myAvatar) to process billing and reporting data from County-run programs and programs run by community-based organizations.

HealthLink was already in use as the electronic health record for the County's medical system of care (hospital, primary care, emergency, pediatrics, medical/surgical specialties, etc.). Because contracted community-based organizations use their own electronic health record systems, myAvatar was planned to integrate data from HealthLink (County programs), other electronic health record systems (community-based organizations), and other systems used within the County. The division between the two information systems and the planned integration with other County systems is shown in Figure 9.1 on page 87.

Figure 9.1: *Plan for New Electronic Health Record System, January 2018*

HealthLink (Epic)	MyAvatar (Netsmart)
Clinical information: • Call center screening and referral • Appointment scheduling • Patient registration • Clinical documentation • Medical orders • Results and messaging • Charge generation	Billing and reporting information: • Claims processing • Fee for service billing • Managed care plan administration • State and federal reporting • Capacity management • Interoperability with community-based organizations • Data aggregation for system-wide performance measurement
Integration with other systems: • HealthLink already in use in County medical system of care (hospital, primary care, emergency, medical/ surgical specialties, etc.) • HealthLink planned to send clinical information to myAvatar for billing	Integration with other systems: • Planned to collect data from HealthLink, community-based organizations, inpatient settings, residential care facilities, and fee for services

Source: Behavioral Health Board January 5, 2018 Agenda Packet.

The Behavioral Health Services Department planned the following phased transition timeline:

- February 2018
  - County-run mental health programs transition to HealthLink and myAvatar
  - County-run substance use treatment programs and programs run by community-based organizations continue to use Unicare
- May 2018
  - County-run substance use treatment programs transition to HealthLink and myAvatar
  - Programs run by community-based organizations continue to use Unicare
- June 2018
  - Programs run by community-based organizations transition to myAvatar (while continuing to use their own electronic health record systems)

Clinical Performance Measurement Tools for County-Run Clinics Are Not Reliable After February 2018

However, the transition from Unicare to HealthLink was not successful. Clinicians at County-run clinics, which were scheduled to switch from Unicare to HealthLink between February and May 2018, continued to enter clinical data during the transition, but HealthLink was not able to aggregate the data in the same way as the Unicare system had been able to. As a result, the performance measurement data and the Tableau dashboards that aggregate Performance Learning Measures for County-run clinics are considered incomplete and unreliable by Behavioral Health Department Services staff and County clinicians since February 2018.

Clinical and Billing Information for Outpatient Behavioral Health Services Is Spread Out Across Three Major Information Systems

During the transition in 2018 from Unicare to HealthLink, interoperability between HealthLink and myAvatar could not be accomplished. As reported in the Santa Clara County Mental Health Plan External Equality Review Report for FY 2018-19,[32] the primary issues identified using HealthLink and myAvatar were difficulty in accurately and reliably submitting Medi-Cal claims through myAvatar based on HealthLink documentation. The lack of interoperability HealthLink and myAvatar between required Behavioral Health Services Department staff, Technology Solutions and Services staff, and Patient Business Services staff to perform manual system workarounds to generate claims, limiting the Behavioral Health Services Department's ability to collect earned revenues.

Due to the lack of interoperability between myAvatar, Unicare, and HealthLink, clinical and billing data remains spread out across these three major systems. As noted in the External Equality Review Report for FY 2018-19, there is no enterprise data warehouse that brings data from these different systems together in a way that facilitates reporting for clinical and financial information.

32 The United States Department of Health and Human Services, Centers for Medicare and Medicaid Services requires an annual, independent external evaluation of State Medicaid Managed Care Organizations by an External Quality Review Organization. External Quality Review is the analysis and evaluation of aggregate information on quality, timeliness, and access to health care services furnished by Prepaid Inpatient Health Plans and their contractors to recipients of State Medicaid Managed Care Services.

Given the problems with using HealthLink as the electronic health record for behavioral health services, in November 2018 the Behavioral Health Services Department decided to contract with NetSmart, the provider of myAvatar, for NetSmart's comprehensive electronic health record solution for behavioral health services and to discontinue the use of HealthLink as the electronic health record for County-run behavioral health outpatient services. The Behavioral Health Services Department's FY 2019-20 Mental Health Services Quality Improvement Workplan states that the targeted date for full use of myAvatar for billing and electronic health record functionalities is July 2020. However, according to Department staff, as of July 2020 the anticipated dates are now September 2020 for County-operated programs and November 2020 for contract providers. As noted in the External Equality Review Report for FY 2018-19, the implementation of myAvatar would be a major undertaking in any organization but is a particular challenge in an organization that went through a major new system implementation the prior year (HealthLink) that did not deliver the anticipated results. Until the transition is complete, the County continues to use all three systems—myAvatar, HealthLink, and Unicare—for clinical and billing data records.

The Department's New Contract Monitoring Tool Emphasizes Outputs Instead of Client Outcomes

As mentioned above, in November 2018, the Department decided to suspend the Performance Learning Measures review process in favor of a new contract monitoring tool to streamline the workflow of contract service providers and avoid duplication with other reporting tools, although the Performance Learning Measures dashboards would continue to be updated for providers' and contract monitors' usage. All the metrics tracked in the new contract monitoring tool, shown in Figure 9.2 on page 90, are outputs, rather than outcomes.

Output measures are units of clinical or administrative activity or timeframes, such as submission of required reports or time to first appointment. In contrast, outcome measures are the effects, results, or consequences of a program or activity. Outcome measures provide insight into client wellness and recovery, such as changes in behavior, attitudes, or individual functioning that can be attributed to program activities. Outcome measures may be time-limited (meaning that results are expected within a certain period) and involve a specific change in a target population. As shown in Figure 9.2 on page 90, the new contract monitoring tool does not track any client outcomes and focuses solely on outputs.

Figure 9.2: *Metrics Tracked in New Contract Monitoring Tool*

Measure	Type
Program integrity/compliance	
Ownership and control and prohibited affiliation disclosures submitted	Output
Evidence of Medi-Cal provider certification or re-certification	Output
Financial reporting	
Claims for covered services submitted and certified consistent with MHP requirements	Output
Annual certified cost report submitted to MHP	Output
Financial utilization report	Output
Network adequacy and staffing	
Timely submission of quarterly (mental health) and annual (substance use) network adequacy data	Output
Timely submission of the quarterly (mental health) and annual (substance use) direct service productivity and staffing expenditure matrix	Output
Access, utilization review, and beneficiary experience	
Time to first acute outpatient visit for Level 1 beneficiaries (5 business days)	Output
Time from request to first appointment/contact for Level 2 beneficiaries (10 business days)	Output
Time from request to first appointment/contact for psychiatry services (15 business days)	Output
Beneficiary experience/satisfaction	Output

Source: Behavioral Health Services Department, FY 2019-20 Mental Health Services Quality Improvement Workplan.

The previous contract monitoring tool that used the Performance Learning Measures included a mixture of outputs and outcomes, including Milestones of Recovery progress[33] and successful discharges. The new contract monitoring tool relies exclusively on output measures to evaluate the outpatient services provided by contracted providers. The tool does not measure or give insight into client wellness and recovery, quality of life, or other outcomes of behavioral health services. As a result, client outcomes that provide insight into client wellness and recovery are no longer included in assessments of contractor performance.

The Department states that it is in the process of revising its contract monitoring tool. The Department has contracted with Aurrera Health Group, a healthcare consulting firm, to provide support to the Department related to (a) federal and state behavioral health policy and financing and (b) the Department's efforts to improve quality improvement activities. As of July 6, 2020, Aurrera Health Group has recommended that the Department implement a Performance Pilot with a select group of contracted providers related to improving performance monitoring.

33 The Milestones of Recovery Scale, or MORS scale, is a numerical scale from 1-8 that assesses a client's level of risk, level of skills and supports, and level of engagement with mental health provider(s). A client with a MORS score of 1 is considered at extreme risk, and a client with a MORS score of 8 is considered to be in advanced recovery. Progress on the scale indicates client improvement.

CONCLUSION

Overall, the Behavioral Health Services Department's ability to monitor the performance out outpatient programs, both contracted and County-run, has been impaired by the County's unsuccessful transition to a new electronic health record system and the switch to a new contract monitoring tool that focuses exclusively on program outputs, rather than client outcomes.

RECOMMENDATIONS

The Behavioral Health Services Department Director should:

9.1 Revise the new contract monitoring tool for community-based organizations to include client outcome measures that were previously tracked in the Performance Learning Measures dashboard, and/or other outcome measures identified by the Department in the Performance Pilot, so that measures that provide insight into client wellness and recovery are included in assessments of contractor performance. (Priority 2)

9.2 Ensure that the new electronic health record system provided by NetSmart will be able to aggregate performance data for County-run outpatient programs, so that the performance of these programs continues to be monitored. (Priority 2)

The Board of Supervisors should:

9.3 Request that the Behavioral Health Services Department continue to provide updates on the electronic health record transition process, and request that the Department provide a breakdown of the causes of the unsuccessful HealthLink transition after the transition to the new NetSmart electronic health record system is complete. (Priority 3)

SAVINGS, BENEFITS, AND COSTS

Recommendations 9.1, 9.2, and 9.3 can all be accomplished with existing resources allocated to the Behavioral Health Services Department. Recommendations 9.1 and 9.2 will improve the County's ability to monitor the performance of both County-run and contracted outpatient programs. Recommendation 9.3 will inform the Board of Supervisors of the status of the electronic health record transition process and provide insight into the causes of the unsuccessful previous transition.

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Attachments A-B

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COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Date: August 14, 2020

To: Board of Supervisors Management Audit Division

From: Sherri Terao, Interim Director
Todd Landreneau, Deputy Director, Managed Care

RE: Response to the Management Audit of the Santa Clara County Behavioral Health Services Department

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The Behavioral Health Services Department (BHSD) has reviewed the Draft Management Audit prepared for the Santa Clara County Behavioral Health Services Department and provides the following formal response.

Introduction (page 4): Exhibit 2 Behavioral Health Services Department Organization

BHSD Response: The organizational chart should reflect two Deputy Directors. One Deputy Director oversees the service delivery system and the second oversees managed care operations.

Section 1: Department Spending and Outlook

Recommendation 1.1 Work with the County Executive and the Board of Supervisors, including ongoing reporting to the Board's Health and Hospital Committee, to plan for service needs and setting priorities for service delivery. (Priority 1)

BHSD Response: Agree

BHSD provides a monthly report to the Board of Supervisors Health and Hospital Committee and will include an annual report identifying service needs, priorities, and expenditures for client service delivery.

Recommendation 1.2 Work with the County Executive to prioritize hiring of directors for Adult and Older Adult, and Children, Youth, and Families systems of care, and for Jail Diversion and Justice (Priority 1).

BHSD Response: Agree

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BHSD has recently hired the Children, Youth and Families Director and is completing the hiring process for the Adult and Older Adult Director. The recruitment for the Jail Diversion and Justice position did not yield a candidate. In the interim, there has also been discussion at the County level regarding the recent decreases in external funding for Justice Services which may impact the types of services currently available in this area. In the context of these developments, the position is currently placed on "Hold" until further evaluation and analysis can be conducted.

Section 2: Slow Spending of Mental Health Services Act Funds

Recommendation 2.1 Continue to monitor and report on spending levels for MHSA Innovations projects and when evaluating new innovation project proposals as part of the MHSA Three-Year Plan review process, consider the timeliness of proposals and whether proposals would allow innovation funds to be spent immediately. (Priority 2)

BHSD Response: Agree

BHSD has recently invited the public to submit ideas for Innovations projects. In August 2020, the BHSD will invite proposers to present their Innovation ideas to the MHSA Stakeholder Leadership Committee and the Department will select final projects to submit to the MHSA Oversight and Accountability Commission for approval by the stated deadline noted by MHSA. BHSD is aware of the importance of timeliness of implementation for these projects and the potential risk of reversion for MHSA funding.

Section 3: Whole Person Care Pilot

Recommendation 3.1 Continue to monitor and track WPC performance metrics as required by DHCS. The WPC team should also report to the Board of Supervisors at the conclusion of the final program year on all performance metrics across all program years as well as lessons learned, and final expenditure amounts, including the amount of federal matching funds that were forfeited. (Priority 3)

BHSD Response: Agree

The WPC pilot had a broad range of goals and targets when compared to other pilot sites. Santa Clara County utilized this pilot to support transformation in the health system across behavioral, physical, and social health including housing, long term care and respite. Other pilot sites had more targeted pilots which does not offer a true comparison. As referenced, we set a goal of 10,000 enrollees and that target may not be met by the end of the pilot. Early in the pilot, with a passive enrollment process, we found that the vulnerable

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populations needed more outreach and intervention to make progress on the health goals. As a pilot, we were able to shift the method of enrollment and modifications were made to the program to increase federal draw down. We have also identified vulnerable populations that may benefit from similar interventions, yet do not qualify for reimbursement through the WPC waiver. By developing an intervention focus, we have been able to provide services to more than just the WPC eligible population which is not captured in the standardly reported metrics. Capture of the impact has required the implementation of several infrastructure projects that we anticipate augmenting the ability for measuring the outcomes of the entire population affected by the transformation of our system in the WPC pilot.

BHSD will continue to summarize and share relevant WPC performance metrics related to each BHSD program (e.g. Peer Respite, SSA Integration, Sobering Center, etc.) during regularly scheduled HHS meetings as well as at the conclusion of the final program year with the Board of Supervisors.

Recommendation 3.2 Report to the Board of Supervisors at the conclusion of the final program year on all performance metrics across all program years as well as lessons learned, and final expenditure amounts, including the amount of federal matching funds that were forfeited. (Priority 2)

BHSD Response: Agree

WPC performance metric improvements and sustainability will be key focus areas for program year five (5) and reported to the Board of Supervisors. Of note, BHSD consistently exceeded its performance targets for two of the four universal metrics pertaining to mental health services. Specifically, BHSD significantly exceeded its targets for follow-up after hospitalization for mental illness within seven days and 30 day. BHSD will summarize and share performance metrics related to relevant WPC programs at the conclusion of the final program year with the Board of Supervisors; results will include targeted program outcomes as they relate to specific BHSD interventions on smaller populations. The smaller population data has been developed over time in the pilot to determine success of specific interventions and how to measure success for the individuals impacted. In addition, as part of the California Department of Health Care Services (DHCS) evaluation efforts, UCLA Center for Health Policy Research was selected to evaluate the WPC pilot programs across the state. Preliminary data suggests several positive data points. As such, BHSD will continue to work to finalize the results from the evaluation and plan to share these with the Board of Supervisors once they are available at the conclusion of the final program year.

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Section 4: Programs to Reduce Emergency and Crisis Services Use

Recommendation 4.1 Finalize and distribute the Quality Improvement Work Plan and Program reports in a timely manner each quarter (Priority 1)

BHSD Response: Partially Agree

BHSD is required to complete an annual Quality Improvement Work Plan. The annual Quality Improvement (QI) Work Plan articulates the goals for the year with respect to quality improvement goals and objectives. The recommendation put forth in the audit report to distribute the QI Work Plan was on a quarterly basis. However, given the alignment required with the annual Quality Improvement Work Plan, the Department requests to release the audit report on an annual basis to coincide with the stated requirement.

Recommendation 4.2 Include in the quarterly Quality Improvement Work Plan and Program reports, initial enrollment, service levels, and data tracking and reporting for the Intensive Full- Service Partnership, Assertive Community Treatment, and In-Home Outreach programs, and by the end of the first year of the programs' implementation, the performance indicators and achievement of improvement objectives (Priority 2).

BHSD Response: Partially Agree

The implementation of the Intensive Full-Service Partnership, Assertive Community Treatment and In-Home Outreach programs is being tracked separately from the Quality Improvement Work Plan. While the recommendation of the audit report is to include data related to initial enrollment, service levels and data tracking to be included in a quarterly Quality Improvement Work Plan, the Department is requesting to track the implementation and outcomes related to program performance through an independent reporting process that is separate from the Quality Improvement Work Plan. Given the alignment required with the annual Quality Improvement Work Plan, the Department requests to release the audit report on an annual basis to coincide with the stated requirement.

Recommendation 4.3 Report semi-annually to the Board of Supervisors Health and Hospital Committee on the Intensive Full-Service Partnership, Assertive Community Treatment, and In-Home Outreach programs' achievement of service targets, performance indicators and improvement objectives, and plans for improvement if these service targets, performance indicators, and improvement objectives are not met (Priority 2).

BHSD Response: Agree

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Supporting Wellness and Recovery

The Department will present on the Intensive Full-Service Partnership, Assertive Community Treatment, and In-Home Outreach programs on a semi-annual basis.

Section 5: Timely Access to Outpatient Services

Recommendation 5.1 Incorporate expanded outpatient services into the Mental Health Services Act Three Year Program and Expenditure Plan for FY 21 through FY 23. (Priority 1)

BHSD Response: Agree

BHSD's FY 21-23 Three-Year MHSA plan includes recommendations for expanded outpatient services for the adult system of care based on the increased demand and need for this level of care.

Recommendation 5.2 Review outpatient services functions, including incorporating outpatient staff in the review, and identify processes and develop formal procedures to increase staff productivity. (Priority 2)

BHSD Response: Agree

1. BHSD has engaged the services of MTM Consulting to assist in developing Departmental efficiencies – including staff productivity. Specifically, during the next contract cycle, the Department will be consulting with MTM on the following two deliverables directly related to increasing staff productivity.
    1. Consulting on optimization of Call Center Workflows, Collaborative Documentation, and other system enhancements as needed.
    2. Implementation, and ongoing training regarding Same Day Access for clinics within Behavioral Health.

Recommendation 5.3 Include in the quarterly Quality Improvement Work Plan and Program reports data on staff productivity and the implementation of new outpatient programs, including the increase in the number of slots and ability to meet the California Department of Health Care Network Adequacy requirements, (Priority 2)

BHSD Response: Partially Agree

BHSD has successfully implemented clinical services in South County prior to COVID-19. In addition, BHSD staff at the Narvaez Clinic have continued to provide clinical services to

individual beneficiaries in the east region of San Jose. Given that a Quality Improvement Work Plan has specific requirements, it is recommended that the tracking of these clinical services through specific programs (as well as data on staff productivity) be tracked separately from the Quality Improvement Work Plan. This can be reported semi-annually to the Health and Hospital Committee.

Section 6: Shortage of Residential Care and Board and Care Facilities

Recommendation 6.1 Develop and maintain a resource for tracking all licensed residential care facilities and unlicensed board and care facilities that accept clients with behavioral health needs. The tracking resource should show real-time capacity, so County providers and community-based organizations can see which facilities have capacity to accept new residents at the time of referral. The tracking resource should also generate monthly capacity reports to allow for an analysis of change in capacity over time. (Priority 1)

BHSD Response: Partially Agree

At this time, tracking real time capacity within the Department is not viable. In the near term, BHSD (and the 24-Hour Care Division within the Department) will work to develop more streamlined processes to track capacity in contracted and licensed residential care facilities. In the future, the Department will explore how to use its' electronic health record so that contracted providers can enter this information on a weekly basis and ultimately provide enhanced tracking of capacity and utilization over time.

Recommendation 6.2 Report regularly to the Board of Supervisors on residential care facility capacity and any costs incurred to the County's General Fund as a result of shortages of residential care facilities. (Priority 2)

BHSD Response: Partially Agree

BHSD is unable to report active capacity but will report impacts to County General Fund (CGF) semi-annually to the Health and Hospital Committee.

Section 7: Quality and Oversight of Board and Care Facilities

Recommendation 7.1 Prioritize the release of the RFP for contract services to develop and manage a professional association of unlicensed board and care facilities, as included in the adopted FY 2018-19 MHSA Annual Update. (Priority 1)

BHSD Response: Agree

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The need for a project focused on the area of unlicensed board and care facilities was expressed by stakeholders during the Fiscal Year (FY) 2021-2023 MHSA Community Program Planning process and approved by the County Board of Supervisors in June 2020. Licensed board and care facilities in the County continue to shut down at increasing rates, resulting in an increase of vulnerable individuals being routed into independent living homes. Some licensed board and cares transition to independent living or operate "under the radar" as unlicensed board and cares to avoid the fees, required training, and oversight required by Community Care Licensing (CCL). Operators of independent living facilities often do not understand or follow existing laws and regulations related to the operation of their type of housing. Without adequate support, both licensed board and cares and independent living homes are unable to address the needs of residents in crisis which frequently results in evictions, hospitalizations, or incarceration.

The Independent Living Facilities Project (ILFP) will create oversight for independent living and licensed board and care operators with voluntary membership. The goal of the project is to promote the highest quality home environment for low-income adults with mental illness in the County of Santa Clara. Participant operators commit to have their homes meet a set of eight quality living standards. In exchange, the ILFP will connect operators to a variety of supportive resources. The key objectives are to expand the number of high-quality licensed board and care and independent living facilities and decrease the use of emergency services, incarceration, and homelessness of persons in the County of Santa Clara.

Recommendation 7.2 Continue to fund the contract for the development and maintenance of a professional association of unlicensed board and care facilities with MHSA funds in future years. (Priority 2)

BHSD Response: Partially Agree

As referenced in response to recommendation 7.1, the Department has submitted an Innovation project to address needs related to unlicensed board and care facilities. Depending on the outcomes and learning gleaned from the proposed Innovation project, future contracts pertaining to the development and maintenance of a professional association should be based on the lessons learned and recommendations from the Innovation project.

Recommendation 7.3 Consider funding proposals that would provide additional support for both residents and operators of licensed residential care facilities and unlicensed board and care facilities in the upcoming FY 2021-2023 Mental Health Services Act Three-Year Program and Expenditure Plan. (Priority 2)

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BHSD Response: Partially Agree

As referenced in response to recommendation 7.1 and 7.2, the Department has submitted an Innovation project to address needs related to unlicensed board and care facilities. Depending on the outcomes and learning gleaned from the proposed Innovation project, future funding in support of residents and operators of licensed and unlicensed board and care facilities should be based on the lessons learned and recommendations from the Innovation project.

Section 8: Access to Services on Discharge from Emergency and Acute Inpatient Care

Recommendation 8.1 Revise, finalize, and formally adopt the Inpatient Discharge Manual, including detailing the Department's procedures for (1) planning for discharge and discharging individuals from Emergency Psychiatric Services and Barbara Arons Pavilion to outpatient services, including the role of the 24 Hour Care Team and Mental Health Urgent Care; and (2) procedures for discharges from Emergency Psychiatric Services between 10 p.m., and 8 a.m. when Mental Health Urgent Care is closed. (Priority 1)

BHSD Response: Agree

As referenced in Recommendation 8.1, the Department has recently partnered with leadership and management from Emergency Psychiatric Services and Barbara Arons Pavilion to implement practices and procedures to streamline and improve efficiency between the Department and these facilities. Recently, a work group has been formed to identify strategies to improve the coordination of services and discharge planning once clients/patients are discharged from these areas. The adoption of the Inpatient Discharge Manual is one of the strategies that the Department planned to implement to improve its goal to improve discharge planning.

Recommendation 8.2 Develop written procedures for quarterly audits of Barbara Aron Pavilion and Emergency Psychiatric Services patient charts to identify referrals to outpatient services and notification of case managers. (Priority 2)

BHSD Response: Agree

The Department recognizes that improvement in this area is required and to address these needs has recently partnered with leadership and management from Emergency Psychiatric Services and Barbara Arons Pavilion to implement practices and procedures to streamline and improve efficiency between the Department and these facilities. BHSD recently formed a multi-division and cross-disciplinary work group to identify strategies to improve

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the coordination of services and discharge planning for these facilities. A review of referrals to outpatient services will be assessed by this workgroup, and policy and procedures will be developed as needed to address the issues identified.

Recommendation 8.3 Include data on individuals' access to outpatient services after discharge from and results from the random audits of Barbara Arons Pavilion and Emergency Psychiatric Services in the Quality Improvement Reports. (Priority 2)

BHSD Response: Agree

The Department recognizes that improvement in this area is required and to address has recently partnered with leadership and management from Emergency Psychiatric Services and Barbara Arons Pavilion to implement practices and procedures to streamline and improve efficiency between the Department and these facilities. BHSD recently formed a multi-division and cross-disciplinary work group to identify strategies to improve the coordination of services and discharge planning for these facilities. A review of client access to outpatient services post discharge will be assessed by this work group and recommendations to address gaps and/or inefficiencies will be implemented as appropriate.

Section 9: Performance Monitoring of Outpatient Programs

Recommendation 9.1 Revise the new contract monitoring tool for community-based organizations to include client outcome measures that were previously tracked in the Performance Learning Measures dashboard, so that measures that provide insight into client wellness and recovery are included in assessments of contractor performance. (Priority 2)

BHSD Response: Agree

As referenced in Recommendation 9.1, the Department has engaged with Aurerra Health Group consulting to develop strategies using a performance pilot with a community-based organization to prioritize mandated requirements (e.g. network adequacy, access, etc.). This pilot with community-based organizations is anticipated to inform the Department on a variety of areas including direct benefits to enrolled beneficiaries, improvements in the quality of services and the overall delivery system, and administrative improvements.

Recommendation 9.2 Ensure that the new electronic health record system provided by NetSmart will be able to aggregate performance data for County-run outpatient programs, so that the performance of these programs continues to be monitored. (Priority 2)

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BHSD Response: Agree

As referenced in Recommendation 9.2, the Department anticipates that with the implementation of the new NetSmart electronic health record, aggregate data will be more readily available. In particular, a number of activities to collect data related to client outcomes and assess clinic volume on a regular basis through standardized reports are underway.

The Board of Supervisors should:
9.3 Request that the Behavioral Health Services Department continue to provide updates on the electronic health record transition process, and request that the Department provide a breakdown of the causes of the unsuccessful HealthLink transition after the transition to the new NetSmart electronic health record system is complete. (Priority 3)

BHSD Response: Partially Agree

The rationale for the transition to the new NetSmart electronic health record was previously documented in the initial legislative file provided to the Board of Supervisors in 2019. The legislative file contained specific information related to the issues associated with billing errors and the overall unsuccessful transition to Healthlink to support billing requirements. Updates on the transition to the new NetSmart electronic health record (and any associated challenges) will be provided on a regular basis to the Health and Hospital Committee.

Attachment B: Survey of Comparable Mental Health Agencies

BACKGROUND AND METHODOLOGY

We sent surveys to ten mental health/behavioral agencies, recommended by the Santa Clara County Behavioral Health Services Department staff, of which eight were in California. Of the ten agencies, seven responded to our survey, as shown in Figure B.1 below.

Figure B.1: *Peer Jurisdictions Approached and Surveyed*

Survey Sent	Respondents
Alameda County	✓
Los Angeles County	
Anonymous	✓
New York City (New York)	✓
Riverside County	
San Diego County	✓
San Francisco County	✓
San Bernardino County	
Sacramento County	✓
San Mateo County	✓

SUMMARY OF RESULTS

All information provided pertained to the 2018-19 fiscal year. Not all questions were relevant to all jurisdictions and not all jurisdictions responded to all questions. Responses of "NA" indicate either that the question was not relevant to the jurisdiction, (e.g. New York City does not have a Whole Person Care program because the state of New York does not fund a comparable pilot) or that the data was not provided.

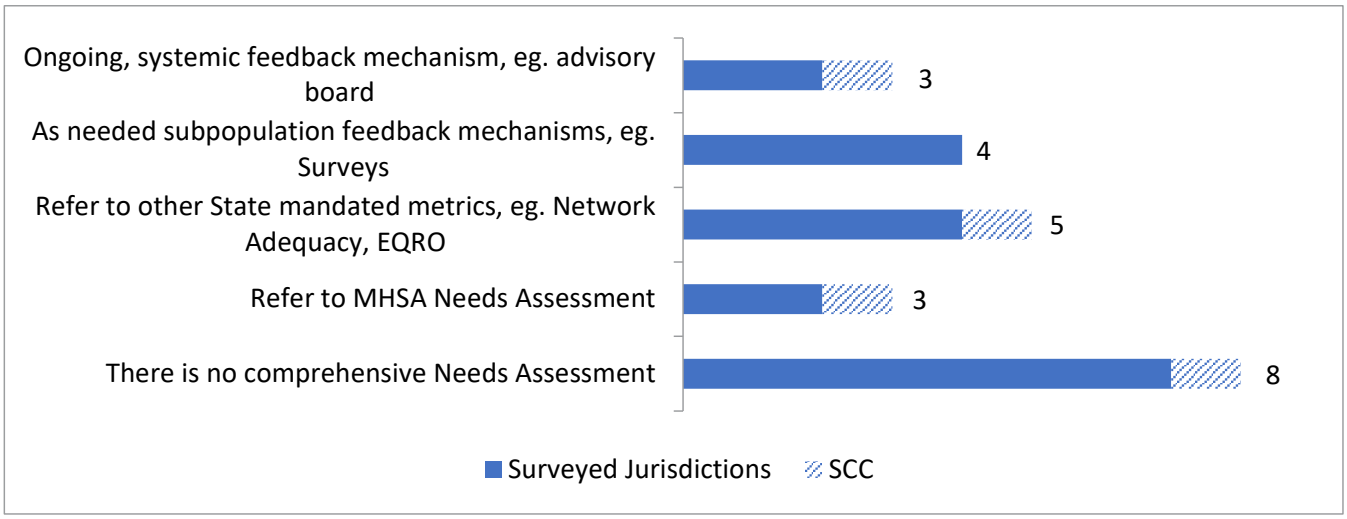
As a benchmarking survey, the results show that the SCC Mental Health Department is comparable to surveyed peers in most areas. Areas where SCC diverges notably from surveyed peers are highlighted below.

- The SCC mental health department does not formally consider past performance of contracted providers when awarding contracts. Only two other counties do not consider past performance, the remaining five consider past performance.
- The SCC mental health department is one of four that does not have a transitions team to facilitate discharges from one mental health service to another The remaining four have full time transitions teams.
- The SCC mental health department is one of four that does not operate a 24/7 call center, the remaining four operate 24/7.

In all charts that follow responses of the surveyed jurisdictions are in solid blue and Santa Clara County is portrayed in patterned fill.

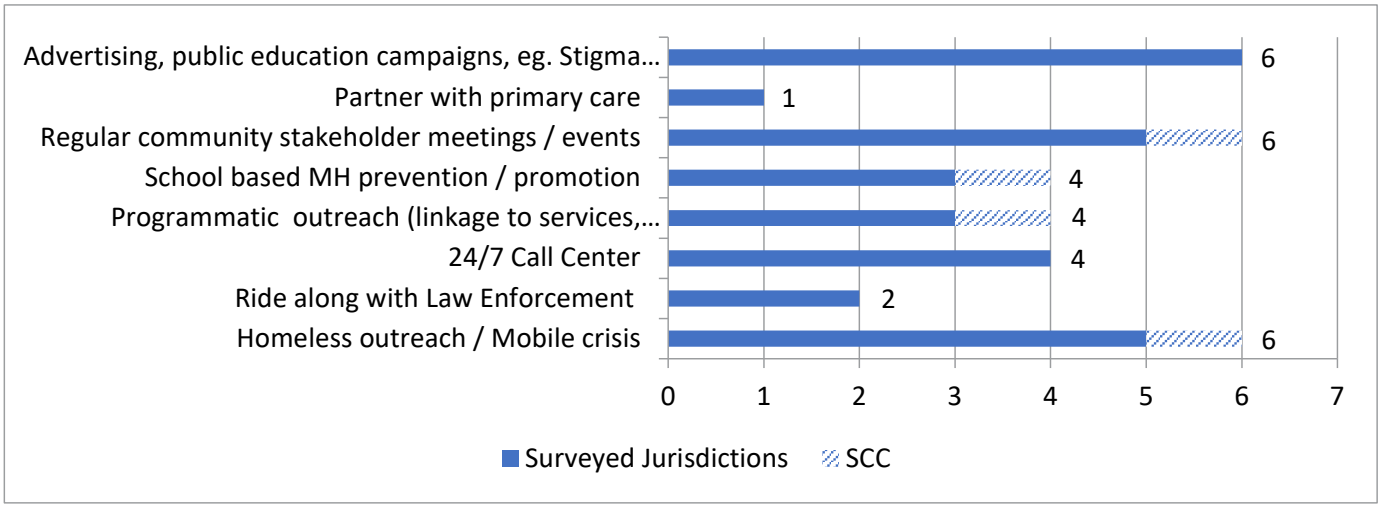
ACCESS

Figure B.2: *Please describe how you perform a county-wide needs assessment for services in terms of the number of low income people in need of services.*



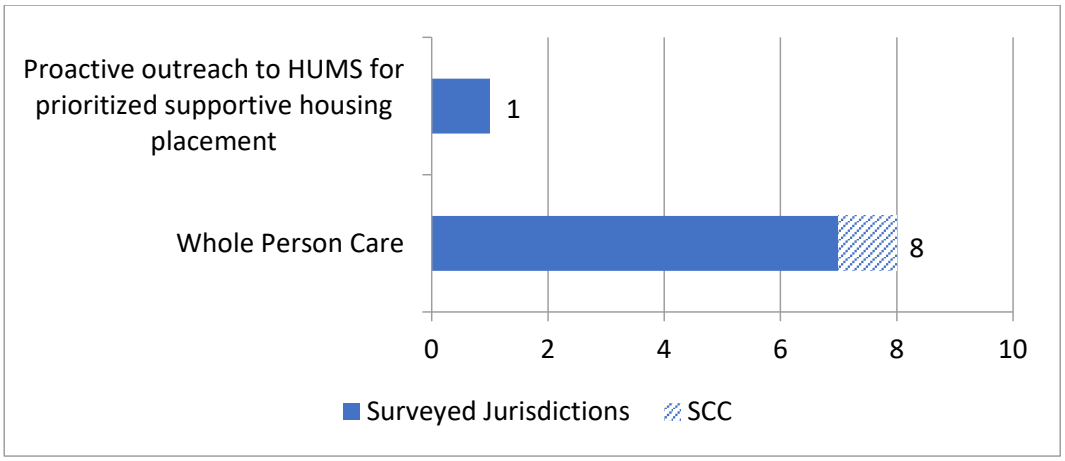
	There Is No Comprehensive Needs Assessment	Refer to MHSA Needs Assessment	Refer to Other State Mandated Metrics, e.g. Network Adequacy, EQRO	As Needed Subpopulation Feedback Mechanisms, e.g. Surveys	Ongoing, Systemic Feedback Mechanism, e.g. Advisory Board
San Francisco	x	x	x	x	
Alameda	x	x	x	x	
NYC	x			x	x
Sacramento	x				
ANONYMOUS	x		x		
San Diego	x				x
San Mateo	x		x	x	

Figure B.3: *Please describe your outreach to potential mental health clients to raise awareness about mental health services available to them*



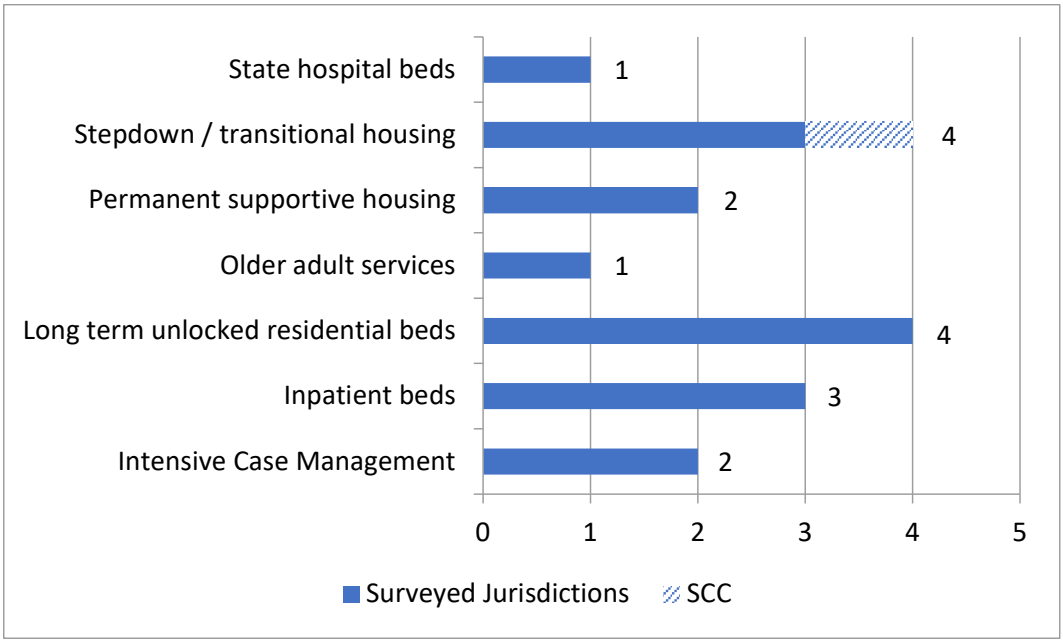
	Homeless Outreach/ Mobile Crisis	Ride Along With Law Enforcement	24/7 Call Center	Programmatic Outreach (Linkage to Services, MediCal Enrollment) to Targeted Population	School Based MH Prevention/ Promotion	Regular Community Stakeholder Meetings/ Events	Partner With Primary Care	Advertising, Public Education Campaigns, e.g. Stigma Reduction
San Francisco	x			x	x			x
Alameda						x		x
NYC	x	x	x					x
Sacramento	x	x	x	x		x		x
ANONYMOUS	x		x		x	x	x	x
San Diego	x		x		x	x		x
San Mateo				x		x		

Figure B.4: *What initiatives are in place to reduce the recidivism of high user clients? (High user = clients cycling through Emergency Psychological Services and Acute Inpatient)*



	Whole Person Care	Proactive Outreach to HUMS for Prioritized Supportive Housing Placement
San Francisco	x	
Alameda	x	
NYC		
Sacramento	x	
ANONYMOUS	x	x
San Diego	x	
San Mateo	x	
San Bernardino	x	

Figure B.5: *Which type of care has the highest demand that you are unable to meet?*



	Intensive Case Management	Inpatient Beds	Long Term Unlocked Residential Beds	Older Adult Services	Permanent Supportive Housing	Stepdown/ Transitional Housing	State Hospital Beds
San Francisco	x						
Alameda		x	x	x			
NYC					x	x	
Sacramento		x					
ANONYMOUS	x	x	x		x	x	x
San Diego			x			x	
San Mateo			x				

PERFORMANCE

Figure B.6: *To what "productivity minimum" (informal or formal) do you hold direct service providers?*

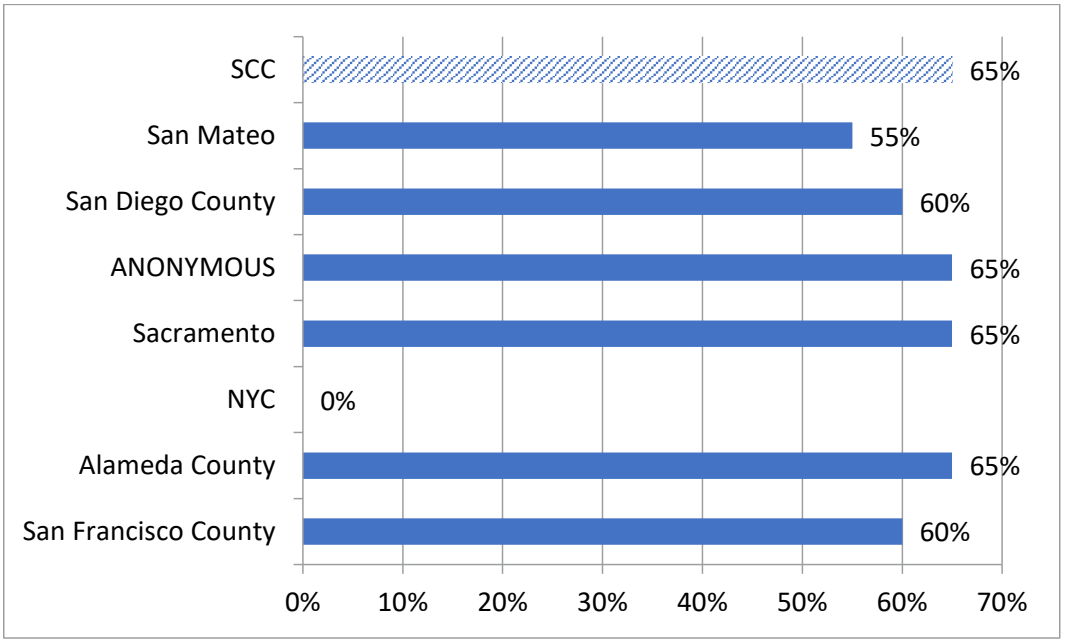
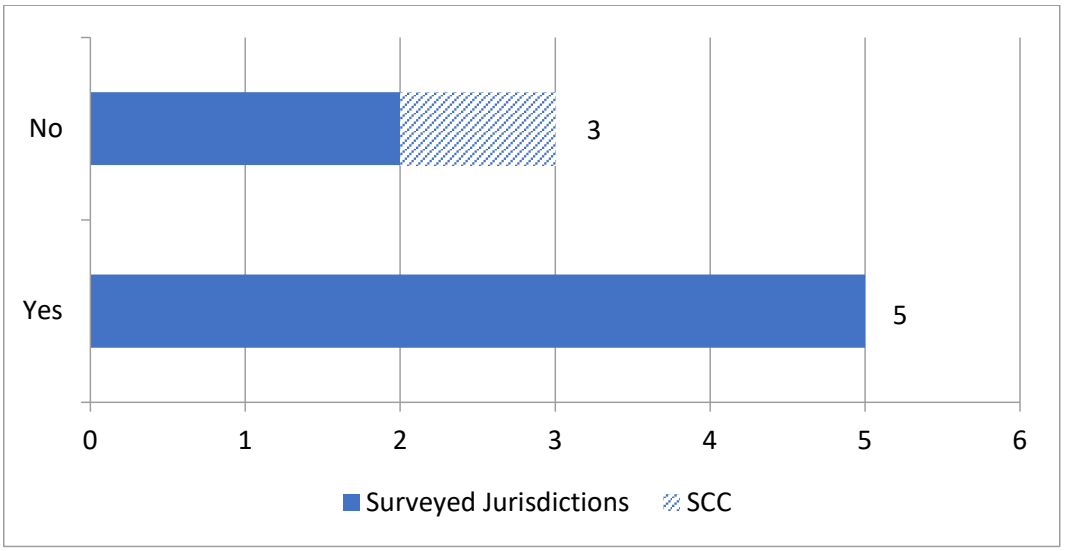
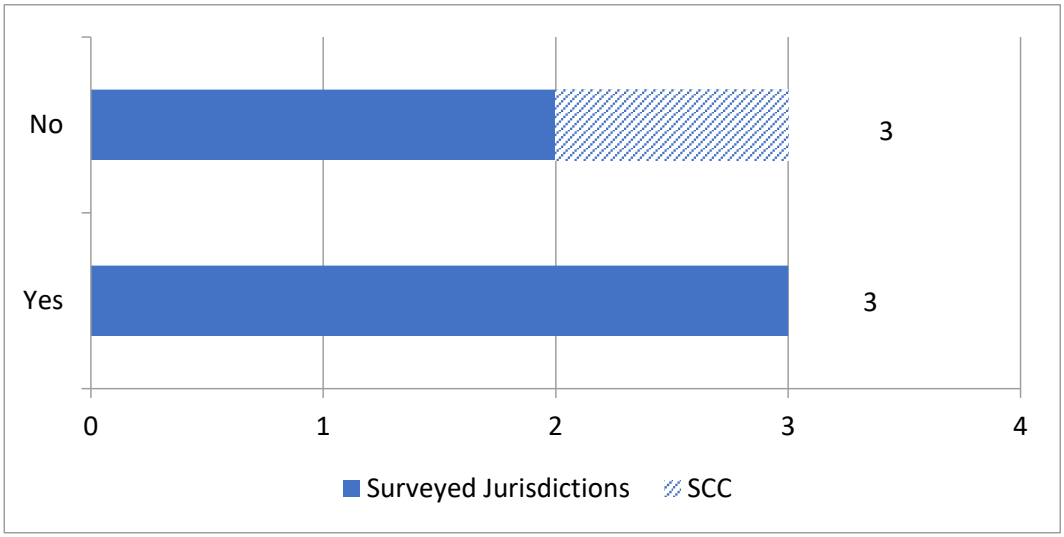


Figure B.7: *If you have previously worked with a contracting provider, do you consider past performance of the provider when awarding contracts?*



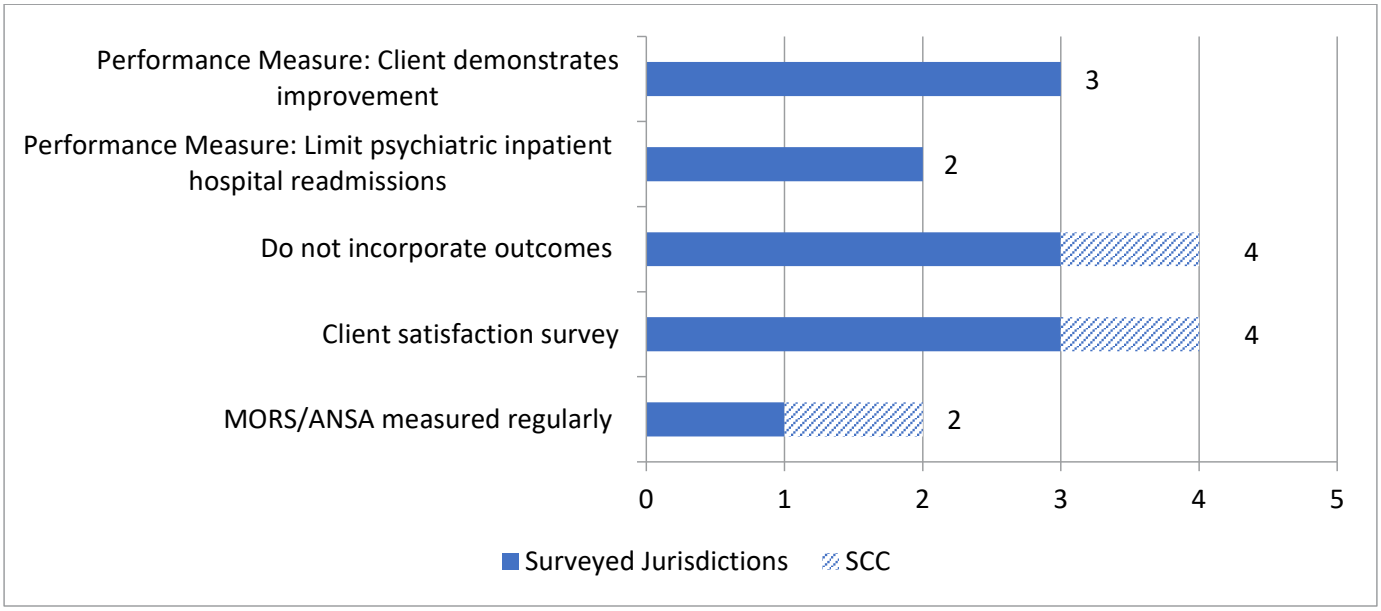
	Yes	No
San Francisco	x	
Alameda	x	
NYC	x	
Sacramento		x
ANONYMOUS	x	
San Diego	x	
San Mateo		x

Figure B.8: *Do you have the same oversight process/use the same performance monitoring metrics for contracted providers as for county-operated (civil service) clinics?*



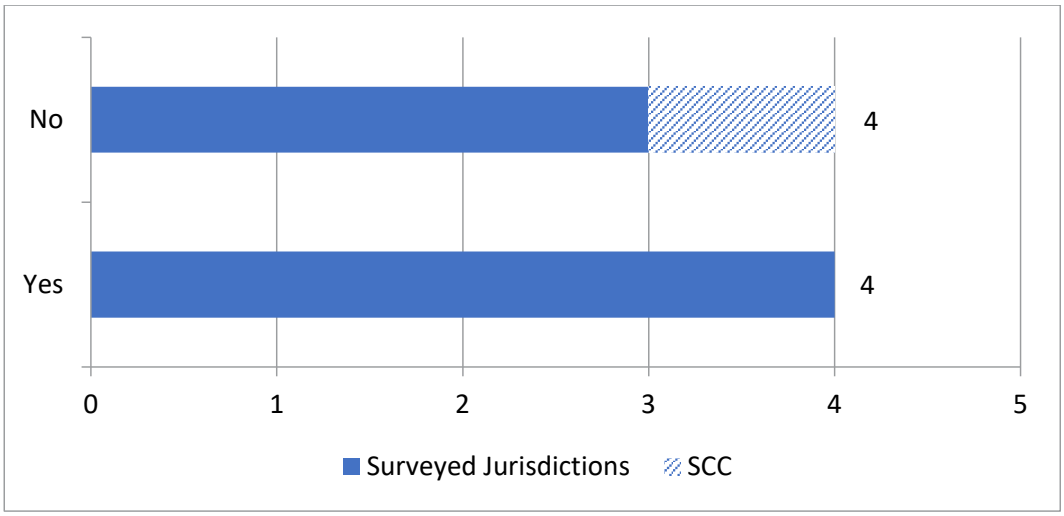
	Yes	No
San Francisco	x	
Alameda		x
NYC	NA	NA
Sacramento	x	
ANONYMOUS	NA	NA
San Diego	x	
San Mateo		x

Figure B.9: *How do you incorporate client outcomes in provider performance evaluation?*



	MORS/ ANSA Measured Regularly	Client Satisfaction Survey	Do Not Incorporate Outcomes	Performance Measure: Limit Psychiatric Inpatient Hospital Readmissions	Performance Measure: Client Demonstrates Improvement
San Francisco	x	x		x	x
Alameda		x			x
NYC			x		
Sacramento			x		
ANONYMOUS		x		x	x
San Diego					
San Mateo			x		

Figure B.10: *Do you have a transitions team to facilitate discharges from one mental health service to another? If so, please describe their functions and responsibilities.*



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