# SYSTEM REDESIGN IMPLEMENTATION PLAN FOR ADULT-OLDER ADULT MENTAL HEALTH SERVICES

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**COUNTY OF SAN DIEGO**
**HEALTH AND HUMAN SERVICES AGENCY**
**MENTAL HEALTH SERVICES**
***ROBERT K. ROSS, M.D., DIRECTOR***
*Sherry Harrison, R.N., M.A.*
*Local Mental Health Director Designee*

**COUNTY OF SAN DIEGO**
**HEALTH AND HUMAN SERVICES AGENCY**
**MENTAL HEALTH SERVICES**

# ADULT-OLDER ADULT SYSTEM REDESIGN IMPLEMENTATION PLAN


**Peggy Gustafson Smith, Ph.D.**
**CHIEF, INTEGRATED PROGRAM SUPPORT SERVICES**
**IMPLEMENTATION PLAN MANAGING EDITOR**

**PLAN PROJECT COORDINATOR /ASSISTANT EDITOR**
**Patricia Honeycutt**

**MENTAL HEALTH PROJECT STAFF:**
**Julianne Crane**
**Peggy Carter**
**Maria Dansalan**
**Russ Paxton**
**Robert Mooney**
**Divina Francia**
**Wendy Rees**
**Ellen Clark**

**PROJECT CONSULTANTS:**
**Dougherty & Associates**
**Dale Jarvis, C.P.A.**

**SRI PLAN WORK GROUP**

**MENTAL HEALTH SERVICES**
**Piedad Garcia, Ed.D.**
**Terrell Mansfield, R.N.**
**Sharon McClure, M.D.**
**Marylyn van der Moer, M.F.C.C.**
**C.P.H.Q.**
**Barbara Pierce, L.C.S.W.**
**L.C.S.W.**
**Gary Hubbard, M.F.C.C.**
**Nancy Williams**

**UNITED BEHAVIORAL HEALTH**
**Marie Schauland, Ph.D.**
**Liz Biolley, M.F.C.C.**
**Ruth Kaplan, L.C.S.W.**
**Eileen Innecken,**

**Vonda LeDay,**

**MANAGED CARE ADVISORY GROUP MEMBERS:**

**Victoria DiCicco, Ph.D.**
**Gary Stephany***
**Karenlee Robinson, M.S., M.H.A. ****
**Lorraine Freitas, Ph.D.**
**Mary Grillo*****
**Walter Sherman**
**Dolores Alegria**
**Jane Fyer**
**Maria Sardinas**
**John Hood III**
**Bill Pye**

* Judith Yates, alternate
** Linda Hammond, alternate
*** Lois Balfour, alternate

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Contemporary concepts of severe mental illness point to a biochemical imbalance that is also influenced by environment and stress. Persons with severe mental illness may experience a wide range of perceptual, emotional and cognitive symptoms that interfere substantially with their ability to acquire basic living needs such as food, clothing and housing, to develop and maintain satisfying relationships, to perform meaningful work, and to experience the sense of contentment and well-being toward which most people strive.

Often the onset of a serious mental illness preempts education and career preparation leaving the individual with few employment skills. Too frequently, the disturbing symptoms of the disorder, lack of employment skills and the still pervasive stigma of mental illness lead to a downward spiral of poverty and isolation. Public mental health systems often contribute to this bleak picture by assuming that the individual will be permanently grossly impaired and that helping the client remain on medications, out of jail, and alive is about all that can be done.

The traditional medical model was once all that was available. Today the concept of psychosocial rehabilitation has come into the foreground as a means of helping people with mental disabilities: (1) learn to manage the symptoms of their disorder; (2) acquire and maintain the skills and resources needed to live successfully in the community; and (3) pursue their own personal goals and recognize and celebrate their individual strengths. Born largely out of the activities of ex-mental health clients, (Beard, Probst, and Malamud, 1982; Estoff, 1983) who desired a practical and less medical mode of support, psychosocial rehabilitation has become one of the cornerstones of mental health treatment[1]. While neither medical treatment nor rehabilitation alone can achieve the best outcomes for most clients, together they provide the most complete approach, given the current state of knowledge.

## Care, Treatment and Service Model

The Health and Human Services Agency's Mental Health Services adopts a **biopsychosocial** approach to the care and treatment of serious mental illness. Professionals from all of the mental health disciplines, working collaboratively and harmoniously, can provide far more effective care and treatment than any can separately. Paraprofessionals and peers also make a vital contribution to the team and should be trained and used wherever possible. No one practitioner is automatically the "captain" or undisputed leader of the team. Rather, all members bring their special training, perspective and experience to the treatment team and are responsible for the value of their contribution. With clients in higher levels of care, the case manager/care coordinator will often be the convener of the team in their efforts to obtain the best care and treatment for their client.

The service focus should be on normalization. When mental health clients are asked about their desires and preferences, their choices sound, not surprisingly, like those of everyone: personal safety, good health, decent housing, enough money to meet at least basic needs, good friends, meaningful work, and a sense of belonging within the community. A biopsychosocial rehabilitation model works, with the client, toward meeting these needs, from the elimination or suppression of disturbing symptoms through medications, to structured activities designed to develop skills needed

[1] Throughout the System Redesign Implementation Plan, psychosocial rehabilitation will be used to cover such areas as "psychiatric rehabilitation" and "rehabilitation and recovery."

for successful daily and community living. To support these activities, there must be county-wide efforts to develop more housing options, sheltered or supported employment programs, and psychiatric and social rehabilitation programs that can demonstrate effectiveness through measurable means. Educational efforts to eliminate the lingering stigma of mental illness and achieve equity and parity in funding for mental health services are also needed.

The client must be at the forefront of care and treatment. They must be at the very center of the treatment planning process, active in the selection of appropriate treatment options, responsible for evaluating treatment effectiveness and progress toward their personal goals. The assessment and development of rehabilitation readiness will be an expected component of all programs. Readiness is a reflection of the clients' interest in rehabilitation and their self-confidence, not of the capacity to complete a rehabilitation program. Those who show a willingness to engage in treatment should be considered ready for psychosocial rehabilitation wherever they may be on the wellness to illness continuum. The objective is to work in partnership with the client to help them "move on," rather than just "hold on" (Hughes, 1995)[2]. The constant activity of moving on creates changes in role performance (Anthony, 1995)[3]. Changes in role performance lead to self-confidence and personal empowerment. Personal empowerment - the ability to manage one's disorder and move toward mastery of one's personal environment - is the path to recovery.

Services need to be community based with little or no institutionalization. Hospitalization is generally the least desirable and most expensive method of treatment (Rogers, and others, 1995).[4] If short-term hospitalization is necessary to stabilize and restore safety, hospital and community staff should work together to assure a smooth transition back to community services at the earliest appropriate time. Long term care should be a temporary placement of last resort and not considered permanent. Many people in long term care settings can make successful transitions back to the community if resources and supports are available to assist them.

Over the next few years the various elements of the San Diego County mental health system must move together toward a more unified, integrated, and consistent whole. Consistent terminology must be used throughout the system. Admission criteria must be developed and uniformly applied. The effectiveness of all services in the system, community based and institutional alike, must be constantly measured and evaluated. Informed decisions about program development or system change must be made by accurate studies of the relative effectiveness of each service modality and faithful to a plan that is developed with clear rationales. Finally, the County's mental health resources must be focused on providing opportunities for mental health clients to live normal lives, to understand and control their illness, to develop the skills to live safely and successfully in their community, and to find and keep meaningful work and satisfying relationships.

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[2]R. Hughes. "The Future of Psychosocial Rehabilitation under Managed Care," *Community Support Network News*, Fall 1995.

[3] W.A. Anthony, M.R. Cohen, & M.D. Farkas. *Psychiatric Rehabilitation*. Boston, MA: Boston University, Center for Psychiatric Rehabilitation, 1990.

[4] E.S. Rogers and others. "A benefit-cost analysis of a supported employment model for persons with psychiatric disabilities," Evaluation and Program Planning, 1995, 18(2), pgs. 105-115.

# INTRODUCTION

The System Redesign Implementation Plan (*SRI Plan*) is a four and one-half year plan covering fiscal years 1998-99 through 2002-2003. The plan brings together, in one document, three major mental health planning efforts, *The Plan for System Redesign* (1995); *The Regional Integrated Service System (RISS) Plan* (March 1998), and *San Diego County Adult and Older Adult Care Management Design* (June 1998). The *SRI Plan* focuses on how to implement the plan and procure the services.

The *SRI Plan* describes expectations for the County of San Diego's Health and Human services Agency's Adult-Older Adult Mental Health System. This system of care is a coordinated service delivery structure that:

- Ensures timely and appropriate access to the services.
- Operates in collaboration with its clients and the agencies and organizations that serve them.
- Produces measurable outcomes and positive client satisfaction with services received.
- Enhances clinical and cost effectiveness to manage treatment, care and risk.[1]

This plan also serves as the foundation for adoption of psychosocial rehabilitation and recovery philosophy and principles systemwide. The SRI Plan is flexible enough to incorporate new knowledge, and best practices, and to also adapt to changes in legislation, the economy, and client demographics.

[1] Adapted from, "Adult Systems of Care in California's Specialty Mental Health Systems" Adult System of Care Committee of the California Mental Health Director's Association, 1997.

# PURPOSE, MISSION AND PRINCIPLES

## Purpose

The purpose of the Health and Human Services Agency/Mental Health Services (Agency/MHS) is to promote mental health and eliminate the debilitating effects and stigma of mental illness.

## Mission

The mission of the Health and Human Service Agency (Agency) is "through partnerships, and emphasizing prevention, assure a healthier community and access to needed services, while promoting self-reliance and personal responsibility."

Mental Health Services adds to that mission: "to provide quality, cost-effective mental health treatment, care, and prevention services by dedicated and caring staff to people in the service population."

## Guiding Principles for the Agency

- Consolidate and integrate programs.
- Establish regional, community-based service delivery systems focused on customer services.
- Expand existing community collaborative pilot efforts into a full partnership.
- Provide services that are child centered and family focused.
- Ensure all activities are outcome driven.
- Achieve a smaller government bureaucracy.
- Assure fiscal responsibility and integrity.
- Emphasize personal responsibility and self-sufficiency.
- Enhance resources for prevention services.

## Guiding Principles for the Adult-Older Adult Mental Health Services System Redesign

- The mission and principles of the organization are a yardstick against which to measure the outcome.
- Consumers (clients and family members) of mental health services are valued members of the community.
- Treatment and care shall be client centered and:
    - Planned in consideration of the client's individual goals, diverse needs, concerns, strengths, and motivations.
    - Culturally, linguistically, and developmentally appropriate to the client.
    - Based on a continuing analysis of the client's need and be flexible enough to incorporate new information and new technology.
    - Planned and delivered in a quality-based, cost-effective manner.

- Mental health services must build on the assets of the clients and their support systems (family and friends).
- Priority must be given to the development of services in the community.

# HISTORICAL DEVELOPMENTAL BACKGROUND

## Mental Health Managed Care–Phase I and Phase II

Under a 1994 legislative initiative which has been consistent with the national movement to reform health care, the State of California 'carved out' the responsibility for Medi-Cal specialty (mental health) services from other health care services. In Phase I, the responsibility for authorizing and managing Medi-Cal funded acute psychiatric hospital services was transferred to counties. Planning for implementing the initiative in San Diego County was accomplished by a focus group that included public and private providers, clients and advocates. The San Diego Managed Mental Health Care Plan for Phase I was implemented on January 1, 1995. During the first year of Phase I, the County was successful in reducing the use of hospital services and establishing cost-effective community alternatives.

Phase II of the state's initiative transferred the responsibility and funding for Medi-Cal fee-for-service non-hospital (outpatient) services to the County. This phase was implemented in the County on July 1, 1998.

## Plan for Mental Health System Redesign

The process of redesigning the County of San Diego's publicly funded mental health system began in spring 1995. A number of important reasons led to the decision to redesign the system, including:

- Effect on continuity of care of repeated decreases in mental health funding.
- Misconceptions about realistic expectations for outcomes of treatment and care.
- Impact of additional responsibilities being added through State and federal initiatives and regulations without additional funding.
- Impact of three major legislative initiatives (Realignment, Rehabilitation Option and Managed Care).
- Complying with the Board of Supervisors policy to privatize mental health services and reduce County staff if it was more cost effective.
- Need to plan for Phase II of the State's mental health managed care initiative.

A group of more than 100 stakeholders met through the summer of 1995 to focus on different components of a system of care and to review and assess alternatives for privatizing mental health services management. Mental Health Services consulted with numerous nationally known experts and other states and communities. The extensive planning process produced the *Plan for Mental Health System Redesign.* The plan proposed that the three main functions of a public mental health system were oversight, management and service provision.

The framework for three systems of care, Child, Youth and Family, Adult and Older Adult, and Adult Forensics were developed. Key points were:

- Services should be integrated and regionally accessible.
- Mental health regions should conform to the six Agency regional areas.

- Clients who are to continue receiving mental health services will be assigned a care coordinator (a single point of accountability for their treatment and care).

During the redesign process, it was proposed that while the County would continue to provide oversight, consideration should be given to contracting certain management and administrative functions for the adult system of care. The redesign plan presented three potential models for this, including contracting with a managed care entity. The recommendation on the particular type of entity was to be included in the public discussion to occur after the Board of Supervisors (the Board) reviewed and accepted the plan.

In December 1995, the Board directed the establishment of a comprehensive mental health system of care for children and adolescents, separate from the system of care for adults. Also, it was decided that further discussions about the adult forensic system would occur under a separate planning process. The remainder of this historical background in this paper relates mainly to the adult and older adult system.

#### MENTAL HEALTH MANAGED CARE MODEL

Following the principles established in the plan, the Board directed that future planning for implementation of system redesign should continue to encourage input from clients, family members, private behavioral health care companies, and other interested parties. The Board approved securing technical expertise to assist in the implementation planning. Subsequently, the County contracted with Dougherty Management Associates, Inc. to provide expertise in further developing the system redesign model, to incorporate managed care principles and practices, to facilitate the community input process and to assist in drafting a statement of work for the managed care entity Request for Proposal.

The System Redesign Development Stakeholders Group was convened and included many participants who had been involved in the redesign plan. Stakeholders meetings and community meetings were held to evaluate several models of managed care management. The stakeholder group also refined the concept of the Regional Integrated Service System (RISS) for service delivery.

Once the group decided on the Administrative Services Organization (ASO) model, another series of public meetings began in October 1996. The group's charge was to provide the best advice on the development and implementation of a Request for Proposal for the adult and older adult system redesign implementation. During the next few months, several public meetings and public review of draft documents were held. On February 18, 1997, the Board of Supervisors approved release of a Request of Proposals for an ASO for adult mental health and authorized the Department of Health Services to develop a risk-sharing RISS plan.

## Regional Integrated Service Systems Plan

On September 15, 1997, the Board authorized a contract with United Behavioral Health (UBH) to be the ASO for adult mental health services. One of UBH's first tasks was to assist in the planning process by taking the concepts in system redesign and bringing them to a regional level. UBH assisted in the development of the *RISS Plan*, which incorporated ideas from the *Plan for Mental Health System Redesign*, the reports from four regional planning groups, and a survey of client service needs. The plan called for the six RISSes to provide or have access to a range of culturally competent services, and be linked to the other RISSes by a common information system, producing seamless, cost-effective service delivery.

The *RISS Plan* was presented to the Board in March 1998. Sections developed by UBH proposing financing, risk management, utilization management, and the procurement process for the RISSes were included. The intent of the risk management approach developed by UBH was to limit the County's exposure to increased costs and set incentives for private providers to manage resources efficiently and effectively.

#### REGIONAL LEAD ENTITIES

The RISS Plan proposed that service planning and delivery be managed by contracted Regional Lead Entities (RLEs) secured through a competitive process during 1998. The concept of the RLEs grew out of meetings held during the RISS planning process (June-December 1997). In addition to managing the RISSes, the RLEs would be required to provide some direct client services to minimize administrative costs. The lead entities could be a consortium of providers, a single provider organization, or a partnership between providers and a managed care organization. Following their selection, the RLEs would be required to establish and expand mental health services in their regions using a competitive process. All existing service providers, including the County, were to have an equal opportunity to compete to be part of the RISSes.

The RISS Plan was approved by the Board of Supervisors on March 17, 1998. Though initially supported by mental health stakeholders, support and enthusiasm began to wane as existing local mental health providers and Agency/MHS staff struggled with the complexities and cost of creating legal entities that would meet Knox-Keene licensing standards.

## San Diego County Adult and Older Adult Care Management Design

To move system redesign and RISS implementation forward, UBH was to:

- Develop a care management model.
- Refine the risk management plan.
- Define the regional service budgets.
- Establish performance withholds and incentives for the RLEs.
- Complete the procurement process for RLEs and regional services.

### Care Management Design

During spring 1998 a team of clients, family advocates, community stakeholders, program providers, independent practitioners, County and UBH staff participated as members of the Care Management Design Team. The Design Team was charged with taking mental services planning to the next level of conceptualization and providing a detailed care management model to be incorporated into the Request for Proposal for RLEs. The Design Team's work also was intended to provide a starting set of assumptions for financial modeling. The financial model presented a challenging set of choices as the Design Team sought to expand service access and capacity within projected revenues.

In the weekly Design Team meetings, members expressed their philosophies, experiences and perceptions about managing the service delivery system, and the difficulty of designing services to fit within available resources. Team members agreed that the delivery system needed to assure that expenditures balanced with revenues. Team members were concerned that they were dealing with untested premises, as well as assumptions about the future based on projected data gathered under an historically different model and set of assumptions. The final *Care Management Design Report*

consists of a series of very specific work products covering access, community education, screening, referral, rehabilitation and recovery, and ongoing methodology in the financial model.

## Next Steps

Based on growing concerns and feedback from the mental health stakeholders, Agency/MHS staff proposed that the RISS implementation process be slowed down and the concept of RLEs be rethought. Time was spent reviewing materials from the planning efforts and studying suggestions from the mental health constituency. It was recommended that an alternative to the RLEs be considered and a revised plan be developed.

The result of this process is the *System Redesign Implementation Plan (SRI Plan)* building on and incorporating material from all previous planning efforts. The *SRI Plan* provides the framework and expectations for the functioning of the Agency Mental Health Adult-Older Adult System, as well as the policies, standards, general procedures and performance expectations. The specific way the *SRI Plan* will be fully implemented in each region is to be finalized by Agency/MHS, in collaboration with the mental health stakeholder constituency, and the Agency's Regional General Managers.

# SERVICE POPULATION

The Agency/Adult-Older Adult System service population for the SRI Plan is Medi-Cal-eligible and uninsured/indigent adults with serious mental illness. Services to this population are primarily funded from two sources, Medi-Cal (state and federal funds) and Realignment (state funds).

## Medi-Cal

By state legislation, specialty mental health services shall be provided to Medi-Cal beneficiaries who meet medical necessity criteria through San Diego County's Mental Health Plan (a contract with the State Department of Mental Health Services).[2] Under state guidelines, persons who qualify under one or more of the following categories are eligible for Medi-Cal:

- Individuals who are eligible for Supplemental Security Income (SSI) and SSI-related Groups.
- Qualified Medicare beneficiaries (QMB) fully eligible for Medi-Cal.
- Pregnant women and infants with income below 185 percent of poverty.
- Institutionalized individuals and individuals receiving Home/Community-based services.
- Aged, blind and disabled persons.

## Realignment

Realignment revenue is State of California funding designated for mental health services in California counties pursuant to the Bronzan-McCorquodale Act. For adults, the funds are to be used for the treatment and care of individuals who have a serious mental disorder.[3]

To the extent resources are available, Realignment funds are to be used for services to uninsured/indigent adults with a serious mental illness who have no other resource for obtaining mental health services. A serious mental illness is defined as a disorder meeting *Diagnostic and Statistical Manual of Mental Disorder* (DSM IV) criteria and is severe in degree. Realignment mental health funding does not cover individuals with a *primary* diagnosis of substance use disorder or developmental disability.[4]

### SERVICE POPULATION NEEDS

Persons with a mental disorder have basic needs for stable housing and finances, personal safety, opportunities for support, respect, and making and keeping friend, and chances to learn, grow and be productive. When these basic needs are not addressed, mental health services provided may not be well utilized or effective. For example, a homeless person who is mentally ill may be unable to maintain a medication regimen or to keep regular appointments for treatment and care. Therefore, future planning for regionally integrated services must include developing an array of community-based supports for clients.

[2] Medical necessity criteria is displayed in Appendix II.

[3] State of California Mental Health Laws and Regulations, Welfare and Institutions Code, Division 5, Part 1.5; Bronzan-McCorquodale Act, Section 5600.3.

[4] Bronzan-McCorquodale Act, Title 9.

# SYSTEM OF CARE

## Purpose

The purpose of the Health and Human Services Agency Mental Health Services (Agency/MHS) is to promote mental health and eliminate the debilitating effects and stigma of mental illness.

## Mission

The mission of the Health and Human Service Agency (Agency) is "through partnerships, and emphasizing prevention, assure a healthier community and access to needed services, while promoting self-reliance and personal responsibility." Mental Health Services adds to that mission: "to provide quality, cost-effective mental health treatment, care, and prevention services by dedicated and caring staff."

### Principles:

- Clients are able to access needed services in a timely and appropriate manner.
- System collaborates with clients, family members, significant others and the agencies and organizations that serve the clients.
- Treatment, care and risk are managed to produce positive measurable clinical outcomes with services delivered, and positive client satisfaction with services received. [5]

## Mental Health System Development

The purpose and mission above are the basis for the *SRI Plan*, which has the following five main components, (1) implementing psychosocial rehabilitation and recovery as the foundation for treatment and care; (2) developing the regional integrated service system; (3) providing care management; (4) achieving regional funding equity; and (5) instituting CARF (The Rehabilitation Accreditation Commission) accreditation, assuring rehabilitation standards meet nationally accepted standards. The details of these five components, and how they relate to one another, are described in detail in this plan.

### PSYCHOSOCIAL REHABILITATION AND RECOVERY

The theory, principles, and practices of psychosocial rehabilitation and recovery are an important part of the foundation of the *SRI Plan.* Psychosocial rehabilitation is a medical necessity for adults and older adults with severe psychiatric disorders. [6,7] The goal of psychosocial rehabilitation is to enable clients to compensate for, or eliminate the functional deficits and interpersonal and

[5] Adapted from, "Adult Systems of Care in California's Specialty Mental Health Systems" Adult System of Care Committee of the California Mental Health Director's Association, 1997.

[6] Note, through the rest of the document "psychosocial rehabilitation" will be used to include both rehabilitation and recovery. "Recovery is the process of managing one's illness and disability with the least amount of interference with normal life. A person may still have symptoms, and still be receiving treatment, but nonetheless be able to pursue his or her goals." International Association of Psychosocial Rehabilitation Services, September 9, 1997.

[7] "Practice Guidelines for the Psychiatric Rehabilitation of Persons with Severe and Persistent Mental Illness in a Managed Care Environment," International Association of Psychosocial Rehabilitation Services, Executive Committee, September 9, 1997.

environmental barriers created by mental disabilities, and to restore ability for independent living, socialization and effective life management.[8]

Psychosocial rehabilitation and recovery is a continuum of interventions from client and support system education to individual treatment. It is designed to work with the whole person to improve individual functioning, increase the person's ability to manage his or her illness, and facilitate recovery.[9] The practice of rehabilitation is not credential driven. All who are involved in service delivery must be able to work with the client on an interpersonal level, and with the client's support systems to set goals and develop logical steps to meet them.[10]

The quality of the clients' lives, and their ability to function in the community, can be enhanced through the development of skills enabling them to be more successful and satisfied in their chosen life situation.[11] Interventions will be designed to help the client learn to compensate for the effects of the symptoms of the illness through the development of new skills and coping techniques and a supportive environment. The interventions to counteract the effects of secondary symptoms, restoring a sense of confidence and building on the client's strengths, should begin at diagnosis and occur concurrently with necessary clinical treatment.[12,13]

To accomplish this, mental health staff must engage clients wherever they may be along the continuum of rehabilitation and recovery.[14] Initially, many clients may only be willing to participate in the recovery part of psychosocial rehabilitation. Their current focus may be on resolving a crisis and eliminating troublesome symptoms. At other times, the focus may be on a single rehabilitation area (e.g., obtaining appropriate housing). However, all clients who show interest in rehabilitation services should be considered "ready." Unfortunately, research shows that it is frequently the programs that are not ready for clients. Therefore, it will be mental health staffs' duty to help clients determine their level of readiness for psychosocial rehabilitation services so that planned interventions can begin where the client is, rather than where the program is.[15]

The assessment and development of rehabilitation readiness will be a standard component of adult system of care programs. "Readiness" is a reflection of clients' interest in rehabilitation and their self-confidence, not of their capacity to complete any formal rehabilitation program. Cohen and

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[8] Adapted from May 4, 1992 material of the International Association of Psychosocial Rehabilitation Services, Columbia, MD.

[9] "Practice Guidelines for the Psychiatric Rehabilitation of Persons with Severe and Persistent Mental Illness in a Managed Care Environment," International Association of Psychosocial Rehabilitation Services, Executive Committee, September 9, 1997.

[10] Hughes, R. and D. Weinstein. *Best Practices in Psychosocial Rehabilitation*. Columbia, MD: International Association of Psychosocial Rehabilitation Services, 1998.

[11] Anthony, W. A., M. R. Cohen & M. D. Farkas. *Psychiatric Rehabilitation*. Boston, MA: Boston University, Center for Psychiatric Rehabilitation, 1990.

[12] Adapted from May 4, 1992 material of the International Association of Psychosocial Rehabilitation Services, Columbia, MD.

[13] "Practice Guidelines for the Psychiatric Rehabilitation of Persons with Severe and Persistent Mental Illness in a Managed Care Environment," International Association of Psychosocial Rehabilitation Services, Executive Committee, September 9, 1997.

[14] Cohen, M. R., W. A. Anthony & M. D. Farkas. "Assessing and Developing Readiness for Psychiatric Rehabilitation," *Psychiatric Services*, May 1997, pgs. 644-646.

[15] Ibid.

others (1997) proposed that clients are *ready* if they show even minimal readiness on the following six dimensions: [16]

- Perceiving a need for rehabilitation to help them pursue life goals
- Viewing personal change as desirable
- Being open to establishing relationships
- Having a *basic* understanding of themselves and their mental health problems
- Being capable of reacting in a meaningful way with their environment
- Having at least a minimal system of significant others who will encourage and support the their participation in rehabilitation programming.

To assist mental health service delivery administrators, program managers, practitioners, and other staff increase their knowledge and understanding of psychosocial rehabilitation, and their ability to put theory into practice, an initial series of training and learning opportunities will be provided through Agency/MHS during the summer and fall of 1999. Following this, there will be ongoing educational experiences throughout the implementation phase of the *SRI Plan.* The curriculum will be developed by the Agency/MHS Adult-Older Adult Quality Improvement Work Group with representation from other work groups, members of the mental health community, and providers. The continuing training plan is to be completed, with the assistance of technical consultants, and forwarded to the Agency/MHS Local Mental Health Director by March 15, 2000.

### Practitioner Skills

The core set of skills practitioners need in order to deliver appropriate psychosocial rehabilitative mental health treatment and care include, but are not limited to:[17]

- *Assisting the client to develop a rehabilitation plan based on client's goals and priorities.*

  The client's rehabilitation plan is the foundation for all the services provided to the client. The rehabilitation plan should cover both clinical treatment indicated, and all of the other services and resources the client needs assistance accessing. The client should have maximum involvement in the development of the plan, with clear choices presented and informed decision making. As much as possible, when requested by the client, family members and significant others should be involved in and integrated in the plan.

  The provider must be able to assist the client in determining personal goals and priorities consistent with the client's values and lifestyle. The process of recovery will be grounded in what clients want to have happen in their lives. The identification of personal goals is empowering to the client and provides the context for treatment and rehabilitation. Clients' strengths and deficits should be assessed within their cultural and family context.

- *Using assessment as an ongoing process to modify the rehabilitation plan as needed.*

[16] Ibid.

[17] The material in this section was adapted from: "Practice Guidelines for the Psychiatric Rehabilitation of Persons with Severe and Persistent Mental Illness in a Managed Care Environment," International Association of Psychosocial Rehabilitation Services, Executive Committee, September 9, 1997; L. Dixon and others. "Services to Families of Adults with Schizophrenia: From Treatment recommendations to Dissemination, *Psychiatric Services*, February 1999, pgs. 233-238. (Note: Interventions based on the premise that family dysfunction is the etiology of the client's disorder shall not be used.) and; Adapted from, R. K. Shreter. "Essential Skills for Managed Behavioral Health Care," *Psychiatric Services*, May 1997

Clients' needs and goals will change over the course of recovery. Continuing assessment and re-evaluation will be built into all interventions and be based on where the client is in the process and what has been achieved at each phase during the rehabilitation.

- *Providing problem-oriented, goal-focused rehabilitation and recovery services.* The rehabilitation plan will be specifically designed to achieve clients' goals and offer them the greatest return for time and resources invested. Clients will be assisted in long term planning since people with serious mental illness may be involved in recovery and rehabilitation for many years. This includes helping the client to recognize the early warning signs of relapse or exacerbation of symptoms and developing appropriate intervention strategies.

- *Including group and alternative modalities when appropriate.* Within the system of care a variety of groups will be offered, including psychosocial-oriented educational opportunities, time-limited groups, specific focus groups (i.e., dual diagnosis and anxiety management), open-ended, long term groups for clients with chronic or recurrent mental health problems, medication management groups, and a spectrum of recovery-based, rehabilitation-focused opportunities. Emphasis will be placed on involving clients in these activities and reserving individual outpatient visits for briefer therapeutic interventions.

  Clients should also be assisted with and encouraged to participate in self-help and consumer support services as these are an essential component in the recovery process.

- *Coordinating care with primary and other health care providers and community resources.* Effective treatment requires that clients be linked with other providers and services.

- *Understanding the principles of psychopharmacology, to the appropriate level for the practitioner's discipline and position in the service delivery system.* Stabilizing the client through medication may be necessary to the recovery process. Non-physician providers must be able to recognize indications for a client's potential need for psychotropic medication. All adult system of care providers should collaborate closely with prescribing physicians to exchange information on symptoms, side effects, and the functioning of the client. Psychiatrists must be able to safely and effectively integrate medication management into treatment provided by other disciplines.

- *Being able to differentiate substance abuse issues from mental health problems before initiating treatment and continuing this through the treatment process.* Every assessment will include a history of drug and alcohol use to determine if it is extensive enough to rule it out or identify as a problem requiring intervention.[18] Clients will be educated on the physiological and psychological effects of abusing substances such as alcohol, drugs, and tobacco.

### System Skills

Just as with service providers, the delivery system will also need a specific skill set, including:

- Employing a coordinated care management approach involving multidisciplinary treatment teams integrating clinical efficacy and cost effectiveness.

- Assisting clients to meet their basic needs for housing, food, monetary needs, health care, and transportation.

- Using evidence-based "best practices" that have been proven to be highly effective.

[18]Adapted from R.K. Shreter. "Essential Skills for Managed Behavioral Health Care," *Psychiatric Services*, May 1997.

- Focusing continuing education on the client, family members, and providers. Clients should be offered opportunities for themselves and their families to participate in psychosocial interventions providing a combination of education about the illness, family support, crisis intervention, and training in effective coping and problem-solving skills. Then, encouraging clients to actively use the information to manage their symptoms and problems.
- Periodically assessing client outcomes and client satisfaction with services. *Outcomes refer to changes occurring in client's life, functioning, and achievement of the goals in the client's rehabilitation plan.*
- Instituting methods for clinically and financially evaluative systematic data collection.[19]

### REGIONAL INTEGRATED SERVICE SYSTEM

Each of the six Agency regions[20] will have an integrated mental health service system, with:

- Psychosocial rehabilitation principles and practices as the foundation for treatment and care.
- The major portion of regional mental health funds used for direct client services.
- Mental health services fully coordinated with the Agency regional service system and the local community-at-large, including, but not limited to, housing, education, and primary care health providers.
- Agency/adult-older mental health services providing leadership in planning and oversight of mental health treatment and care.
- A Regional Mental Health Program Coordinator charged with bringing the mental health services in the region together and coordinating them with other community resources and groups.[21]

*Integrated* means that there will be:

- Seamless movement between levels of care and programs.
- Continuity between services in the treatment plan.
- Ability of staff from all mental health programs (within region and cross regions) to meet, confer, and resolve problems.
- Ability of providers to cooperate with Healthy San Diego providers, fee-for-service providers, and other community resources on behalf of the client.
- Continual regional collaboration to eliminate barriers so client can access needed services and programs.[22]

[19] Adapted from, P. Vega. "Disease Management: Moving from Fledgling concept to Revolution in Behavioral Health Care," *Behavioral Disease Management Report*, Special Supplement 1998.

[20] A map of the regions is available in Appendix I.

[21] Information on the Regional Mental Health Program Coordinator position is contained in the *System Administration and Management* section of the plan.

[22] Note: See Regional Mental Health Program Coordinator description (page 31) and Regional Procurement Recommendations (page 68) for more information on integration of services.

### CARE MANAGEMENT

Care management is a critical part of the framework for the SRI Plan. No matter where a person enters the system, he or she will be assigned to an individual or team as the single point of accountability for integrating treatment and care. For clients with less intensive treatment and care needs, their primary mental health service provider, frequently a fee-for-service practitioner, will be the care coordinator and the "single point of accountability." Clients needing more help or specialized assistance, even on a temporary basis, will be provided a case manager. The assigned case manager will assist the client and integrate his or her treatment and care as long as case management services are needed.

### REGIONAL FUNDING EQUITY

A primary goal of the Regional Integrated Service System's development is to have a comprehensive set of mental health services in each of the Agency's regions. The heart of this effort is to ensure that funding for each of the regions is based upon their unique service needs. This requires establishing methodology for equitably allocating funding among regions for the services.

The *SRI Plan* proposes to move toward "population-based" funding methods. This will result in the equitable distribution of funds based upon the number of clients served and/or other need-based measures. Currently, there is significant variation among regions. Regions with different numbers of clients should receive an appropriate proportion of funds to provide assessment, treatment and rehabilitation services to their clients. To begin to achieve this, those regions having per client funding levels below the County average should receive increases to move them toward the County average. Over time, the County will identify other ways to use savings and increased revenue to work toward greater equity among regions.

### CARF (REHABILITATION ACCREDITATION COMMISSION)[23]

CARF (The Rehabilitation Accreditation Commission) is a private, not-for-profit organization that accredits rehabilitation programs and services nationwide. The mission of CARF is to promote quality, value, and optimal outcomes of services. CARF works in consultation with local programs, including clients, rehabilitation professionals, and consumers, to implement established CARF standards.

CARF develops and maintains practical and relevant standards of quality for the programs and services that are required of all programs seeking accreditation. The standards are applied through a peer review process to determine how well the organization is serving its consumers.

CARF is committed to continuous improvement of both organizational management and service delivery and diversity and cultural competence in all activities. They support outcomes are the true measures of success for an organization. The CARF consultative approach to outcome measurement emphasizes:

- Enhancing the organization's skills in gathering information about program performance
- Using outcome information to plan, manage, and improve treatment and care.

The Agency will begin the process to gain CARF accreditation for County adult-older adult mental health programs in Fiscal Year 1999-2000. It will take a minimum of two years to complete the necessary requirements to achieve the CARF accreditation for the first programs selected for

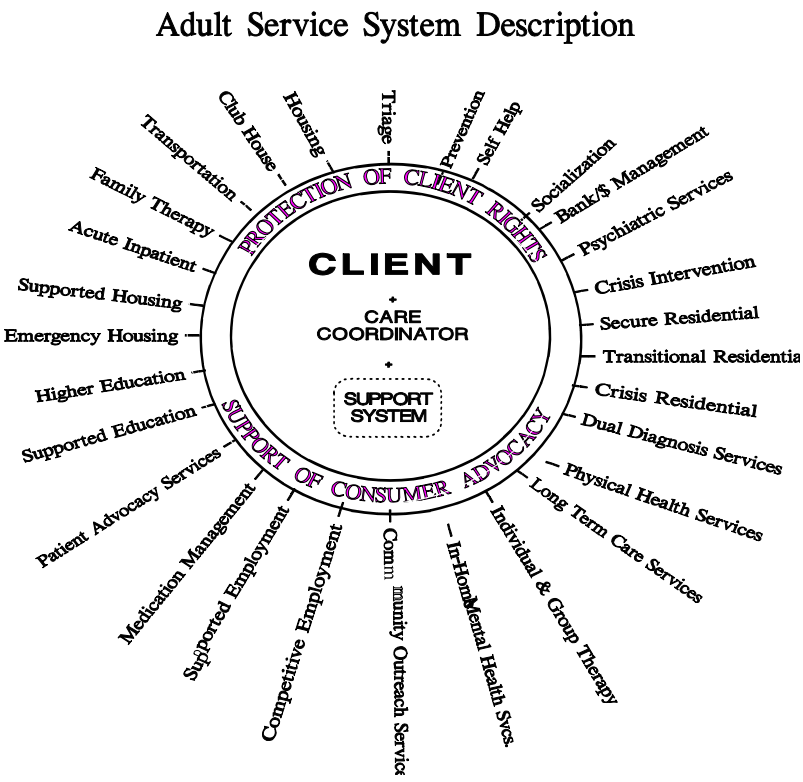
[23] Adapted from CARF Web Page (www.carf.org), June 4, 1999.

submission. Benefits to the County and clients include ensuring that services are cost efficient, effective and based on outcomes and client satisfaction. Following are the steps to CARF accreditation:

- Agency/MHS:
  - Procures CARF accreditation information
  - Conducts a self-evaluation using CARF tools
  - Implements CARF standards for at least six months in the programs to be accredited
  - Applies for an accreditation survey
  - Receives CARF approval for survey
- CARF:
  - Schedules survey and selects survey team
  - Conducts on-site survey using selected team
  - Evaluates result of survey and renders an accreditation decision
  - Awards certificate of accreditation (if merited) along with any suggestions for corrective action
- Agency/MHS responds within 90 days to the corrective action suggestions.

## Mental Health System of Care

The Adult-Older Adult Mental Health System of Care includes services traditionally provided by the mental health system as well as an expanded array of alternatives, organized and developed to meet specific regional needs. The following diagram presents the full array of services for an ideal adult mental health system of care. Existing community resources provide some of these services. As new resources become available, work will continue toward providing the fullest array of services that can be funded with mental health dollars.




### DUAL DIAGNOSIS SERVICES

Individuals who meet mental health eligibility criteria and who also have a secondary diagnosis of substance abuse should receive concurrent substance abuse treatment. The current collaborative efforts will continue between traditional substance abuse services and Agency/MHS. Substance abuse should be treated when it co-occurs with a mental disorder. This is an integral part of the Adult-Older Adult system of care, including the development of new programs when funding becomes available.

The Agency/MHS Adult-Older Adult System Clinical Work Group will convene an ad hoc work group to develop a plan for serving clients with a dual-diagnosis (substance abuse and mental disorder).[24] The ad hoc group shall include representatives from Agency substance abuse and mental health services, mental health consumers, and other interested parties. The plan should address collaborative programming, identification of potential resources, and recommendations for cross-

[24] Work groups are described in the "System Administration and Management" section.

training staff. The group shall complete its work and present a report with recommendations to the Agency/MHS Local Mental Health Director by February 15, 2000.

### SERVICES TO OLDER ADULTS

The Agency/MHS mental health system of care for older adults must include a comprehensive continuum of medical and psychosocial services. At the very least, in the older adult system of care, the following services shall be required: mobile and program-based crisis intervention, outreach, assessment, medical and psychological screening, medication management, c ase management, outpatient services (including day rehabilitation and community support), 24-hour acute level care, older adult peer counseling, and in-home services. As symptoms increase in severity, older adults may experience reduced mobility, then the need for home-based services becomes critical.

The Agency/MHS Older Adult Work Group will develop the specific plan for older adult mental health services.[25] The plan should include recommendations for building and maintaining collaborative relationships with groups such as Elderhelp, senior centers, and local senior food service programs. The work group shall include mental health staff who work with older adults and representatives from other County services, older adult community stakeholders, local service providers and other parties interested in developing the plan. The plan should be completed and forwarded to the Agency/MHS Local Mental Health Director by January 15, 2000.

### LONG TERM CARE SERVICES

The Long Term Care Service continuum shall be an integrated system of services, including the following levels of care:

- State hospital beds.
- Institutions for Mental Diseases (IMD).
- Mental Health Rehabilitation and Social Rehabilitation Centers.
- Specialized Adult Residential Facilities with Supplemental Rate Funding.
- Dedicated Long Term and Transitional Residential Placements.

Individuals needing long term care due to the persistence and severity of their illnesses, require gradual therapeutic movement to less restrictive care while continuity in treatment is maintained. Though the number of persons needing this level of care is relatively small, the services are expensive and consume more than 20 percent of the current system's resources. Because providing long term care is expensive, these services may not be duplicated in each region. However, each region shall have equal access to placements.

Because this level of care is so costly, the Long Term Care Plan shall include a process for "gate keeping" and monitoring services. The Plan shall present the array of service to be developed, identify potential sources of funding, and describe how resources will follow clients so that all San Diego residents in out-of-county placements can ultimately be brought back to the County. Funding to be explored includes Medi-Cal Rehabilitation Option dollars, SSI/SSA, Supplemental Rate, and fee-for-service Medi-Cal for ancillary services.

The Long Term Care Plan shall specify:

- Priorities for the development of locally based long term care programs

[25] Adapted from "The Planned System of Care for Older Adults," California Mental Health Planning Council letter to the Older Adult Committee, January 5, 1999 (reproduced copy).

- Suggested geographic locations for these programs
- How case management will be provided
- Monitoring and performance outcome protocols
- Plan for transitioning long term care clients into outpatient level programs

The Long Term Care Plan shall be finalized by the Agency/MHS Adult-Older Adult Mental Health System Medical Director using and ad hoc group to include older adult stakeholders. United Behavioral Health is to provide assistance to the group. The plan is to be forwarded to the Agency/MHS Local Mental Health Director by October 1, 1999.

## SPECIAL POPULATIONS

All future SRI planning must consider groups and individuals with special needs who fall within the service population and have special needs: such as homeless persons, blind and visually impaired individuals, and people who are deaf or hard of hearing. Regional planning efforts, under the Regional Mental Health Program Coordinators, shall consider these and other region-specific unique populations and seek cooperative relationships with local programs serving these individuals.

One area to receive particular attention is the transition of youth from Agency Child, Youth, and Family Mental Health Services to the Adult-Older Adult Mental Health System. Developing the policies and procedures, and planning for transitional services will be a responsibility of Agency/Adult-Older Mental Health Services' Clinical Work Group. The work group is to convene an ad hoc committee to develop the plan for transitioning youth that continue to need mental health services. The work group is to include members of Agency Child, Youth and Family Services, representatives from community organizations serving children, family members and advocates, and other concerned parties. The plan, which should include recommendations for the ongoing relationship and dialogue between the adult and child, youth, and family systems of care, is to be completed and forwarded to the Agency/MHS Local Mental Health Director by October 1, 1999.

## Service Delivery

### ACCESS TO SERVICES

The *SRI Plan* strongly supports the County of San Diego's philosophy of "no wrong door." Clients may access services at multiple points in the county including:[26]

- Calling the Access and Crisis Line (24-hour crisis intervention, information and referral).
- Calling or coming into the Emergency Psychiatric Unit at the County of San Diego Health Services Complex.
- Contact with a Psychiatric Emergency Response Team (PERT).
- Being referred through the emergency room of one of the local hospitals.
- Walking into or calling for an appointment at a regional program.
- Being referred by an Agency primary health care provider; any other County service; or community and governmental agencies.

*(The diagrams on pages 21 & 22 show ways to access the system and the process for client flow through treatment and care).*

All individuals seen at mental health services will be screened to determine that if mental health treatment is needed they meet the criteria for receiving publicly funded services. Screening is performed to determine if there is a likelihood that the person is exhibiting symptoms of a mental disorder or emotional distress, and if there is the probability that mental health treatment and care will reduce the suffering and alleviate or eliminate the presenting problems. If the initial access point is not the appropriate service, the client will be referred to appropriate treatment and care, and the first appointment scheduled. [27] At that appointment, the person's specific mental health treatment needs will be assessed and an initial treatment and care plan developed.[28]

Mental health services, which are considered "specialty services," are reserved for individuals who have serious mental and/or emotional problems. Therefore, consultation and seamless referral interface will be available for persons needing mental health services from Agency/Adult-Older Adult Mental Health Services, Healthy San Diego providers, other primary care providers in the community, and County Medical Services. Medi-Cal clients with mild to moderate mental health treatment needs who are enrolled in a Healthy San Diego Plan, or who see a fee-for-service (FFS) physical health provider in the community, are expected to have their mental health needs met by their primary caregiver. Interventions provided by their primary caregiver should include:

- Short-term interventions (primary care behavioral, psychosocial and/or prescribing medications).

[26] Following the recommendation of the San Diego Mental Health Consumer Council, *client* is used for individuals receiving treatment and care in the adult mental health system of care. *Consumer* refers to any user of services, including clients, their family members and significant others. [Undated document for the San Diego Mental Health Consumer Council by Mary Jo O'Brien.]

[27] *Referral* is defined as the determination of an individual's need for a different mental health service or other community resource and connection/linkage of the person to that service or resource.

[28] As contracts with all service providers are renewed, the County will ensure that requirements for clinically appropriate screening and referral are included in every program.

- Referral to necessary counseling resources in the community for those patients who do not meet the criteria for public specialty mental health services.
- Basic mental health prevention activities that traditionally have been incorporated in public health education.

Healthy San Diego clients who have a serious mental disorder needing specialty mental health treatment can be referred for treatment and care directly into any appropriate County mental health program or regional fee-for-service provider network though the Access and Crisis Line.

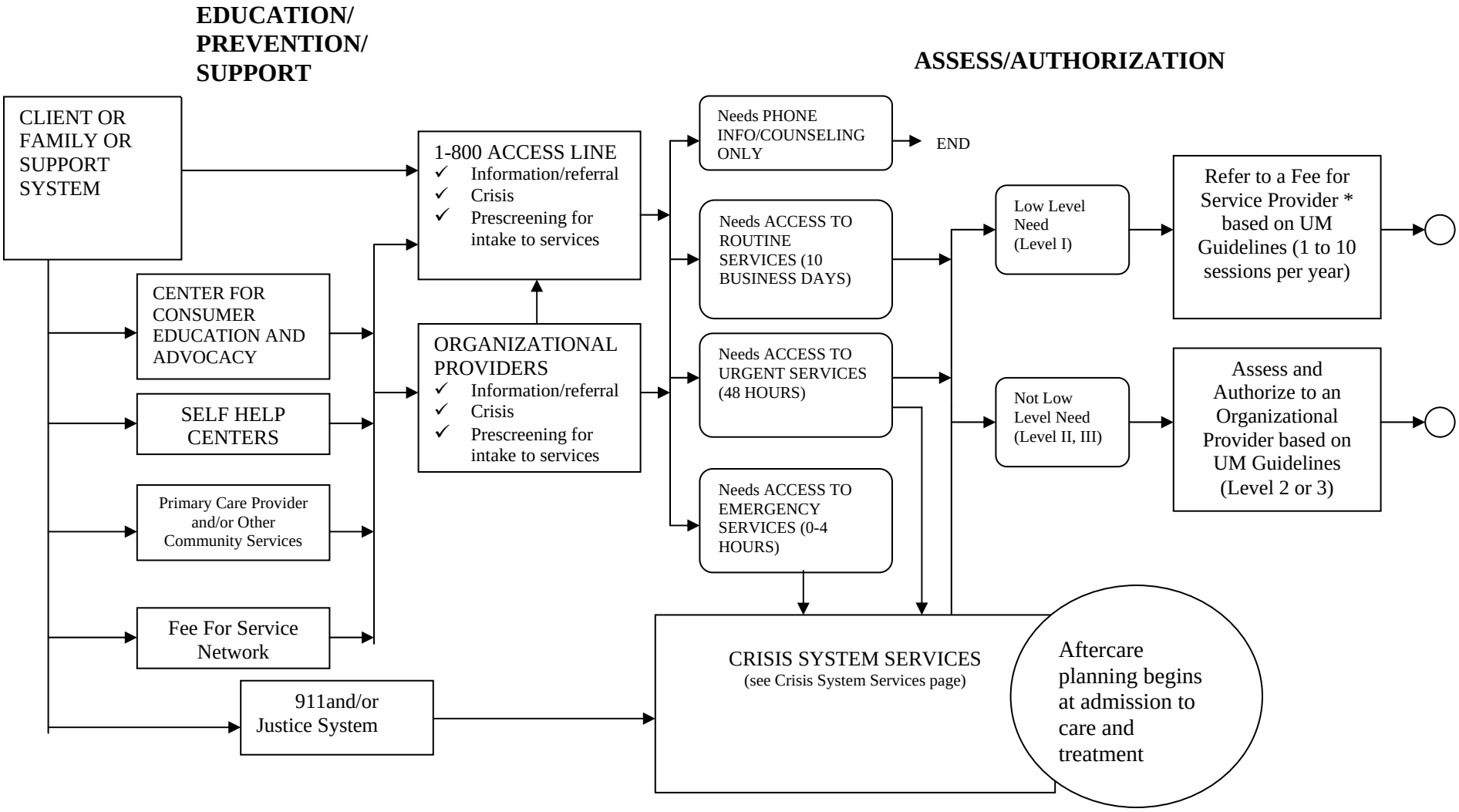
#### ASSESSMENT FOR SERVICES NEEDED

All clinical services will have staff capable of performing a complete assessment of the client's needs and translating these into an initial rehabilitation plan. Each program shall elaborate on the initial plan by identifying the particular interventions that program will deliver. The client's goals will be considered and how the planned interventions will contribute to these goals will be clarified during the assessment process. The assessment, at a minimum, shall include reviewing:[29]

- Personal and Community Skills
  - *Daily living skill capabilities*
  - *Social network and supports*
  - *Finances and benefits*
  - *Housing situation and needs*
  - *Educational status*
  - *Employment experience, skills, and goal*s
  - *Legal status*
  - *Transportation needs*
  - *Advocacy*
- Presence of co-existing medical problems and/or disabilities, including substance abuse
- Level of risk and need for intensive treatment for clients who are suicidal, violent, or experiencing serious medical complications
- Presence of cognitive deficits, such as problems in attention span, information processing, memory and judgment
- Accuracy of clients' perceptions of their emotional state and impact of their behavior on themselves, their significant others and their life in the community.

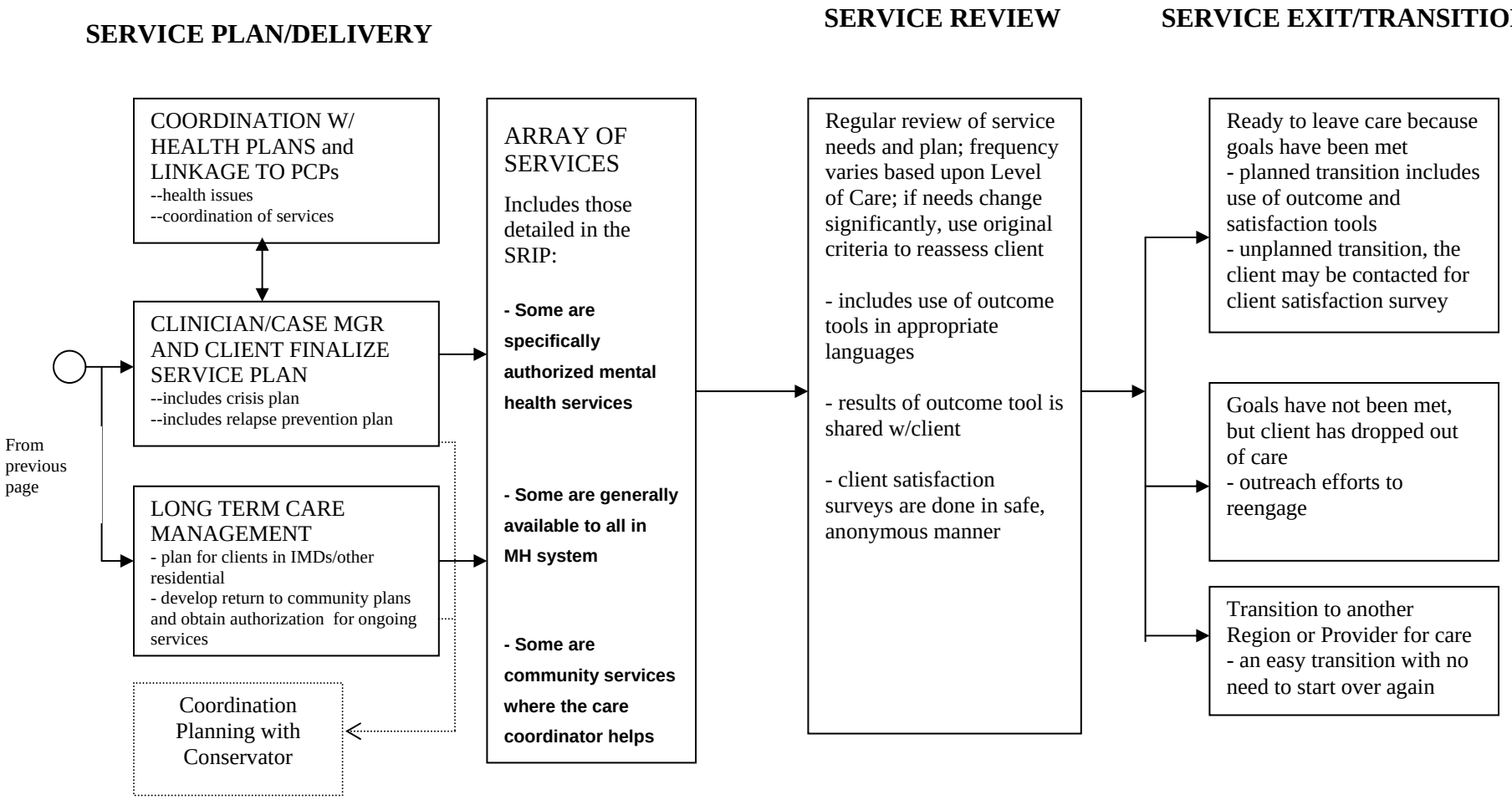
[29] Adapted from International Association of Psychosocial Rehabilitation Services, Executive Committee, September 9, 1997. NOTE: If the mental health diagnostic evaluation and the rehabilitation assessments are done by different individuals, they need to be closely integrated and coordinated into the rehabilitation plan.

# SAN DIEGO COUNTY/UBH
# ADULT-OLDER ADULT SPECIALTY MENTAL HEALTH
## CLINICAL PROCESS OF CARE




Note * = At this point, only Level I clients with Medi-Cal would be referred to Fee for Service Providers, based on provider availability. Other Level I clients will be referred to Organizational Providers.

# SAN DIEGO COUNTY/UBH
# ADULT-OLDER ADULT SPECIALTY MENTAL HEALTH



## CENTRALLY MANAGED SERVICES

Funding for the following programs crossing regional boundaries will continue to be managed centrally:

- Access and Crisis Line (24-hour crisis intervention, information and referral).
- Psychiatric Emergency Response Team (PERT).
- Emergency Psychiatric Unit.
- Acute psychiatric inpatient services.
- Crisis residential services.
- Long Term Care.[1]
- Case Management Program.

### Access and Crisis Line

The Access and Crisis Line is available by phone, 24 hours a day, 7 days a week to citizens of San Diego County. Licensed and masters-level counselors answer the phone, assess the presenting problem, provide crisis intervention and suicide prevention and counseling, and offer mental health information and referral. Spanish speaking counselors are available and other language needs are met through the interpreter services of the AT&T Language Line. A separate TDD line is available for deaf and hearing-impaired persons.

### Psychiatric Emergency Response Team (PERT)

The Psychiatric Emergency Response Team is a countywide partnership between mental health and law enforcement. PERT teams consist of a law enforcement officer/deputy and a licensed mental health clinician who provide rapid response to field officer requests for assistance with mentally disordered individuals or people in crisis. The PERT team remains with the individual to complete an evaluation and assessment of the situation and make a referral to appropriate County mental health services or other suitable community resources.

### Emergency Psychiatric Unit

Approximately 950 individuals are seen each month in the County-operated Emergency Psychiatric Unit (EPU); half are voluntary and half are involuntary clients. Between July 1997 and June 1998, 4,160 (35%) of the referrals were from law enforcement, with the major portion of these from the San Diego Police Department (2,997). Emergency short stays accounted for 4,350 (37%), while 1,144 (10%) were admitted to the San Diego County Psychiatric Hospital; 1,475 (13%) were admitted to other psychiatric hospitals; and 679 (6%) were referred to crisis residential facilities.

Of the clients seen in EPU during this period, 4,763 (41%) had a drug and/or alcohol use problem. Within this group, 2,492 had a drug-related diagnosis; 1,750 had an alcohol-related diagnosis; and 521 had both a drug and alcohol-related diagnosis.

### Acute Psychiatric Inpatient Services

Acute psychiatric inpatient hospital beds are available at the San Diego County Psychiatric Hospital and at local hospitals in the community. These inpatient beds are used for clients who require 24-hour voluntary or involuntary treatment. Voluntary admission to an acute psychiatric hospital bed is generally reserved for clients who require more acute psychiatric care than can be provided safely in a crisis residential facility.

[1] Plan to be completed October 1, 1999 as noted previously.

If a client already has a care coordinator, who may be either the primary treatment provider or a case manager, the coordinator shall be involved as soon as possible in hospital discharge planning for the client. If the individual does not have a care coordinator and the individual is being referred for continuing mental health services, a transitional case manager will be assigned before the client is discharged from the hospital.

#### *San Diego County Psychiatric Hospital (SDCPH)*

SDCPH has approximately 95 admissions per month. It has 26 beds and is licensed by the Health Care Finance Administration (HCFA) and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Clients admitted to SDCPH do not have a third-party source of funding. In the event a client is admitted and it is later determined that the client does have a third-party source of funding, he or she is discharged from SDCPH and transferred to a private facility.

#### *Contracted Acute Psychiatric Hospital Beds*

For Medi-Cal-funded clients, the County contracts for bed days with local private hospitals. Incentives will be built into the *SRI Plan* for regional services to work toward shortening hospital lengths of stay and/or preventing hospitalization by developing local alternatives, such as respite beds and 23-hour crisis stabilization beds.

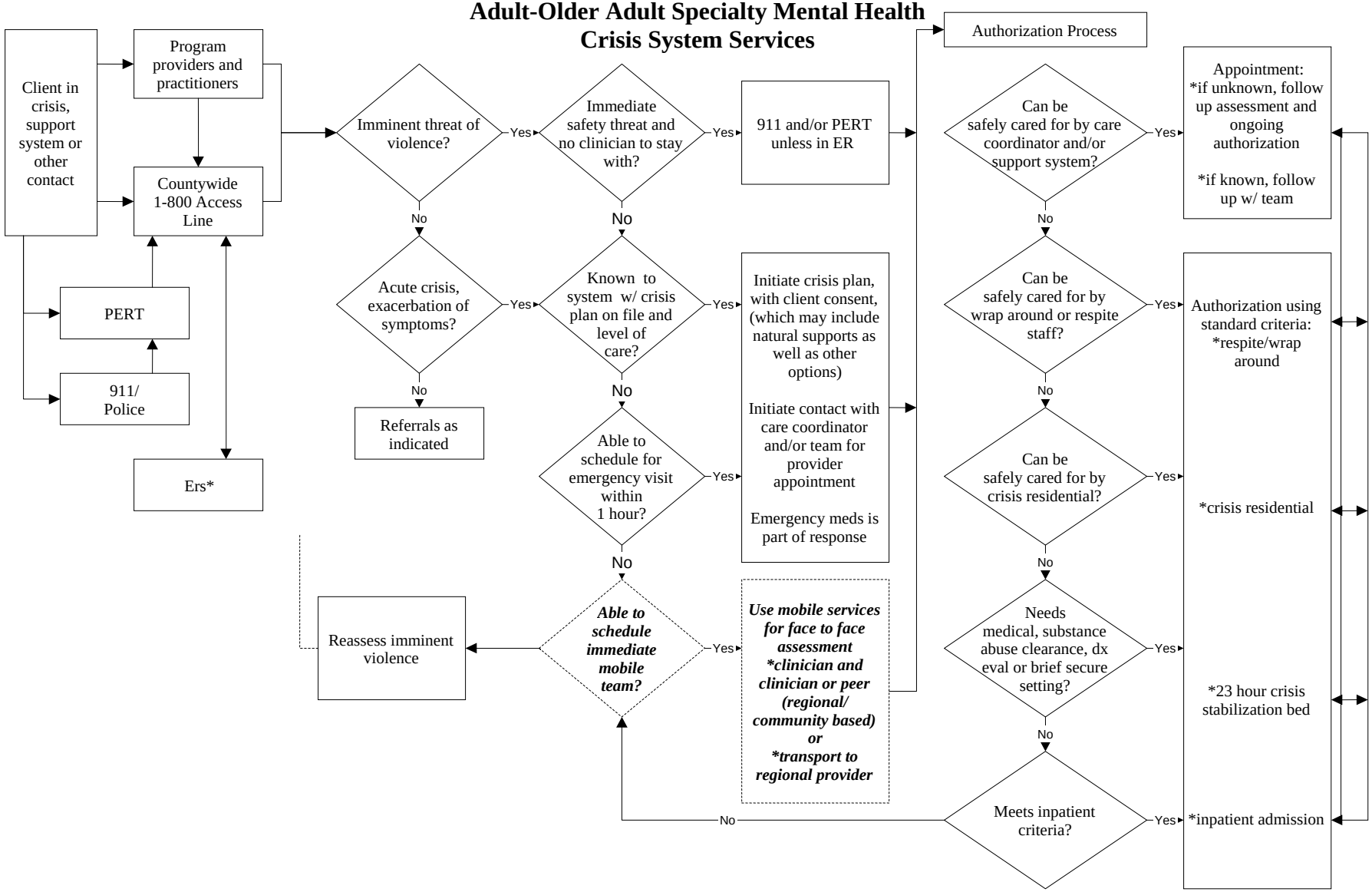
The Adult-Older Adult mental health system will continue to investigate ways that acute inpatient bed day usage can be tracked and charged back to each region based on regional population utilization. Work on this will be assigned to the Agency/MHS Management Information System Work Group with the addition of other members as needed.

### Crisis Residential Services

Crisis residences are cost-effective alternatives to acute psychiatric inpatient care for the client needing 24-hour intensive crisis intervention and who voluntarily agrees to accept the service. The facilities are community-based, home-like settings of 15 beds or less. The services shall be accessible to clients in every region. All who do not have an existing care coordinator (primary mental health provider or case manager) will be assigned a transitional case manager before discharge from the crisis residence.

The flowchart on page 25 displays the usual places where a client in crisis enters the mental health system, decision points, and the process for referral to an appropriate program or resource.

# San Diego County/UBH
# Adult-Older Adult Specialty Mental Health
# Crisis System Services



### Case Management Program

Case managers function in a collaborative relationship with the client and the client's treatment provider. Together they assess, plan, coordinate, monitor, and evaluate options and services to meet the client's mental and physical health needs. Case managers use a combination of psychosocial interventions and community resources to maintain an individual at their highest level of functioning in the least restrictive placement possible. In consultation with the client and treatment providers, case managers provide assessment, treatment planning, placement, counseling, advocacy, linkage to services, assistance with daily living, and money management services as representative payee.

### Levels of Case Management

The *SRI Plan* includes different levels of case management such as:

- **Transitional (temporary) case management** for all mental health clients discharged from an acute psychiatric hospital stay or a crisis residential program. Temporary case management services are provided to mentally ill homeless individuals during the period that regional outreach staff is attempting to get the person into a stable living situation. Assessment for continuing case management is performed at that time. A work group will be returning recommendations on additional case management services for individuals transitioning from child and youth mental health services to adult mental health services.
- **Intensive case management.** The service, using multi-disciplinary teams who carry smaller caseloads, focuses on clients who require an intensive level of mental health services in the community and those who, with additional assistance, can be safely transitioned from 24-hour institutionalized care to non-hospital services.
- **Traditional case management services.** The service is intended for individuals who are able to function at a higher level than those requiring intensive services, but who have significant needs that require ongoing case management to remain stable in the community.
- **Care coordinator aide services.** Aides, who might be mental health clients or family members, assist clients in acquiring benefits and other needed services.

Case managers will have access to multi-disciplinary consultation. The Case Management Program will include 24-hour access to a program member for emergency situations by way of a 1-800-telephone number.

Case management services are a major "safety net" for seriously mentally ill clients in the Adult-Older Adult mental health system of care. Therefore, to maintain stability while other system redesign changes are being implemented, case management will be among the last of the procurements, proposed for Fiscal Year 2002-2003. In the meantime, to move existing case management services in the direction of system redesign, Agency/Adult-Older Adult Mental Health Services will convene a consortium of providers of County-funded and contracted case management providers. The consortium will meet during spring and summer 1999, and be charged with producing a plan by September 15, 1999 for:

- Proposing how the case management program will embody the principles and practices of psychosocial rehabilitation and recovery.
- Developing standards for the way that clients will be assigned to a case manager, taking into consideration special needs of the client, including cultural and linguistic needs.

- Developing current case management services into an integrated, coordinated system with a system wide method for identifying the client's care coordinator (single point of accountability).
- Recommending the types and amount of additional services and activities that should be connected to the case management program, for example:
  - outreach services to specific clients,
  - additional intensive case management for clients being discharged from long term care (with lower staff to client ratio that also incorporates psychiatry and nursing).
- Identifying potential funding sources for enhancing and expanding case management services to include all of the levels previously described, as well as, case management for long term clients.
- Identifying additional ways case management-type services can be billed to Medi-Cal.
- Providing input into the plan for future case management procurement.

## REGIONAL SERVICES

Each of the six Agency regions will have a regionally integrated mental health service system. The same basic core services will be present in each region and in addition, a range of additional services selected to meet the mental health needs of the region's population.

### Core Services

Each region will have a solid core service cluster of psychosocial rehabilitation treatment and care programs as the foundation of outpatient mental health services. Research and practice have shown that when these core services are not in place in the capacity needed, large waiting lists develop and access to services is delayed. This affects almost every other part of the mental health system.

All core services must have staff capable of completing a thorough assessment of clients' status, life situations, and developing goals for treatment. Organizational providers will be expected to designate staff capable of performing this function.

#### *Core Services Cluster*

The services in the core cluster can be delivered in a clinic or in satellite settings. (*See Regional Services Diagram, page 30.)* The core service cluster includes:

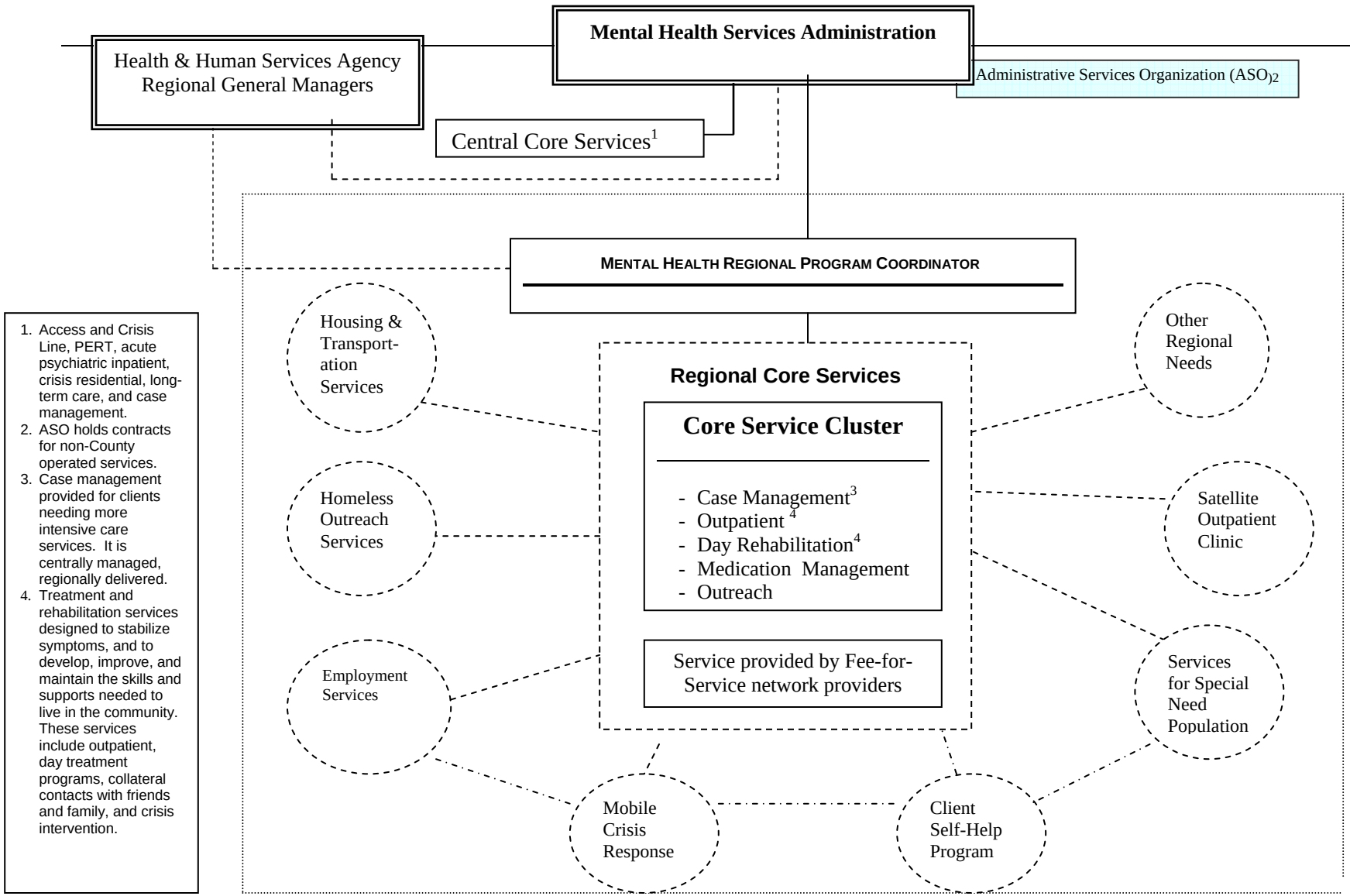
- Screening, assessment, information, and referral
- Crisis intervention
- Basic psychosocial rehabilitation services
  - Individual, group, and collateral treatment
  - Full and partial day rehabilitation
- Outreach to homeless and special need populations

Clients can enter the system through any access point and be referred to the appropriate service. In addition, each region will have at least one highly advertised and visible place where a new or returning client can go for initial screening and information. Standard screening, intake and assessment procedures will be used system wide. For individuals who meet mental health services' eligibility criteria, all necessary paperwork for system entry will be completed at this point. If the

person is not going to receive County mental health services, referrals will be made to other appropriate community resources.

The screening function will cover assessing the client's presenting situation, needs, and desired outcomes. Brief crisis intervention will be included as part of the screening process. Members of the screening team also will have the ability to provide services in the community when needed and appropriate.

# Mental Health Services Adult Regional Services Diagram




1. Access and Crisis Line, PERT, acute psychiatric inpatient, crisis residential, long-term care, and case management.
2. ASO holds contracts for non-County operated services.
3. Case management provided for clients needing more intensive care services. It is centrally managed, regionally delivered.
4. Treatment and rehabilitation services designed to stabilize symptoms, and to develop, improve, and maintain the skills and supports needed to live in the community. These services include outpatient, day treatment programs, collateral contacts with friends and family, and crisis intervention.

### *Regional Fee-for-Service Provider Network*

The other component of the regional core cluster is the fee-for-service providers network (currently psychiatrists and psychologists who see clients in providers' private practice). These providers, under contracts with the State Department of Health Services, have delivered services to Medi-Cal clients for many years. Phase II of Medi-Cal consolidation programmatically and financially integrated the fee-for-service network with the County's Short-Doyle Medi-Cal system. Fee-for-service network providers will continue to be an important part of regional treatment and care under the *SRI Plan.*

## OTHER TREATMENT AND CARE OPTIONS

Each region will develop other treatment and c are options planned around the region's specific needs and building on services already existing in the area. Some services will be "regionally accessible" – available to clients in the region, but not necessarily provided in each region or provided on a regionally scheduled basis (in each region, but on a different day). Other times arrangements will be made to transport clients to centrally provided or regionally shared services such as vocational and employment services, respite care, and self-help programs. These enhanced rehabilitation service options include 23-hour crisis stabilization, transitional residential, and community resource development (transportation, and supported housing and employment). Each of the regions will have a Regional Mental Health Program Coordinator responsible for the development and procurement of the enhanced rehabilitation services in their region.[1]

To give clients the widest possible range of service delivery options, and to encourage participation by a broad spectrum of service providers, the County will continue to seek ways to include all interested Healthy San Diego Plan providers and local community health centers in the mental health service delivery continuum.

Additionally, the fee-for-service provider network may be expanded to include other disciplines, such as licensed clinical social workers, marriage and family counselors, and nurse practitioners. The Agency/Adult-Older Adult System Clinical Work Group shall convene an ad hoc committee to study the feasibility and make recommendations on expanding the disciplines in the County Mental Health Plan fee-for-service network. The study should include looking at the need for additional service providers, particularly around language and cultural issues and coverage for geographic areas where there is a limited number of providers. It should also establish credentialing requirements (for example, experience working with persons with severe mental illness) and examine the financial impact of any recommended changes. The group's recommendations should be completed and forwarded to the Agency's Local Mental Health Director by March 15, 2000.

### Service and Care Development Positions

Clients, family members and advocates have consistently identified the need for mental health personnel dedicated to expanding community resources in the areas of housing, transportation, employment, and educational opportunities for clients. As a start, the *SRI Plan* proposes to add the following three positions:

[1] Details about this position and the duties are found in the *System Administration and Management* section of this document.

***Housing/Transportation Developer***

The Housing/Transportation Developer will be charged with finding ways to expand housing and transportation options for clients, including developing relationships with housing authorities throughout the county and with local groups providing and/or funding transportation assistance. There will also be coordination within the Health and Human Services Agency, which is already looking at ways to meet transportation needs of welfare clients as well as elderly and disabled individuals. Clients should be assisted with signing up for subsidized housing and in accessing other needed services.

***Employment/Education Developer***

The Employment/Education Developer will be expected to expand openings for clients to engage in learning experiences and productive work. This means creating a continuum of opportunities from assistance to complete GED requirements through vocational and skill training to supported and competitive employment. To accomplish this, the developer must work with all groups in the County that are involved in educational, pre-vocational and vocational training and employment development. This includes commercial enterprises such as temporary office help and employment placement firms.

***Psychosocial Rehabilitation Program Developer***

The Psychosocial Rehabilitation Program Developer will be expected to develop and/or utilize a variety of educational experiences for clients, family members, and the community to enhance and encourage the continued development of rehabilitation and recovery options. This person will assist County and contracted programs in developing or strengthening rehabilitative programming. Because of limited resources, the developer should identify and make use of all appropriate existing material and modules. Among the tasks to be handled by the Psychosocial Rehabilitation Program Developer are:

- Creating educational modules related to various aspects of mental illness, psychosocial rehabilitation and recovery that can be used for groups in clinical and self-help settings.
- Creating additional educational training and skill development for clients in aspects of daily living (for example, assistance with time management and communication skills).
- Securing additional funding to support development, printing, and implementation of these modules.
- Developing and implementing a continuing public education program to combat the stigma of mental illness.

The Psychosocial Rehabilitation Program Developer will involve clients, family members, advocates, and community members in the planning and/or selection and implementation of psychosocial rehabilitation and recovery modules and educational experiences.

## System Administration and Management

The Agency/Adult-Older Adult Mental Health System of Care has responsibility for oversight in planning and implementing standards and procedures; and for the knowledge, understanding and implementation of regulations.

### LOCAL MENTAL HEALTH DIRECTOR

Under the State of California Mental Health laws and regulations, and the Welfare and Institutions Code, the Local Mental Health Director (or designee) has certain powers and duties including:

- Serving as chief executive officer of the community mental health service responsible to the governing body though administrative channels designated by the governing body.
- Exercising general supervision over mental health services.
- Recommending to the governing body, after consultation with the advisory board, the provision of services, establishment of facilities, contracting for services or facilities.
- Submitting an annual report to the governing body reporting all activities of the program, including a financial accounting of expenditures and a forecast of anticipated needs for the ensuing year.
- Carrying on studies appropriate for the discharge of duties including the control and prevention of mental disorders.
- Possessing authority to enter into negotiations for contracts or agreements for the purpose of providing mental health services in the County.[2]

The Local Mental Health Director will continue to be responsible for all areas of adult mental health services including those provided in the regions. The Local Mental Health Director will oversee and exercise general supervision to assure that all laws, regulations, codes and standards related to mental health are followed.

### REGIONAL MENTAL HEALTH PROGRAM COORDINATOR

The *SRI Plan* includes four Regional Mental Health Program Coordinators (RMHPC). The RMHPC, to be obtained by reclassifying existing County positions, will report to the Local Mental Health Director. The North Coastal and North Inland mental health regions will have one shared program coordinator, as will the South and North Central regions. Due to the large number of clients and programs in theses regions, the Central and East mental health regions will each have one program coordinator, responsible for only that region. The program coordinators will be expected to work with Agency Regional General Managers, the regional community, mental health stakeholders, and Agency strategic planning groups to integrate mental health services by:

- Overseeing their regional mental health budget and reviewing service use to ensure that regional mental health revenues balance with expenditures and proposing appropriate action if shortfalls are projected.
- Coordinating and integrating mental health services with other County services and local community resources.

[2] Bronzan-McCorquodale Act, Section 5608.

- Developing, implementing, and monitoring the regional plan for adding and expanding services as funding becomes available.
- Evaluating service needs that may be unique to the region and recommending appropriate solutions.
- Working with the fee-for-service network to expand therapeutic options that are available.
- Participating in the selection process for any service procurements conducted for their region.

The RMHPCs will be expected to:

- Convene frequent (at least monthly) case conference sessions with regional providers and case managers to:
  - Problem solve around resolutions to difficult cases.
  - Smooth transition and referral of clients from one program to another.
  - Ensure that clients being discharged from a 24-hour intensive care settings are connected to regional programs and resources.
- Meet at least monthly with the other RMHPCs to ensure that clients moving between regions are connected to services and to share information and resources.
- Meet at least monthly with Agency Mental Health Administration to provide input on regional needs and concerns, problem solve about system wide issues, assist in the development and refinement of procedures and standards that affect regional services.
- Convene a monthly meeting of all mental health providers in their regions to share information, explain any changes in operational procedures or regulations, resolve concerns, and discuss quality management issues.
- Participate in regional quality management efforts including site reviews, audits, client satisfaction surveys, focus groups, and total quality management processes.
- Continually review regional statistics and provide information to quality management and ongoing planning efforts.
- Review information on regional clients using emergency services and acute psychiatric hospital services to find out what happened to the client post discharge (for example, did the client get connected with other mental health services) and problem solving regarding incompleted referrals.

In the past, County Mental Health Services Regional Managers also served as clinic managers and delivered direct services. In contrast, the RMHPCs, will be expected to focus on the region as a whole to see that clients are able to access needed treatment and care. RMHPCs should be continually looking for ways to increase and enhance mental health resources and to develop collaborative working relationships with other providers and groups in the community.

Other members of the regional staff will include:

- Part-time Analyst (transferred from existing County positions).
- Intermediate Clerk Typist (using existing County positions or contract help).
- Quality management staff (United Behavioral Health Quality Management staff assigned to work at least part-time in the region).

## ADMINISTRATIVE SERVICES ORGANIZATION (ASO)

For the length of its contract period, United Behavioral Health, as the administrative services organization for the Agency Adult Mental Health Services, shall continue to provide the services specified in its contract with the County. This includes, but is not limited to, such duties as:

- Credentialing fee-for-service providers.
- Claims and billing for fee-for-service providers.
- Holding contracts for mental health services.
- Developing and maintaining the fee-for-service provider network.
- Managing the Access and Crisis Line.

## SYSTEM REDESIGN COMMITTEES AND WORK GROUP STRUCTURE

To accomplish operational tasks and special projects, following are the standing committees and work groups related to Agency Adult-Older Adult Mental Health Services. All of the committees and work groups shall have the ability to set up ad hoc committees (which may include clients, family members, individuals with special expertise, and other appropriate parties related to the particular task or subject matter under consideration).

### Research Committee

The Agency/MHS Research Committee provides coordination, general oversight, and direction to research and evaluation activities conducted within the mental health services system. The committee is dedicated to protecting the rights, and supporting advocacy for the needs, of patients in all these research and evaluation studies. Its responsibility is to review, support and seek to encourage intramural evaluation and assessment studies to advance the efficiency and effectiveness of the service delivery system, and encourage and review research investigations of critical issues of importance to the County's service population.

### System Redesign Implementation (SRI) Steering Group

The SRI Steering Group is the coordination and integration point for most of adult mental health system of care operations. It consists of the chairpersons of the SRI Work Groups and ASO representation. Among the tasks assigned to the steering group are problem solving around operational issues and assignment of responsibility for special projects. The work groups of the SRI Steering Group are:

#### *Clinical Work Group*

Standards, procedures and processes related to treatment planning and direct service delivery and establishment of standards of practice will be the responsibility of Agency/MHS' Clinical Work Group. These will be based on reasonable scientific evidence and knowledge of "best practices" for the treatment and care of mental health clients.

#### *Management Information System (MIS) Work Group*

The MIS Work Group monitors management information system performance and usage; makes policy recommendations concerning the system; proposes prioritization of tasks; serves as a forum for complaints about the system; and assists in removing road blocks to project completion. The work group also reviews complaints from users and takes appropriate action to resolve these issues.

***Finance Work Group***

The overall responsibilities of the Finance Work Group include:

- Monitoring expenditures, revenues and performance indicators.
- Recommending revenue enhancement activities.
- Coordinating revenue contracts.
- Reviewing priorities.
- Performing financial analyses.
- Making recommendations for finance policy, and assigning roles and responsibilities.

***Quality Improvement Work Group (QIWG)***

The QIWG leads the Agency Adult-Older Adult Mental Health Services' Quality Management Program and is accountable for the development and implementation of the annual quality management plan. The Agency/MHS Quality Management Program Manager chairs the group. A more detailed description of the group and its work is in the quality management section of the SRI Plan.

**Performance Outcome Sub-Committee (POSC)**

A Performance Outcome Committee will be established as a sub-committee of the Quality Improvement Work Group chaired by the Agency/MHS Quality Management Program Manager. Participation in the sub-committee shall include members of the Agency/MHS Adult Administrative and Management Information Work Groups, and representatives from client, family and advocate groups, current mental health service providers, and individuals with performance outcome expertise. The POSC shall develop proposed performance and process outcomes for treatment and case management services. For the measures to be included in the first round of regional procurements, the POSC proposal is to be completed by October 1, 1999 and forwarded to the Agency/MHS Local Mental Health Director. Examples of potential measures to be considered are displayed in Appendix V.

The POSC will also be responsible for making recommendations related to implementation of the State of California, Department of Mental Health performance outcome protocols.

***Administrative Work Group***

The Administrative Work Group will handle system wide tasks, special projects, and problem solving related to operational administration and management of the *SRI Plan.* The work group also serves as the initiating body for projects and assignments that involve representation from all of the work groups and external members.

## OTHER MENTAL HEALTH RELATED GROUPS

### Mental Health Board (MHB)

Established under Welfare & Institutions Code 5604.2, the MHB advises the Board of Supervisors on mental health needs, services, facilities and special problems in the County. The local Mental Health Board duties include the following:

- Review and evaluate the community's mental health needs, services, facilities and special problems.
- Review any County agreements entered into pursuant to Section 5650 (of Welfare & Institutions Code).

- Advise the governing body and the local mental health director as to any aspect of the local mental health program.
- Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.
- Submit an annual report to the governing body on the needs and performance of the County's mental health system.
- Review and make recommendations on the applicants for the appointment of a local director of mental health services. The board shall be involved in the selection process prior to the vote of the governing body.
- Review and comment on the County's performance outcome data and communicate its findings to the California Mental Health Planning Council.

### Managed Care Advisory Group (MCAG)

The MCAG is an advisory group established by Agency/Adult-Older Adult MHS to provide ongoing review, advice, and comment on the implementation of the adult and older adult managed care initiative and system redesign. Membership shall be representative of the ethnic, cultural and organizational groups in the community and include clients, family members, advocates, professionals and Mental Health Board representation.

### Quality Review Council (QRC)

The QRC provides guidance to the Agency/Adult-Older Adult Mental Health System on the development and implementation of quality management planning. Establishment of the QRC is a requirement of the state Department of Mental Health under Medi-Cal managed care consolidation. A more complete description of this group can be found in the quality management plan section of the *SRI Plan.*

### Clinical Staff Association (CSA)

The purpose of the CSA is to increase the value and contributions of clinical staff in carrying out the mission of Agency/Adult-Older Adult Mental Health Services. The CSA provides a forum where clinical administrative issues are discussed and opportunities for formal input and recommendations in matters of program policy and practice are extended. The Agency / CSA executive committee is to work with the Adult-Older Adult Mental Health System Clinical Director to review existing bylaws and to redefine the role and function of the association and develop a timeline for implementing any proposed changes.

### AGENCY REGIONAL GENERAL MANAGER

The Agency has divided the County of San Diego into six geographical service areas: North Coastal, North Inland, Central, North Central, South and East. Each region has unique characteristics distinguishing it from other regions, and mental health regional planning will consider that uniqueness throughout planning efforts.

Five Regional General Managers, under the Agency Chief Operating Officer, oversee County health and human service operations in the regions, including eligibility functions and protective services. Equally important is their responsibility for community and network development and coordination. Countywide services that are located in the region are also the responsibility of the Regional General

Manager. [3] Regional General Managers will provide input to the Local Mental Health Director and the Regional Mental Health Program Coordinators to address mental health needs in their regions. The Regional Mental Health Program Coordinators will continue to work with the Agency Regional General Managers in efforts to integrate and coordinate mental health services into the overall service integration scheme of the Agency, consistent with the Agency's Synergy Plan.

[3] North Inland and North Coastal regions are under one Agency Regional General Manager

# UTILIZATION MANAGEMENT

"Managing care means matching each [client] with a level and duration of care that is most cost-effective. (i.e., provides for the reasonable expectation of achieving specific outcomes with the best use of resources)." A utilization management system must ensure that people who need care get the most appropriate and cost-effective level and type of care, no more and no less *(Mauer and others, 1995).*[4]

## Utilization Management Defined

The National Committee for Quality Assurance defines utilization management (UM) as the processes that "ensure that enrollees have equitable access to care across the delivery system." The American Accreditation HealthCare Commission/Utilization Review Accreditation Commission defines UM as "evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures and facilities...." The goal of UM is to provide for the "reasonable expectation of achieving specific outcomes with the best use of resources." To accomplish this goal, UM processes focus on defining and regulating the level and duration of services in relation to overall capacity and the needs of the clients.

Utilization Review (UR) is one of the UM process tools. UR is the systematic review of case records to assess the appropriateness of the services delivered and to examine the existence of decision and documentation practices required by the provider, delivery system and/or payer. UM functions also include Resource Management and Care Management.

## Agency Mental Health Services Utilization Management Framework

Agency Mental Health Services proposes a system of UM that includes:

- Prospective provider interface when service is requested and concurrent review when service requests extend beyond established criteria for level, amount and timelines for care. Criteria vary according to intensity of services, i.e. inpatient, outpatient, etc.
- Retrospective outpatient chart review on a targeted basis to monitor compliance with County, state and federal guidelines for documentation of care delivered adherence to medical necessity guidelines, and claims and billing accuracy.
- High-risk utilization review and/or utilization management in those circumstances meeting specified, functional, high-risk criteria.

The UM Program will be a cooperative effort between the Agency Mental Health Services, contractors, fee-for-service providers and the ASO to identify and meet the behavioral health care needs of the County's Medi-Cal and Realignment-funded clients. The UM Program will aim to foster communication, collaboration, and information exchange in the delivery of mental health services, and to provide input and feedback to mental health services continuous quality improvement efforts. It will strive to facilitate high quality care, innovation and resource management as a result of both individual and aggregate data collection and to provide information to support establishment of multiple levels of care and expansion of options within the system of care.

[4] Mauer, Barbara and others. *How to Respond to Managed Behavioral Healthcare*. Tiburon, CA: CentraLink, 1995.

The UM Program will conform to established County appeal procedures for denials, reductions, and termination of services. The program will assure cooperation with the procedures for acute levels of care and for other specialty mental health services. This includes the requirement for clients and their providers to be notified of their right to a second opinion and/or a Fair Hearing through the State of California, Department of Mental Health. All direct service contracts shall include the requirement for providers to comply with the appeal procedures, including a log of all complaints, forwarding grievances according to the established process, and following denial and appeals procedures.

## Scope of the Utilization Management Program

In order to assure best practice service delivery, align demand for service with capacity, and manage financial risk, the Agency Adult-Older Adult Mental Health Services' UM Program covers utilization of all aspects of care, including 24-hour acute services, outpatient services, and long term care services. The UM Program will provide oversight of service utilization at multiple levels of the delivery system:

- Individual consumers.
- Organizational providers (Short-Doyle/Medi-Cal certified organizations that are County-operated or have a contract with UBH to provide mental health services in the County).
- Fee-for-service providers (individual M.D.s, Ph.D.s, and other licensed providers who have been credentialed by UBH to provide public mental health services in the County).

Oversight will be accomplished through planned activities at each stage in the delivery of services: (1) prospective review or pre-authorization, (2) concurrent review, (3) and retrospective review.

## Service Need Levels

The UM Program will comply with the requirements of Title 9, California Code of Regulations, Chapter 11, Medi-Cal Specialty Mental Health Services. (*See Appendix II: Medi-Cal Medical Necessity Criteria.)*

In addition, the County will adopt criteria for outpatient service need to further distinguish levels and duration of care. The following information is based on work accomplished by the Care Management Design Team.[5] In summary, the levels of care are:

- **Level I:** Clients who:
  - Require brief services of moderate intensity.
  - Have been treated previously and who require ongoing treatment of low intensity to preserve gains achieved.
  - Require brief or ongoing treatment of low intensity to prevent development of more serious symptoms and/or functional impairment.
- **Level II**: Clients whose vulnerability combined with a serious mental condition creates a need for multiple mental health services of moderate to high intensity in order to address *potential* danger to self or others, significant functional impairment and/or need for case management.

[5] *San Diego County Adult and Older Adult Care Management Design Report*, 1998.

- **Level III**. Clients who present a significant risk to self or others and who cannot be maintained in the community without multiple services of high intensity.[6]

A more complete display of the "Level of Care Criteria - Adults" is included in the Appendix III.

## Utilization Management Processes

The following tables summarize UM processes as they relate to the key elements of the scope of the UM program described above. Detailed protocols and procedures to support the management of 24-hour acute services are currently in place and will be continued.

Following guidelines established during the care management design process, responsibility for completing staff work on the protocols and procedures for outpatient services, is assigned to the Agency/MHS Adult-Older Adult Clinical Work Group. The final plan is to be completed by August 15, 1999. Initial external review of the draft will be by Agency/MHS' Managed Care Advisory Group and will include a process for public comment. After incorporation of recommended changes and editing, the plan will be presented to the Agency/MHS Local Mental Health Director.

Concurrent work also assigned to this group includes drafting the assessment tool, further refining service need criteria, and developing other needed standard forms, including developing the specific UM program documentation requirements. Review and revision of these will follow the procedures discussed in the preceding paragraph. The following matrices display details related to drafting of protocols and procedures assigned to the Clinical Work Group.

[6] When the UM plan is implemented, all new clients will be assigned to a Level of Care at the point they are registered in the system. Clients currently in the system at the time of implementation will be assigned to a Level of Care at the time their treatment plan is due for review.

## 24-Hour Acute Psychiatric Inpatient Services[7] (Medi-Cal Only)

| | PROSPECTIVE REVIEW | CONCURRENT REVIEW | RETROSPECTIVE REVIEW |
|---|---|---|---|
| **FOCUS** | All voluntary and involuntary Medi-Cal clients seeking or referred for inpatient services. | Individuals already in acute psychiatric inpatient beds that have stayed beyond the projected length of stay and/or for whom an extension has been requested. | System wide and provider-level analysis of aggregate utilization and client demographic data. |
| **CRITERIA** | All clients must meet State of California, Title 9 medical necessity criteria for authorization for acute psychiatric inpatient services. | All clients must meet State of California, Title 9 criteria for continued acute psychiatric inpatient services. These are:<br>• Continued presence of indications which meet the medical necessity criteria for admission; or<br>• Serious adverse reaction to medications, procedures, or therapies requiring continued hospitalization; or<br>• Presence of new indications which meet admission criteria; or<br>• Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in an acute psychiatric inpatient setting. | Admission and length of stay data will be part of the data gathering and analysis described above. |
| **METHODS** | • Inpatient facilities' staff will call the Provider Line for notification of admission.<br>• ASO licensed clinical staff will review clinical presentation for medical necessity and approve payment authorization for inpatient admission. | • Designated inpatient facilities' UR staff will call the Provider Line for concurrent review of inpatient stays.<br>• ASO licensed clinical staff will review current clinical presentation for ongoing medical necessity and approve payment authorization for continued stay. | • Analysis of admissions and length of stay extensions by age, voluntary/ involuntary status, inpatient provider, referral source and diagnosis.<br>• Analysis of rates of admission per 1,000 Medi-Cal eligibles, benchmarked to state and national data. |

[7] UM for 24-Hour Acute Psychiatric Inpatient Services funded by Realignment funds will continue to be the responsibility of San Diego County Psychiatric Hospital.

## 24-Hour Acute Psychiatric Inpatient Services Administrative Bed Days

| | PROSPECTIVE REVIEW | CONCURRENT REVIEW | RETROSPECTIVE REVIEW |
|---|---|---|---|
| FOCUS | As described above for acute psychiatric inpatient services. | Individuals already in acute psychiatric inpatient beds that have stayed beyond the projected length of stay and/or who request an extension. | System wide and provider level analysis of aggregate utilization and client demographic data. |
| CRITERIA | All clients must meet State of California, Title 9 requirements for authorization for administrative days. | Admission to the acute psychiatric inpatient service was medically necessary and continued stay necessitated by a temporary lack of appropriate residential placement options at a non-acute facility. | Admission and length of stay data will be part of the data gathering and analysis described above. |
| METHODS | • Inpatient facilities' staff will call the Provider Line for authorization of administrative bed days.<br>• ASO licensed clinical staff will review provider's actions to assure those actions comply with Title 9 requirements. | • Designated inpatient facilities' UR staff will call the Provider Line for concurrent review of inpatient stays.<br>• ASO licensed clinical staff will review provider's actions to assure those actions comply with Title 9 requirements. | • Analysis of admissions and length of stay extensions by age, voluntary/ involuntary status, inpatient provider, referral source and diagnosis.<br>• Analysis of rates of admission per 1,000 Medi-Cal eligibles, benchmarked to state and national data. |

## 24-Hour Acute Services – Crisis Residential Services

| | PROSPECTIVE REVIEW | CONCURRENT REVIEW | RETROSPECTIVE REVIEW |
|---|---|---|---|
| **FOCUS** | All voluntary and involuntary Medi-Cal clients seeking or referred for crisis residential services. | Individuals already in a crisis residential program who have stayed beyond the projected length of stay and/or who request an extension. | System wide and provider-level analysis of aggregate utilization and client demographic data. |
| **CRITERIA** | Individuals in psychiatric crisis requiring 24-hour support and structure to maintain safety or current level of functioning who have no medical complications requiring hospitalization. | Criteria for extension of length of stay:<br>• Continued presence of indications which meet admission medical necessity criteria; or<br>• Serious adverse reaction to medications, procedures, or treatment; or<br>• Presence of new symptoms which meet admission criteria; or<br>• Need for further medical evaluation or treatment that can only be provided within the crisis residential setting. | Admission and length of stay data will be part of the data gathering and analysis described above. |
| **METHODS** | • Crisis residential facilities' staff will call the Provider Line for pre-authorization of admission.<br>• ASO licensed clinical staff will review clinical presentation for medical necessity and approve payment authorization for crisis residential stay. | All clients must meet Mental Health Plan criteria for continued stay in a crisis residential facility. | • Analysis of admissions and length of stay extensions by age, voluntary/ involuntary status, inpatient provider, referral source and diagnosis.<br>• Analysis of rates of admission per 1,000 Medi-Cal eligibles, benchmarked to state and national data. |

## System Access to Adult-Older Adult System of Care Outpatient Services

| | PROSPECTIVE REVIEW | CONCURRENT REVIEW | RETROSPECTIVE REVIEW |
|---|---|---|---|
| FOCUS | • Individuals seeking crisis intervention, screening, assessment, and/or information and referral.<br>• Homeless persons and other individuals needing special outreach services. | Individuals seeking services who are wait-listed for routine[8] access and for whom the time elapsed to receive these services exceeds established standards. | System wide and provider-level analysis of aggregate utilization and client demographic data. |
| CRITERIA | No medical necessity criteria for screening services. | • Services for emergent conditions are to be provided within 4 hours.<br>• Urgently needed services are to be provided within 48 hours.<br>• Routine services are to be provided within 10 business days. | All data on clients seeking this level of care will be analyzed, including telephone logs and in-person requests throughout the system. |
| METHODS | • Access and Crisis Line staff will perform screening and specially trained staff in centrally managed and regional integrated services system programs.<br>• Clients who contact the Access and Crisis Line directly, and screening indicates that the individual meets criteria for psychiatric rehabilitation services, will be given a choice of providers based on their level of service need, region of residence, and in consideration of issues such as provider specialty and gender.<br>• For a client who has made a direct contact with them, the fee-for-service network providers will contact the Access and Crisis Line for telephone screening of the client. | • Provider organizations are to notify the ASO if they are unable to accommodate, within the established standards, individuals who are on a waiting list for services.<br>• In this case, ASO Access and Crisis Line staff will refer clients to fee-for-service or other organizational providers who have appointments available within the established standards for the client's current needs. | Client access to services, availability of service by type and provider level, as well as quality of care, and client involvement in care will be analyzed. |

[8]Routine: Requests for services for an ongoing psychiatric condition where no immediate or urgent danger exists to client or others.

## Psychiatric Rehabilitation Outpatient Services

| | PROSPECTIVE REVIEW | CONCURRENT REVIEW | RETROSPECTIVE REVIEW |
|---|---|---|---|
| FOCUS | Individuals referred for psychiatric rehabilitation services including individual, group, medication support, collateral treatment, and full and partial day rehabilitation services. | Clients currently using psychiatric rehabilitation services who are proposed for:<br>• A change in level of care or amount of services.<br>• Reauthorization after the initial period of services. | • Annual analysis of systemwide and provider level aggregated utilization and client demographic data.<br>• Sample review of a percentage of cases over the course of the fiscal year. |
| CRITERIA | • Medi-Cal eligible clients must meet State of California, Title 9 medical necessity criteria for authorization of specialty mental health services.<br>• Indigent clients must meet Welfare and Institutions Code criteria for Realignment-funded services.<br>• Service Need Criteria will be applied to determine level and duration of psychiatric rehabilitation care.<br>• Individuals meeting Level I criteria will be generally served by fee-for-service network providers.[9]<br>• Organizational providers will generally serve individuals meeting Level II and III.<br>• Individuals meeting Level III criteria will have priority for case management program services. | • Medi-Cal eligible clients must meet State of California, Title 9 medical necessity criteria for authorization for continuing specialty mental health services.<br>• Realignment-funded clients must meet the requirements of the Welfare and Institutions Code.<br>• Service Need Criteria will be applied to determine level and duration of continued psychiatric rehabilitation care. | • A minimum of a five percent stratified sample of all psychiatric rehabilitation services cases across all outpatient providers, including stratification of other variables such as diagnosis, demographics, and cases receiving significantly more or less service than anticipated, will be reviewed and analyzed.<br>• Variances from established standards (in excess of an error rate to be established after beta testing of proposed review tool) will require a more comprehensive case review, corrective action, and/or additional ongoing review and monitoring. |

[9] Certain procedures need to be developed and processes worked out by Agency/MHS staff prior to Level I realignment-funded clients being referred to Mental Health Plan fee-for-service providers. Responsibility for completing this work is assigned to the Agency/MHS Adult Administrative work Group with representation from the Financial and Management Information System Work Groups and other County staff in consultation with representatives of the fee-for-service network. The proposal for accomplishing this process is to be completed by November 1, 1999 and forwarded to the Agency/MHS Local Mental Health Director.

## PSYCHIATRIC REHABILITATION OUTPATIENT SERVICES (CONTINUED)

| | PROSPECTIVE REVIEW | CONCURRENT REVIEW | RETROSPECTIVE REVIEW |
|---|---|---|---|
| METHODS | • All individuals referred from screening for psychiatric rehabilitation services will be assessed using standardized procedures and tools. Up to three visits may be used for this assessment.<br>• When a fee-for-service network provider assesses clients who are deemed not appropriate for psychiatric rehabilitation services, the provider will contact the Access and Crisis Line for assistance in locating appropriate referral to other community resources. | • For **emergent** referrals, the ASO will connect the client with services immediately and ensure that the client is connected to services.<br>• For **urgent** referrals, ASO staff will make 24-hour follow-up calls to assure the client was connected with the provider.<br>• For **routine** referrals, the ASO will match claims data against referrals, to identifying individuals who connected with the provider to which they were referred.<br>• If indicated at any time, depending on the level of need and risk, ASO utilization managers can request outreach services.<br>• For most Level I clients, their primary mental health provider will be their care coordinator (single point of accountability).<br>• All clients meeting Level III criteria and some clients meeting Level II criteria will be referred to the case management program. The assigned case manager, while cooperating with the primary mental health provider, will be the care coordinator (single point of accountability). | Sample cases will be reviewed for:<br>• Medical necessity documentation.<br>• Appropriate care provided.<br>• Documentation of individualized treatment planning, including appropriate timelines, in collaboration with the client.<br>• Financial/claims/billing accuracy.<br>• Documentation meeting standards.<br>Summary data from the reviews will be analyzed. In addition, analysis will be done on:<br>• Hours used, by modality.<br>• Service re-authorizations.<br>Findings from the reviews and analysis of data will be used in continuous quality improvement activities. Regional reports on hours used by modality and service reauthorization will be provided for analysis by County regional mental health staff. These findings will also be used in continuous quality improvement activities. |

**PSYCHIATRIC REHABILITATION OUTPATIENT SERVICES (CONTINUED)**

| | PROSPECTIVE REVIEW | CONCURRENT REVIEW | RETROSPECTIVE REVIEW |
|---|---|---|---|
| **METHODS** (CONTINUED) | **Organizational Providers**<br>At the access point, individuals meeting Level II and Level III criteria will be referred to organizational providers, unless waiting list time prohibits appropriate access to care, a specific provider request is made, or circumstances dictate otherwise on a case by case basis.<br>Organizational providers will be budgeted on an aggregate basis to provide a targeted annual range of units of services in order to manage under and over utilization.<br>**Fee-for-Service Network Providers**<br>At the access point, Medi-Cal eligible individuals meeting Level I criteria will be referred to a fee-for-service network provider. [Note: Whenever possible, clients will be offered a choice of providers.]<br>Providers will receive authorization in advance for medically necessary services within the specified parameters.<br>Functional criteria for ***high risk*** will be established. At the access point, for a client meeting these criteria, the provider will be notified of the client's ***high risk*** status. A referral for case management program services may also be made at the same time. | **Organizational Providers** will be responsible for continuing management of the level and intensity of services provided to their clients.<br>**Fee-for-Service Providers**.<br>Any request for services that exceed 10 sessions, excluding medication management services which are not subject to concurrent review, or that require transfer to a higher level of care or to an organizational provider, will require advance authorization. For ***high risk*** clients, UM staff will review client data on utilization of services and conduct a telephonic review with the fee-for-service network provider to determine:<br>• Client's current clinical status and support needs.<br>• Provider needs related to delivery of comprehensive quality care to the client.<br>• Need for case management program referral.<br>Based on each client's status and stability, ongoing utilization management of ***high-risk*** cases will continue during the episode of care. | |

The following applies to utilization review and management after the tenth session of outpatient psychotherapy by a fee-for-service network provider (excluding medication management):

Utilization management at the client's tenth session of outpatient psychotherapy delivered by a fee-for-service network provider will follow one of two possible courses:

- *For the client receiving brief outcome focused psychotherapy for an acute, non-chronic disorder*, the utilization process will collaboratively clarify treatment outcome goals, assist in focusing intervention strategies to achieve these goals, and determine the number of

sessions needed to complete the episode of care. At this point, sessions needed to complete treatment will be authorized.

- *For the high need/high risk client receiving treatment for a more chronic, complex, and/or multiple disorders*, the utilization process will help clarify and focus treatment outcome goals and authorize care. The process will also collaboratively identify provider needs related to the delivery of comprehensive, integrated quality of care, including additional clinical, case management and support services needed. The provider will be supported to make key linkages with community-based services and other local resources.
- *Individual fee-for-service network providers, whose practice patterns indicate a high volume of clients receiving psychotherapy in longer episodes of care,* will be invited to continuing education workshops designed to develop and support skills. Areas such as; effective treatment strategies with the seriously and persistently mentally ill, utilization management-focused clinical practices; outcome-focused psychotherapy, care coordination strategies, and linkage to the case management program will be included among the educational experiences.

## Specialized Adult-Older Adult Outpatient Services

| | PROSPECTIVE REVIEW | CONCURRENT REVIEW | RETROSPECTIVE REVIEW |
|---|---|---|---|
| FOCUS | Individuals for whom a specialized service is being considered, including psychological testing, Electroconvulsive Therapy (ECT), and consultations to medical units. | No concurrent UM activity after pre-authorization. | Annual analysis of systemwide and provider level aggregated utilization and client demographic data. |
| CRITERIA | **Psychological Testing**<br>• Client meets State of California, Title 9 medical necessity criteria.<br>• Questions exist that can materially affect treatment and care and that have not been answered by comprehensive historical information and interviews.<br>**Electroconvulsive Therapy (ECT)**<br>The client meets DSM IV criteria for a mental disorder known to be responsive to ECT and:<br>• Has failed two adequate trials of antidepressant medications; and/or<br>• Has a past history of positive response to ECT; and/or<br>• Has a life threatening mental illness for which rapid response is needed; and/or<br>• Has a medical condition that precludes use of medication.<br>**Consultations to Medical Units**<br>• Client must be hospitalized for a medical condition and must also meet State of California, Title 9 medical necessity criteria. | No concurrent UM activity. | All data on those seeking care is part of the analysis. |

## SPECIALIZED ADULT-OLDER ADULT OUTPATIENT SERVICES (CONTINUED)

| | PROSPECTIVE REVIEW | CONCURRENT REVIEW | RETROSPECTIVE REVIEW |
|---|---|---|---|
| METHODS (CONTINUED) | • Referring provider (e.g. Primary care physician, Inpatient attending physician) calls the Provider Line and reviews clinical information with ASO clinical staff.<br>• ASO clinical staff approves payment authorization for requested service, and assists in locating appropriate provider. | No concurrent UM activity. | • Services used are analyzed by type (e.g., by level of care, age, provider, diagnosis). |

## Long Term Care Services

| | PROSPECTIVE REVIEW | CONCURRENT REVIEW | RETROSPECTIVE REVIEW |
|---|---|---|---|
| FOCUS | Individuals for whom Long Term Care services are being considered. | Individuals currently in Long Term Care services. | Annual analysis of aggregated system wide and provider level utilization and client demographic data. |
| CRITERIA | Client meets State of California, Title 9 medical necessity criteria and is gravely disabled and has a history of inability to care for self outside of a 24-hour locked setting. | Admission criteria continues to be met and continued stay is required to facilitate rehabilitation to a lesser level of care or is indicated to prevent regression to a more acute level of care. | Admission and length of stay data will be analyzed. |
| METHODS | • Applications or referrals to Long Term Care are made telephonically to the ASO.<br>• A licensed clinician will review the request and assess that the client meets general admission criteria.<br>• The clinician will take the referral request to the ASO's weekly Long Term Care Facility meeting. Appropriate placement will be decided by meeting members.<br>• ASO staff will notify referring organization of acceptance to specific facility and proposed admission date. | Long Term Care facility completes the quarterly treatment progress report, and forwards to the ASO for review. A licensed clinician reviews and approves or denies payment for continued stay. | Long Term Care admissions and days (e.g., by level of care, age, provider, and diagnosis) will be analyzed. |

# QUALITY MANAGEMENT

## Program Goals

Goals of the Agency Adult-Older Mental Health Services Quality Management Program are:

- To assure that quality, cost-effective services are delivered to the clients through continuous improvement of service delivery and supportive services.
- To direct quality improvement efforts toward increasing clients' satisfaction with services and improving treatment and care outcomes.

The Quality Management Program will support system wide, broadly based, continuous quality improvement as an essential management method. "A high-quality [mental] health organization reduces the cost of and need for care by adopting better practices, not by restricting care (*Entoven and Vorhaus,* 1997)." To accomplish this, the Quality Management Program will involve clients, family members, providers and stakeholders in quality improvement recommendations and in evaluating the quality of the services delivered.

## Overview

Agency Mental Health Services has overall responsibility for the development and implementation of the Quality Management Plan. The Administrative Services Organization (ASO) will support this effort as negotiated in its contract.

Quality management efforts pertaining specifically to Medi-Cal clients are described in Attachment F of the County of San Diego's *Implementation Plan for Phase II Consolidation of Medi-Cal Specialty Mental Health Services*, approved by the State of California, Department of Mental Health on May 1, 1998. The County is charged with updating the plan if changes are indicated or as required to conform to new state regulations. The Quality Improvement Plan is incorporated in the *SRI Plan* by reference.

## Program Description

Responsibility for developing standards, procedures, and processes related to quality improvement activities is assigned to Agency Mental Health Services' Quality Improvement Work Group (QIWG), under the Mental Health Quality Management Program Manager. The program manager also serves as chair of the QIWG.

Standards, procedures and processes related to treatment planning and direct service delivery and establishment of standards of practice are the responsibility of County Mental Health's Clinical Work Group. The Quality Management Program ensures that these and all quality improvement activities are consistent with State of California Rehabilitation Option and Title 9 regulations, and other relevant federal, state, and County regulations and requirements.

## Program Oversight

### ADULT-OLDER ADULT MENTAL HEALTH SYSTEM QUALITY MANAGEMENT OVERSIGHT

Quality improvement activities will focus on reviewing implementation of the processes, standards, and procedures for treatment, care, and service delivery. Members of the QIWG will be responsible

for oversight coordination of quality management activities for the Agency Adult-Older Adult Mental Health System. This includes planning and coordination of quality management activities for administrative and direct service functions and components, such as access to services, authorization decisions, medical records, billings and claims, coordination with the physical health care, and reviewing data from the management information system. Findings from these activities shall be shared within the adult system (and externally as appropriate) for joint planning, decision making about changes needed, and corrective action where indicated.

Implementation of the Quality Management Plan and quality improvement oversight and monitoring for Agency Adult-Older Adult Mental Health Services will be performed by the Quality Improvement Work Group to include both County and ASO staff.

### REGIONAL QUALITY IMPROVEMENT COMMITTEE (RQIC)

Each Regional Mental Health Program Coordinator will be responsible for quality management monitoring in his or her region(s). The Regional Mental Health Program Coordinator will develop the regional annual quality management work plan with input from the RQIC and other interested parties, including the Regional General Managers. The work plans shall be an attachment to the Agency *Adult-Older Adult Mental Health System Quality Management Plan* due September 1, 1999, and annually thereafter. The specific composition of these committees, assigned activities, meeting times, and products will be finalized after being presented to the QIWG.

### WORK GROUPS AND COMMITTEES

Most of the tasks related to quality management and improvement will be done through the following groups and committees:

#### Mental Health Quality Improvement Work Group (QIWG)

The Agency/MHS Quality Management Program Manager, as chair of the QIWG, will lead the QM program and be accountable for development and implementation of the plan. The work group will consist of County Mental Health administrative and regional mental health services staff, and ASO personnel. The QIWG shall meet monthly or as often as needed to:

- Discuss and draft action plans to resolve quality issues.
- Draft new quality management standards and procedures and/or revise existing ones.
- Review quality improvement monitors.
- Review appropriate ASO reports.
- Coordinate Phase I and Phase II State of California Medi-Cal managed care audits.
- Review regional mental health activities and outcomes.

The QIWG shall develop the Agency Adult-Older Adult Mental Health Services' *Quality Improvement Plan*, incorporating by reference the Managed Care Mental Health Plan *Quality Management Plan*. The Agency Adult-Older Adult Mental Health Services' *Quality Improvement Plan* is to include, but not be limited to, the process for how the following will be included in quality improvement activities:

- Information from complaints, grievances, and serious incident reports.

- Continuing trend analysis of acute psychiatric hospital day usage and a review of times for entry to outpatient treatment.
- Analysis of client satisfaction and provider satisfaction surveys.
- Review and analysis of service delivery including access to the system, 24-hour acute services, psychiatric rehabilitation services, and Long Term Care.

The *Quality Improvement Plan*, including the annual work plan shall be developed by the QWIG, with input from the Quality Improvement Council, Regional Quality Improvement Committees, the Managed Care Advisory Group, and the Mental Health Board. The plan shall be submitted to the Local Mental Health Director by October 1, 1999, and updated annually as needed. The annual work plan shall:

- Identify quality improvement activities for the fiscal year.
- Identify any special studies proposed.
- Include the plan for interfacing with the State Department of Mental Health for audits expected during the year and with the Health and Human Services Agency Contract Operations for the annual audit of Mental Health Plan contracts.

**Quality Review Council**

The purpose of the Quality Review Council (QRC) is to provide guidance to the County on the development and implementation of the Agency Adult-Older Adult Mental Health Services' quality management planning and program. Establishment of the QRC fulfills a contractual obligation of Medi-Cal managed care consolidation to create a standing, Countywide body charged with implementation of the quality improvement program and the annual work plan. Broadly, the mission of the QRC is to recommend quality improvement policies and activities and to review and evaluate results of quality improvement activities.

The QRC will have 17 members as follows:

- 2 fee-for-service network clinicians, one of whom is a psychiatrist.
- 5 client members.
- 4 family members.
- 1 client advocate.
- 2 representatives of organizations that provide services in the adult mental health system.
- 2 designees from the Agency Mental Health Administration.
- 1 Agency Mental Health Administration Quality Assurance Program Manager.

# FINANCIAL MANAGEMENT PLAN

## Introduction and Goals of Analysis

The Financial Management Plan provides information on recent and current financial operations of Agency Adult-Older Adult Mental Health Services and outlines financial implications for proposed changes to implement system redesign. The document includes data and reports describing aspects of the current mental health needs in the County, current regional utilization and financial reports.

The first part of this section reports County population characteristics and outlines different approaches to projecting mental health service needs in the County. Next, Fiscal Year 1997-1998 actual program expenditures are described and projections made for contractor and County-operated regional services in Fiscal Year 1999-2000. The data presented in these analyses are drawn from the following major sources.

- **Programs by Region and Type Fiscal Year 1997-1998 Expenditures.** ***(Appendix VI)*** This includes data on County-operated and contracted services showing the reported cost of these programs by regional location of the program. Costs were obtained from the County Medi-Cal cost report.
- **Regional Budget Projections.** ***(Appendix VII)*** Fiscal Year 1999-2000 budget projections were developed from several sources, including proposed Fiscal Year 1999-2000 program budgets for organizational contractors that are managed by the ASO and Fiscal Year 1998-1999 County budgets for County-operated regional programs.
- **Historical Clients and Utilization – Fiscal Year 1998-99.** ***(Appendix VIII)*** This section summarizes an analysis of recent claims experience from the ASO for nine months of Short-Doyle costs and four months of Medi-Cal fee-for-service costs showing actual and annualized projected utilization of services by region of residence of the client. These were used as a basis for allocating fee-for-service utilization and identifying the total number of clients served and the relative number of clients in each region.

County staff prepared several different analyses of overall system revenue and cost as part of this planning process which were distributed and reviewed by mental health stakeholders. For the *SRI Plan*, however the analysis and reporting has been simplified and feedback from the planning efforts, prioritization of needs, and revenue assumptions incorporated into the annual County budget process.

## Review of Needs and Prevalence Estimates

In the following section, a number of basic demographic issues are reviewed as a basis for determining an appropriate method for allocating funds among the regions. These include overall population estimates, poverty level and Medi-Cal populations in each region; estimates of prevalence of serious mental illness; and the number of clients currently served. Based upon these data and the current regional utilization and expenditure levels, Agency Mental Health Services has prepared recommendations for additional funding over the next three years to improve regional equity.

### REGIONAL POPULATION ESTIMATES

Table I data on recent County population characteristics (1995 estimates) was drawn from County sources and the 1997 Data Book prepared for the ASO procurement. Population characteristics that have been used for the Fiscal Year 1999-2000 projections are consistent with the following data.

County 1995 total population for adults and children has been estimated at 2,720,906 by SANDAG. Of this 1,911,283 were adults and older adults. Table I displays the regional distribution of the estimated adult and older adult population.

**TABLE I**

| Region | 1995 Estimated Adult Population | Percentage of Total County Adult Population |
|---|---|---|
| Central | 323,806 | 16.9% |
| No. Central | 472,349 | 24.7% |
| No. Coastal | 302,134 | 15.8% |
| No. Inland | 254,757 | 13.3% |
| East | 311,701 | 16.3% |
| South | 246,536 | 12.9% |
| **Total** | **1,911,283** | **100.0%** |

*Source: San Diego Association of Governments (SANDAG), Demographic Characteristics, 1995.*

Based upon County estimates of population growth, for Fiscal Year 1999-2000 Agency Mental Health Services assumes a population increase of approximately 5.3 percent from the 1995 levels.

### MEDI-CAL ELIGIBLE AND POVERTY POPULATION ESTIMATES BY REGION

Table II shows the totals for persons eligible for Medi-Cal and adults-in-poverty (according to Federal Poverty Levels) in each region. Also, the regional percentages of total Medi-Cal eligibles and total estimated adults-in-poverty have been calculated, since these data are different ways for the possible allocation of funds for each region. The poverty estimates and the percentages of the regional adult population permit ready identification of a key indicator for each region's economy. Research indicates that poverty levels have been the most highly correlated population statistic with mental health utilization.

**TABLE II**

| Region | Number of Medi-Cal Eligibles | % of Total Medi-Cal Eligibles | Number of Adults in Poverty | % of All Adults in Poverty | Poverty % of Reg. Adult Pop. |
|---|---|---|---|---|---|
| Central | 48,250 | 31.5% | 56,476 | 30.7% | 17.4% |
| No. Central | 20,868 | 13.6% | 33,664 | 18.3% | 7.1% |
| No. Coastal | 12,653 | 8.3% | 24,777 | 13.5% | 8.2% |
| No. Inland | 12,799 | 8.4% | 19,114 | 10.4% | 7.5% |
| East | 26,604 | 17.4% | 24,151 | 13.1% | 7.7% |
| South | 30,024 | 19.6% | 25,737 | 14.0% | 10.4% |
| Other | 1,817 | 1.2% | - | - | - |
| **Total** | **153,015** | **100.0%** | **183,926** | **100.0%** | N/A |

*Source: Data on Adults-in-Poverty from San Diego Mental Health Services: County Population by Age Group and Ethnicity Under Proposed PAS Regions (1990 Census by Zip Code).*

In developing population projections for Fiscal Year 1999-2000, projections include a zero percent growth assumption for Medi-Cal eligibles, a conservative estimate of the impact of Temporary Aid to Needy Families (TANF) and CalWORKs on the Medi-Cal rolls.[1] In fact, recent County data shows a decline in Medi-Cal eligibles. The estimated indigent population has been assumed to grow by 5.3 percent, consistent with overall population trends. Obviously, if there is a significant change in the San Diego economy, or should Medi-Cal levels decline substantially, these numbers would need to change accordingly.

### PREVALENCE ESTIMATES

According to the Center for Mental Health Services (CMHS), the 12-month prevalence of serious mental illness in people over 18 years of age is estimated at 5.4 percent of the total population. CMHS also estimates that approximately half of these individuals report receiving some type of treatment during a year. Based on these estimates and the total adult and older adult population of each region, Table III estimates the number of adults and older adults with serious mental illness in each region and projects the number who can be expected to receive some mental health services. However, many of those projected to have serious mental illness may receive services through family resources, commercial insurance carriers, community resources, or other funding sources. In the County, as well as in most other mental health programs in the country, public funds support only a fraction of the individuals predicted to have serious mental illness according to the federal prevalence levels. An analysis of the regional utilization as a percentage of the prevalence estimate is presented in Table V.

**TABLE III**

| Prevalence Estimates | | | | |
|---|---|---|---|---|
| **Region** | **1995 Estimated Adult Pop.** | **SMI Prevalence Estimate (5.4%)** | **Projection of SMI Individuals Receiving Services** | **% of Total Projected to Receive Some MH Services** |
| Central | 323,806 | 17,486 | 8,743 | 16.9% |
| No. Central | 472,349 | 25,507 | 12,753 | 24.7% |
| No. Coastal | 302,134 | 16,315 | 8,158 | 15.8% |
| No. Inland | 254,757 | 13,757 | 6,878 | 13.3% |
| East | 311,701 | 16,832 | 8,416 | 16.3% |
| South | 246,536 | 13,313 | 6,656 | 12.9% |
| **Total** | **1,911,283** | **103,209** | **51,605** | **100.0%** |

*Source: San Diego Association of Governments, Demographic Characteristics, 1995 and Center for Mental Health Services prevalence estimates.*

### NUMBERS OF CURRENT CLIENTS

Table IV shows the annualized number of Short-Doyle Medi-Cal clients, fee-for-service (FFS) Medi-Cal clients and indigent/uninsured clients in each region derived from ASO annualized reports using the most recent claims data available for a portion of Fiscal Year 1997-1998 and some of Fiscal Year 1998-1999. The regional distribution of clients is shown as the percent of total clients residing in each region, excluding cases for which regional identifying data was missing.

[1] Note: Most states and many California counties are currently experiencing declines in Medicaid enrollment levels. *(Medicaid in California is called Medi-Cal)*

TABLE IV

| Region | Short-Doyle Medi-Cal Clients | Indigent / non-Medi-Cal Clients | Short-Doyle and Indigent Client Percent | FFS Medi-Cal Clients | Total | Percent of Total Clients |
|---|---|---|---|---|---|---|
| Central | 2,664 | 3,290 | 25.3% | 1,134 | 7,088 | 33% |
| No. Central | 750 | 2,009 | 14.8% | 333 | 3,092 | 14.4% |
| No. Coastal | 683 | 1,180 | 14.2% | 148 | 2,011 | 9.4% |
| No. Inland | 664 | 939 | 12.4% | 212 | 1,815 | 8.5% |
| East | 1,541 | 1,737 | 22.1% | 1,250 | 4,528 | 21.1% |
| South | 999 | 1,100 | 11.2% | 426 | 2,525 | 11.8% |
| Out of Area | 100 | 244 | N/A | 49 | 393 | 1.8% |
| Unknown | 631 | 1,450 | N/A | 5,017 | 7,098 | N/A |
| **Total** | **8,032** | **11,949** | **100%** | **8,569** | **28,550** | **100%** |

Note for the total clients, 5,017 of the projected 7,098 clients in the unknown category are from fee-for-service data where the zip code is missing from the claims and/or eligibility file. For the purposes of additional analysis of possible allocation methods, one approach would be to make the assumption that these unknown cases are distributed evenly across the regions. Although some have questioned this assumption, it represents the best data currently available. As operations continue and data collection improves, Agency Mental Health Services will seek to reduce the number of unknown clients in the data. A more appropriate allocation method may be to use only the client percentages shown for Short-Doyle Medi-Cal and indigent services, since fee-for-service outpatient services will not be a part of the Core Service Cluster procurement.

## GAP ANALYSIS

The actual number of clients as a percent of the projected number of clients is displayed in Table V. The analysis compares the number of adults projected to receive services from Table III with the number of adults actually receiving services from Table IV. Note that these comparisons are useful to understand some of the regional characteristics, however, regions vary significantly in their degree of commercial insurance coverage and economic characteristics. This limits the ability to use the gaps identified in Table V for allocation purposes.

TABLE V

| Region | Projected # "SMI" receiving services | Actual # receiving SDMHS services | Actual as % of Projected Prevalence |
|---|---|---|---|
| Central | 8,743 | 7,088 | 81.1% |
| N. Central | 12,753 | 3,092 | 24.2% |
| N. Coastal | 8,158 | 2,011 | 24.7% |
| N. Inland | 6,878 | 1,815 | 26.4% |
| East | 8,416 | 4,528 | 53.8% |
| South | 6,656 | 2,525 | 37.9% |
| Out of Area | N/A | 393 | N/A |
| Unknown | N/A | 7,098 | N/A |
| **Total** | **51,604** | **28,550** | **55.3%** |

The analysis in Table V should be used only to compare *estimates* of regional access and needs. A more precise allocation of the number of clients of unknown location may significantly change each

region's actual percentage. However, Agency Mental Health Services is using the data to illustrate one view of the *relative* need for publicly funded services among regions. According to these figures, the Central region has the highest percentage of individuals receiving services compared to projected incidence levels. Central region also has the highest rate of poverty and incidence of Medi-Cal eligibility as evidenced in the previous tables. It is not surprising the Central region has a higher share of possible clients, since these are data for publicly assisted mental health services only. The presence of a large number of providers in the Central region may be another reason, since in many areas access and the use of services are highly correlated with the number of providers. Some have argued that this is a sign of "provider-induced" demand for services, rather than "client-driven" demand. Similarly, East County has a relatively high level of clients in comparison to projected need. This may be due in part to the number of board and care facilities in that region.

## Summary of Current Mental Health System Expenditures

### OVERVIEW OF FY 1997-1998 AGENCY/MHS SERVICE EXPENDITURES

Total County program expenditures for Agency Adult-Older Adult Mental Health Services for Fiscal Year 1997-1998 were $68,421,196. This includes all County-operated and contracted programs and an estimate for the actual outpatient Medi-Cal utilization for that year, since the outpatient program did not become the County's responsibility until July 1, 1998. It does not include administration costs. Details of this are shown on Appendix VI. Data have been collected from County Medi-Cal cost report data for Fiscal Year 1997-1998.

Appendix VI outlines all Agency Mental Health Services program expenditures for adult and older adult services in Fiscal Year 1997-1998 by location of provider.[2] The data provide a summary of all contracted agencies and County-operated services and can be used as a baseline for the analysis of changes that may need to occur in provider financing if Mental Health Services shifts to more of a "needs-based" method of allocation. The regional designations have been updated to reflect current Health and Human Services Agency's regional boundaries.

County-operated services and contracted organizational providers are shown with their total expenditures broken out by service and region in the detailed schedule. Service totals, for County-operated and contractor services are shown separately for 24-hour services, case management, "wrap-around" services[3], day treatment, outpatient (by modality) and outreach services. Subtotals for each region by contract, County-operated and fee-for-service expenditures are also summarized.

Appendix VII provides updated information showing only details for the regional distribution of contracted services and County operations based upon data from annualized Fiscal Year 1998-1999 budgets and projected for Fiscal Year 1999-2000. Outpatient services are shown in the aggregate[4]. County operations are shown on the last summary page, using Fiscal Year 1998-1999 budgeted appropriations. Centralized services, such as inpatient services, and fee-for-service outpatient services are not shown in the table as the purpose of these tables is to summarize regional operations *only* for system redesign. The regional data provide more reliable estimates of funds that would be available from current regional operations for the re-procurements of contracted services that are planned as a part of system redesign.

[2] Analysis is for Fiscal Year 1997-1998 expenditures and as a result does not cross-reference exactly with projected Fiscal Year 1999-2000 budget numbers.

[3] Wrap-around services include peer programs and other rehabilitative services.

[4] Services cannot be reliably broken out by modality since cost report data are not yet available for the current year.

To determine projected budget levels for regional core services, the budgets for outpatient, outreach services and day treatment contracts and County operations by the location of the program are summarized in Table VI [5] as a percentage of the total available outpatient and day treatment services in the County.

**TABLE VI**

| Percent of Outpatient and Day Treatment Spending by Location of Providers | | | | | |
|---|---|---|---|---|---|
| ***Central*** | ***No. Central*** | ***No. Coastal*** | ***No. Inland*** | ***East*** | ***South*** |
| 31.1% | 19.7% | 11.6% | 9.7% | 16.6% | 11.3% |

The percentages shown above should be compared to the utilization-based percentages for outpatient and day treatment services developed by residence of client in Table VII (below), since this comparison provides one basis for considering gaps in regional funding equity. Stated another way, the gaps in some regions between the distribution of program funding (Table VI) and the distribution of utilization for current mental health clients shown in Table VII, suggest that some areas with high proportions of mental health clients (such as East County) may have to access services in other regions or may not receive the same levels of service as in other regions. One of the primary goals of system redesign is to ensure that each region has appropriate and equitable levels of services for clients.

## Analysis of Historical Client Service Utilization

Current outpatient and day treatment service expenditures are analyzed by the zip code of the clients' residence in Appendix VIII, using recent ASO data. For this analysis, the region of residence was determined by the most recent mailing address of record. Four months of fee-for-service data and nine months of data for Short-Doyle services were used. The figures have been annualized and reported by modality in Appendix VIII. The regional utilization percentages for outpatient and day treatment services that resulted from this analysis are shown in Table VII.[6]

**TABLE VII**

| Percent of Utilization by Client Residence | | | | | |
|---|---|---|---|---|---|
| ***Central*** | ***No. Central*** | ***No. Coastal*** | ***No. Inland*** | ***East*** | ***South*** |
| 25.3% | 14.8% | 14.2% | 12.4% | 22.1% | 11.2% |

Penetration rates are often used as a measure of access to services. Since the County's mental health system serves both Medi-Cal and indigent clients, penetration must be measured as a percent of the total population. While not all services have been included, the penetration rate for clients who have accessed Short-Doyle services (not fee-for-service outpatient or inpatient services) varies significantly across regions from 0.6 percent in the North Central, North Coastal and North Inland regions to 1.7 percent in Central region. On the other hand, the annual core service cost (outpatient,

[5] Centrally managed services are not included in the percentage allocations since they are available to all regions. These figures do not include outreach services.

[6] Note that this calculation uses each region's total outpatient/day service program expenditures divided by the total for all regions, excluding the data for unknown and out of area clients. The data differ from the ratios shown at the bottom of the page in Appendix VIII because they do not include case management and fee for service costs, since those are not part of the reprocurement process at this time.

outreach and day treatment) per Short Doyle client is somewhat narrower, though the variation is still worthy of further study. It ranges from $1,046 per year in East County to $1,469 in North Central. As a part of the procurement process, Agency Mental Health staff will identify the causes for the variations, seek to reduce the variation, and set targets with providers for cost and access to meet these goals.

## Regional Allocations and Equity

Reallocating funds to be more equitable among regions is sometimes desirable to ensure a more uniform level of access to services. However, experts in the health care fields do not all agree on specific methods for reallocating these funds.[7] Based upon feedback from stakeholders about possible allocation methods and additional analysis of the potential impact of reallocating funds, the *SRI Plan* recommends that:

- Funding for the regional procurement for the first two regions should be based on current funding levels by location of provider; $ .6 million for North Coastal and $ .6 million for North Inland regions.
- As resources become available, regions that are currently receiving funds below the average County per client expenditure for outpatient and day treatment services (not including fee-for-service providers) should be allocated additional equity funds for the expansion of rehabilitation services in their region. Based upon the completed analyses, the South and Central regions are under the County average. North Central is over equity, however many of these programs also serve Central region clients (such as the County clinic located in the North Central region).

Allocation recommendations are based on the following rationale:

- None of the regions is sufficiently funded to warrant taking funds away from any of them. This is based upon a review of benchmarks from other states and counties in California.
- Currently, according to the available data, many clients access service in regions outside their region of residence. These patterns of service utilization across regions are expected to continue at least for the near future. For some clients there may be a clinical reason for the service selection and for others, it may be personal choice. As a result, regional programs should continue serving clients from other regions. This policy supports the maintenance of the current funding levels in the regions until the patterns of client utilization are better understood and additional funds are available to begin to establish regional equity. The plan proposes to make funding adjustments for regional equity incrementally, allowing for review of the utilization patterns before committing additional funds.
- The use of other allocation methods, such as Medi-Cal or poverty levels, resulted in even greater levels of potential change in the existing financing of regions. This would be extremely disruptive to clients and programming.

## Fiscal Year 1999-2000 Budget

As noted above, Agency Mental Health Services and the ASO have annualized Fiscal Year 1998-1999 contracted services and rolled forward current County-operated direct service budgets in order to provide a basis for projections of the regional funding available for system redesign. In order to

[7] For instance the Federal Health Care Financing Administration calculates County specific capitation rates for Medicare HMOs. Differences in these reimbursement rates have limited the expansion of HMOs in many areas of the country and have sparked a federal lawsuit concerning the lack of comparability of benefits across many HMOs in different parts of the country.

continue planning for the regional service system, population-based analyses used in this report will be updated as needed based upon the budget approved by the Board of Supervisors.

There are several sources of new revenue anticipated for Fiscal Year 1999-2000 that might assist in reaching some of the goals for implementing system redesign. These include the following revenue sources:

- Mental Health realignment growth funds.
- State Medi-Cal funding, as a part of Phase II consolidation, for the carve-out benefits from HMOs and pre-paid health plans. These funds have been estimated at $600,000.
- CalWORKs funding for mental health services, recently approved by the Board for $2 million in additional mental health services. Additional funds are available from the state.
- Revenue derived from targeted case management billings generated by the Public Conservator's Office, estimated at more than $400,000.

The Health and Human Services Agency will continue to identify other revenue sources, including the potential for increased Medi-Cal funding (the federal match) for existing County-funded services.

## Unmet Needs

The development of regional integrated systems of psychosocial rehabilitation programs will improve services provided to Agency Mental Health Services adult and older adult clients with serious mental illness. To *fully* meet system redesign goals, additional resources for programming will be required, including funding for:

- Transitional case management services for young people transitioning from Child, Youth and Family Services to the Adult-Older Adult Mental Health system.
- Transitional case management services for clients being discharged from a psychiatric inpatient stay and crisis residential services and who do not have a case manager or primary mental health service provider.
- Expansion or enhancement of resources to expand capacity and build equity between regions.
- An increase in traditional and intensive case management services for seriously mentally ill clients.
- Development of a continuum of crisis intervention programs.
- Addition of regional crisis stabilization beds, using local hospitals where possible and cost effective.
- Specialized services for under-served and special need populations.
- Enhanced psychosocial rehabilitation and recovery services to supplement core services in each of the regions, also including respite care, employment services, transportation, socialization services, self-help and peer support.
- Development of prevention and early intervention services.
- Development of a client and family-staffed "warm line" to support clients and their family members.

Funding to meet these service needs is not currently available. However, locating the financial resources for transitional case management services and the achievement of at least a minimum level

of regional equity is essential to meeting the goals of and ensuring the success of system redesign. Estimated costs for the two priority unmet needs are:

| | |
|---|---|
| Transitional case management | $ 500,000 |
| Regional equity | $ 600,000 |

Establishing a transitional case management program will allow case management services to be provided to an additional 150 to 200 existing clients. The regional equity estimate is based on bringing regions currently below the Agency Mental Health Services average expenditure per client up to the average. Funding for these two high-priority needs is included in the adopted Fiscal Year 1999-2000 Agency budget.

As revenue from cost savings and new revenue is generated, additional unmet needs can be addressed.

# RISK MANAGEMENT PLAN

Health and human services programs involve various levels of program and financial risk for public agencies, contractors and the community. In actuarial terms, "risk" refers to the likelihood, or probability, that something will vary from projections. While risk is most commonly associated with a negative outcome, in health care financing it can mean the likelihood of profits as well as losses.

The SRI Risk Management Plan identifies various methods that public administrators can employ to mitigate the negative consequences of risk. The types of risk that are addressed in the SRI Risk Management Plan include:

- **Performance Risk--**chance that a program or contractor will not perform according to the requirements of the contract or the program of service.
- **Revenue Risk--**likelihood that revenue levels achieved for the health care program may vary from the projected levels. This can include both additional and reduced levels of revenue.
- **Cost Risk**--eventuality that costs for individual services may not be the same as projected in developing budgets and reimbursements. Cost risk can occur at an individual program level or at the overall managed care plan level.
- **Utilization Risk--**likelihood that utilization of services varies from the expected level. For instance, without effective utilization management techniques, the average length of stay for individuals requiring hospitalization may exceed the projected average.
- **Case Mix Risk**--chance that the need for services varies as a result of characteristics of the population being served. For example, the presence of a high number of homeless individuals.
- **Penetration--**possibility that the total number of enrollees, or individuals requiring services, is different than the expected level. Penetration is generally shown as the percent of individuals receiving mental health services in comparison to the total number of individuals eligible.
- **Eligibility or Population Risk**--probability that the number of individuals eligible to receive services is different than projected. An example would be an increase in persons eligible for Medi-Cal.

Each type of risk requires different management. The *SRI Plan* recommends employing a full range of risk management techniques including oversight, data reporting, utilization management, and financial incentives. Plans for each type of risk are outlined in the following chart. The plans vary according to the type of service being managed and the method of contracting for these services.

| Type of Risk | Risk Management Strategies |
|---|---|
| Performance Risk | • Competitive procurement to ensure the most qualified providers.<br>• Implementation of performance incentives in regional contracts over time.<br>• Extensive monitoring of performance by the ASO and County contracts.<br>• Implementation of regional Quality Improvement efforts with contractors. |

| Type of Risk | Risk Management Strategies |
|---|---|
| Revenue Risk | • Continue contingency payments for additional revenue through ASO contract.<br>• Penalize reduced revenue levels.<br>• Centrally manage revenue recovery and maximization efforts to ensure consistency of implementation and data collection.<br>• Explore the use of other revenue contractors if not meeting targets. |
| Cost Risk | • Financial monitoring of providers, including review of Medi-Cal cost reports and financial statements.<br>• Regular reporting on expenditures of the plan.<br>• Negotiations on reimbursement levels and competition with providers over the implementation period.<br>• Use of maximum obligations on organizational provider contracts and cost reimbursement provider payments.<br>• Maintain a Countywide risk reserve for variable cost services. |
| Utilization Risk | • Implementation of program and service standards for levels of care to clients.<br>• Monitoring of provider utilization and implementation of provider report cards on utilization targets.<br>• Implement Utilization Management procedures for variable cost services, including prior authorization, concurrent review and retrospective review. |
| Case Mix Risk | • Data collection on level of client need, using the extensive work invested in Levels of Care.<br>• Monitoring of provider and regional enrollment by level of need and review when data indicates enrollment shifts.<br>• Development over the next several years of reimbursement models for regional core providers based on case mix using approaches such as Levels of Care. |
| Penetration Risk | • Monitoring of client access and enrollment by region and by Level of Care.<br>• Providing continued access to low cost services across the County.<br>• Ensuring the use of other community resources wherever possible.<br>• Maintain access to needed services while keeping costs down using self-help and other rehabilitative models of service. |
| Eligibility Risk | • County assumes eligibility risk for Medi-Cal from the State under California waiver.<br>• Work collaboratively with small businesses to support comprehensive health insurance.<br>• Manage Medi-Cal caseload and maximize federal revenue for indigent eligibles.<br>• Explore comprehensive health care reform options. |

## Cost Shifting

Another risk to be managed involves shifting costs and client responsibility from one provider or type of service to another; from regional services to centrally managed services and vice versa [8]; and between and among regions. For example, if regional mental health services do not develop local alternatives to acute psychiatric inpatient care and/or make a concerted effort to shorten clients' length of stay in inpatient settings, costs for the centrally managed services may exceed budgeted projections. [9]

Cost shifting will be managed through County oversight at the regional and central levels. This is expected to reduce inappropriate use of services and lead to better management of resources. While a client will be able to access services in any region, the goal is to provide responsive and appropriate rehabilitative services in the region of the client's residence.

Another possible area for cost shifting is between regional core services and fee-for-service clinicians in the region, since these funds will not be "fixed" for each region. To manage this, regions will have expenditure targets for the fee-for-service network and expenditures will be monitored monthly to permit corrective actions and plan for the use of reserves, if needed.

It is recommended that each region be permitted to share in some of the savings realized from centrally managed services. With central County oversight at the regional level and with incentives for providers through the reinvestment of savings and performance measures, significant strides can be made in reducing inappropriate use of services, and in better managing regional resources.

### RISK RESERVE AND MENTAL HEALTH TRUST FUND

The Mental Health Trust fund was established by the Board of Supervisors to permit the County to retain funds that may be saved from inpatient Medi-Cal services for which the County assumed responsibility under Phase I Consolidation. The trust fund receives funds primarily from State managed care sources, though interest is also earned from other State and federal sources. Trust fund monies have been used to start new programs and pay for administrative services required for Phase II Consolidation. The adult services trust fund balance is currently $1,638,222.

The development of an appropriate reserve for system risks is an important piece of the financial plan. A risk reserve may be used to cover unanticipated costs during the year and to build up sufficient capital to weather effects of random variation in costs from projections on a year-to-year basis. It is recommended that the Mental Health Trust Fund be available as the reserve fund (risk pool) to finance possible over-utilization for all variable cost services that will continue to be reimbursed on a fee-for-service basis. These include contracted acute inpatient services (currently for Medi-Cal eligible clients only) and fee-for-service outpatient services. The trust fund balance is excess of 10 percent of the total funding for these variable cost services. From an actuarial perspective, this is more than adequate for this service level.

[8] Specific targets will be developed for each region's projected spending on these services. This will be based on an analysis of historical costs with projections for performance improvement. Regions saving money for the County should be able to reinvest the funds, or a portion of them, in developing their regional mental health system of care.

[9] Agency/Adult Mental Health Services has asked the stakeholder community for additional suggestions and feedback regarding approaches to providing appropriate financial incentives to regional core service providers to avoid cost shifting.

The Trust Fund balance for adult services as of June 1999 is shown below:

| | |
|---|---|
| Balance at 7/1/98 | $ 4,206,870 |
| FY'98-99 UBH Contract | ($1,855,740) |
| FY'99-00 UBH Contract | ($ 712,908) |
| Projected Unobligated Balance – FY'99-2000[10] | $ 1,638,222 |

[10] Does not include any potential savings from Inpatient costs from Fiscal Year 1998-99.

# REGIONAL PROCUREMENT RECOMMENDATIONS

To realize system redesign goals and move from a traditional clinic-based model of treatment and care to one of psychosocial rehabilitation and recovery, competitive procurements for certain regional core services are proposed over the next four and one-half years. The initial procurements will be for specific regional core services (outpatient, outreach, and day rehabilitation), followed by designated case management services. Over time, Agency Mental Health Services proposes to re-compete all existing contracted adult and older adult mental health programs on a regularly scheduled basis.

To recommend the first two regions for competitive procurement of core services, data were reviewed on current adult and older adult expenditures, the size of the regions, the scope of services provided and relative regional funding levels. As a result, the North Coastal and North Inland regions are proposed for the first round of competitive procurement. These two regions are recommended for the first year because they are the closest to equity within existing funding, as explained earlier under "Regional Allocations and Equity." Specified services in the South and East regions would be in the second year, and services in Central and North Central in the third year. Competitive procurement of designated case management services would follow.

As the psychosocial rehabilitation model is implemented, it is essential that there is minimal disruption to client care. As psychosocial rehabilitation training, implementation, and accreditation gets underway, services in regions not yet scheduled for procurement will also begin to phase into the rehabilitation model.

## Request for Proposal

A Request for Proposals for adult and older adult mental health outpatient and day rehabilitation services will be developed with assistance from psychosocial rehabilitation specialists. As the administrative services organization for adult and older adult mental health services, United Behavioral Health's contract requires them to assist in competitive procurements for contracted mental health services. Under the direction of Agency mental health staff, UBH will develop the statements of work. The County will handle the procurement process.

The Request for Proposals will specify the service population, describe services to be provided, and establish rehabilitation and recovery standards and criteria for treatment and care. Also, responders will be required to have CARF accreditation, or be actively preparing for this accreditation. The procurement will cover existing, contracted adult-older adult mental health services in the North Coastal and North Inland regions. Responders will have opportunities to propose ways to maximize existing resources, bring new resources into the system, and tailor treatment and care to meet the cultural diversity and geographic configuration of the region. Outpatient service proposers will be expected to describe how they will deliver outreach services to mentally ill homeless persons, and the efforts they will make to connect these individuals with housing and other needed community resources.

Ideally, core service programs in each region will be located together or in close proximity with good access to transportation. For example, a multi-functional psychosocial rehabilitation center might include mobile crisis capability, day rehabilitation with emphasis on vocational and employment

services, individual and group psychotherapy, medication management, support for families and significant others, a drop-in center, and a van and driver for transportation of clients.[11]

Each proposal must include a transition plan for moving clients from existing services into any new services or services delivered by a different provider. The transition plan shall describe steps that will be taken to assure the process is as smooth as possible and that any special needs of the clients will be considered. The procurement process will have a Statement of Work for outpatient clinic-type services including outreach and day rehabilitation services.

Plans for managed competition of some County-provided services have been suspended to allow the Health and Human Services Agency to focus on implementing system redesign, which incorporates psychosocial rehabilitation, throughout the county.

The proposed schedule for procurements for regional core services and case management services is presented in the following section.

## SYSTEM REDESIGN IMPLEMENTATION PLAN TIMELINE

The following timeline describes the steps of the process completed to date and the proposed times for training and competitive procurements in order to implement system redesign in the County.

**DECEMBER 1998 - JUNE 1999**

- System Redesign Implementation concept approved by Health and Human Services Agency Administration, County Chief Administrative Officer and reviewed with Board staff.
- *System Redesign Implementation* Plan *(SRI Plan)* finalized and approved for release for public comment.
- Draft document released for 14-day public comment period.
- Public comments received and document edits completed.

**JULY - DECEMBER 1999**

- *SRI Plan* and Board Letter approved by Agency Administration and County Chief Administrative Officer.
- *SRI Plan* presented to Board of Supervisors for approval.
- Planning for and initial psychosocial rehabilitation and recovery training workshops for mental health community members.
- Psychosocial rehabilitation conference for mental health community.
- Request for Proposal (RFP) statement of work for designated regional core services for North Coastal and North Inland developed and released for public review.

**JANUARY - FEBRUARY 2000**

- North Coastal and North Inland Request for Proposal statement of work and standard terms finalized.

[11] Adapted from feedback on the draft *SRI Plan* received during February 1999.

- Request for Proposal released.

**MARCH - JULY 2000**

- Proposals submitted.
- Source Selection Committee evaluates proposals and makes recommendations.
- Contracts negotiated and signed.

**AUGUST - SEPTEMBER 2000**

- Implement North Coastal and North Inland regional core service contracts.

**YEAR 2001**

- Request for Proposal process for Regional Core Services developed (South and East Regions).
- Implement next two regional core service contracts.

**YEAR 2002**

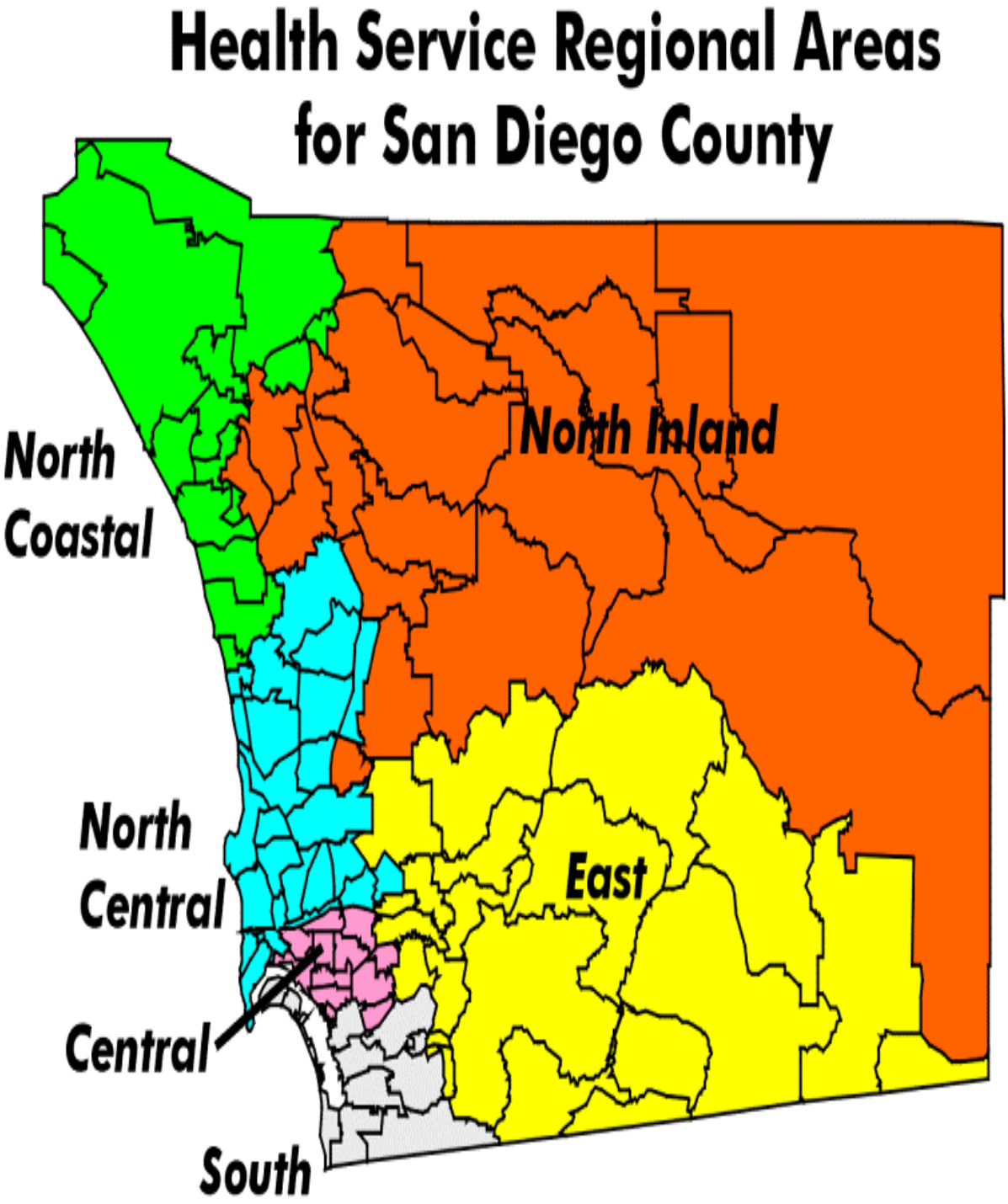
- Request for Proposal process for Regional Core Services developed (Central and North Central Regions).
- Implement last two regional core service contracts.

**YEAR 2003**

- Request for Proposal process for Case Management Services developed (centrally managed, regionally deployed)
- Implement Case Management service contracts.

# APPENDICES

# APPENDIX I: REGIONAL MAP



# APPENDIX II: MEDI-CAL MEDICAL NECESSITY CRITERIA

**CALIFORNIA CODE OF REGULATIONS, TITLE 9, CHAPTER 11, MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES**

The San Diego County Utilization Management Program complies with the requirements of Title 9; specifically the medical necessity criteria of the Code state that:

***Psychiatric Inpatient Hospital***

For Medi-Cal reimbursement for an admission to a psychiatric inpatient hospital, the beneficiary shall meet medical necessity criteria set forth in (1) and (2) below:

1. One of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:
   - Pervasive Developmental Disorders
   - Disruptive Behavior and Attention Deficit Disorders
   - Feeding and Eating Disorders of Infancy and Early Childhood
   - Tic Disorders
   - Elimination Disorders
   - Other Disorders of Infancy, Childhood, or Adolescence
   - Cognitive Disorders (only Dementia with Delusions, or Depressed Mood)
   - Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder
   - Schizophrenia and other Psychotic Disorders
   - Mood Disorders
   - Anxiety Disorders
   - Somatoform Disorders
   - Dissociative Disorders
   - Eating Disorders
   - Intermittent Explosive Disorder
   - Pyromania
   - Adjustment Disorders
   - Personality Disorders

2. A beneficiary must have both:
   - Cannot be safely treated at a lower level of care; and
   - Requires psychiatric inpatient hospital services, as the result of a mental disorder, due the indications in either 1 or 2 below:
     1. Has symptoms or behaviors due to a mental disorder that (one of the following):
        - Represent a current danger to self or others, or significant property destruction; or
        - Prevent the beneficiary from providing for, or utilizing, food clothing or shelter; or
        - Present a severe risk to the beneficiary's physical health; or
        - Represent a recent, significant deterioration in ability to function.
     2. Require admission for one of the following:
        - Further psychiatric evaluation; or
        - Medication treatment; or
        - Other treatment that can reasonably be provided only if the client is hospitalized

***Specialty Mental Health Services***

For Medi-Cal reimbursement for specialty mental health services, the beneficiary shall meet medical necessity criteria set forth in (1), (2), and (3) below:

1. One of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:
   - Pervasive Developmental Disorders, except Autistic Disorders
   - Disruptive Behavior and Attention Deficit Disorders
   - Feeding and Eating Disorders of Infancy and Early Childhood
   - Elimination Disorders
   - Other Disorders of Infancy, Childhood, or Adolescence
   - Schizophrenia and other Psychotic Disorders
   - Mood Disorders
   - Anxiety Disorders
   - Somatoform Disorders
   - Factitious Disorders
   - Dissociative Disorders
   - Paraphilias
   - Gender Identity Disorder
   - Eating Disorders
   - Impulse Control Disorders Not Elsewhere Classified
   - Adjustment Disorders
   - Personality Disorders, excluding Antisocial Personality Disorder
   - Medication-Induced Movement Disorders related to other included diagnoses

2. Must have at least one of the following impairments as a result of the mental disorder(s) listed in (1) above:
   - A significant impairment in an important area of life functioning; or
   - A probability of significant deterioration in an important area of life functioning; or
   - Except as provided in Section 1830.210, a probability a child will not progress developmentally as individually appropriate. *For the purpose of this section, a child is a person under the age of 21 years.*

3 Must meet each of the intervention criteria listed below:
   - The focus of the proposed intervention is to address the condition identified in (2) above; and
   - The expectation is that the proposed intervention will:
     - Significantly diminish the impairment; or
     - Prevent significant deterioration in an important area of life functioning; or
     - Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate; and
     - The condition would not be responsive to physical health care based treatment.

# APPENDIX III: ADULT LEVELS OF CARE CRITERIA

**Assessment Tools for Baseline, Outcomes and Periodic Service Review**

**BASIS 32 (completed by client or with peer assistance)**
**TL-30S, if adopted by the state (completed by client or with peer assistance)**

The San Diego Domain Scale (completed by clinician and client together) is a possible future tool to quantify functioning in domains. However, significant development and testing would be required over a period of at least a year before a valid and reliable tool would be appropriate for use in establishing Service Benefit Categories.

**Context for Utilization of Criteria**

**A clinical interview, psychosocial history and mental status examination has been performed, using DSM-IV, resulting in a clinical assessment, diagnosis, and GAF score. Within this process, information is gathered about strengths and needs in various life domains and about precipitating events in the recent past.** (It is desirable to establish both the current GAF and the highest in the last 12 months.)

**Role of the Client**

**The client is an active participant in the assessment process, and whenever possible, information from and/or participation of the client's support system is highly desirable.**

**General Admission Criteria**

**A DSM-IV diagnosis exists and is the focus of the intervention provided.**

**Included diagnoses:**

- Pervasive Developmental Disorders, except Autistic Disorders
- Disruptive Behavior and Attention Deficit Disorders
- Feeding and Eating Disorders of Infancy and Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia and other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorder
- Eating Disorders
- Impulse Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders related to other included diagnoses

**Excluded diagnoses:**

- Mental Retardation (when this is the only psychiatric diagnosis)
- Learning Disorders
- Motor Skills Disorder
- Communication Disorder
- Tic Disorders
- Delirium, Dementia, and Amnestic and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance Abuse and Substance Dependence Disorders (when this is the only psychiatric diagnosis)
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorder (when this is the only psychiatric diagnosis)
- Other Conditions That May Be A Focus Of Clinical Attention, except Medication Induced Movement Disorders which are included

**A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present.**

- Mental Retardation, Delirium and Dementia, Disorders Due to a General Medical Condition, and Head Trauma conditions that are accompanied by behaviors that require the specialty services of psychiatry or behavioral services are included.
- Substance induced disorders are included.

**AND All of the following:**

- The condition, while meeting the criteria for a specific level services, cannot be safely and effectively serviced at a lower level of care, AND
- The focus of the proposed intervention is to address the impairment and/or symptoms

identified above, AND
- It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment or preventing significant deterioration in an important area of life functioning, AND
- The condition would not be responsive to physical healthcare based treatment.

| **Level I** | **Adult** |
|---|---|
| **Description** | Adults who:<br>• require brief services of moderate intensity, or<br>• have been treated previously and who require ongoing treatment of low intensity to preserve gains achieved, or<br>• require brief or ongoing treatment of low intensity to prevent development of serious symptoms and/or functional impairment<br><br>Clients at this Service Benefit Category have the following characteristics:<br><br>• a good support system<br>• resources to meet basic needs as defined and available by and for client<br>• an understanding of their difficulties<br>• not a danger to self or others<br>• actively involved in recovery. |
| **Admission Criteria** | **General Admission Criteria are met**<br><br>**AND**<br>• GAF score of 51-70<br>**AND**<br>**At least one of the following**:<br>• Significant impairment in an important area of life functioning (home, work, peer relationships)<br>• Significant impairment in sleeping, eating<br>• Significant impairment created by mood changes and/or other symptoms of anxiety or depression<br>• A chronic low risk pattern of threats to self or others with no imminent risk<br>**OR**<br>**At least one of the following**:<br>• Documented past history of high risk to self or others<br>• Documented past history of a higher level of care |
| **Expected Outcomes** | • The beneficiary will maintain gains achieved in previous treatment, preventing the need for more intensive services such as inpatient treatment or IMD placement, AND/OR<br>• The beneficiary will have a stable residential setting, AND/OR<br>• The beneficiary, caregivers, and/or referring system will find the services offered to be satisfactory, AND/OR<br>• Functioning will be improved as demonstrated by changes in the BASIS 32 or TL-30S, AND/OR<br>• Symptoms will be improved with the beneficiary having gained skills regarding symptom self management (including the used of prescribed medications), AND/OR<br>• Linkage will be made to medical care and appropriate aftercare services, AND/OR<br>• Linkage will be made to community supports in consideration of life domain issues (life domains include the spiritual/emotional), AND/OR<br>• The beneficiary and/or caregivers will have an improved ability to use community support services. |

| | |
|---|---|
| **Range of Hours and Expected Service Duration** | **0-10 Standardized Service Hours for one year. Service plan to be reviewed every 12 months** |
| **Level II** | **Adult** |
| **Description** | Adults whose vulnerability combined with a serious mental condition creates a need for multiple services of moderate to high intensity in order to address potential danger to self/others, significant functional impairment and/or need for care coordination. |
| **Admission Criteria** | **General Admission Criteria are met**<br><br>**AND**<br>• GAF score of 41-50<br>AND<br>At least one of the following:<br>**Significant impairment in one or more important area of life functioning (home, work, peer relationships)**<br>• Potential danger to self/others as shown by one of the following in the past 12 months:<br>  • A serious suicide attempt/gesture/ideation<br>  • Documented recent history of violence due to mental illness<br>• Functional impairment with at least one of the following:<br>  • Documented deterioration in daily living activities<br>  • Disruption in activities due to symptoms which respond to mental health intervention<br>  • Symptoms manifested by a thought, mood, memory or perception disorder which require ongoing mental health treatment<br>• Combined impact of diagnoses, symptoms and functioning leading to complex treatment needs<br>• Services are part of a planned program of aftercare services following high intensity treatment<br>**AND**<br>**At least one of the following:**<br>• Unclear diagnostic picture<br>• Symptoms manifested by a thought, mood, memory or perception disorder which require ongoing mental health treatment<br>• Requires concurrent substance abuse services<br>• Persistent history, duration and/or intensity of impairment in sleeping, eating<br>• History, duration and/or intensity of impairment created by symptoms of anxiety, affective psychosis or personality disorders<br>• Behaviors/symptoms that are unresponsive to current psychiatric medications<br>• History of inpatient mental health admissions or at risk for admission<br>• There are ongoing issues of medication compliance putting the beneficiary at risk of decompensation<br>• History suggests will require periodic services to maintain the residential and community relationship |
| **Expected Outcomes** | • The beneficiary will be maintained in the least restrictive setting possible, preventing the need for more intensive services such as inpatient treatment or IMD placement , AND/OR<br>• Substance abuse recovery will be initiated, AND/OR<br>• The beneficiary will be in a stable residential setting, AND/OR<br>• The beneficiary, caregivers, and/or referring system will find the services offered to be satisfactory, AND/OR<br>• Functioning will be improved as demonstrated by changes in the BASIS 32 or TL-30S, AND/OR<br>• Symptoms will be improved with the beneficiary having gained skills regarding |

symptom self management (including the used of prescribed medications), AND/OR
- Linkage will be made to medical care and appropriate aftercare services, AND/OR
- Linkage will be made to community supports in consideration of life domain issues (life domains include the spiritual/emotional), AND/OR
- The beneficiary and/or caregivers will have an improved ability to use community support services.

**Range of Hours and Expected Service Duration**

**11-70 Standardized Service Hours for one year. Service plan to be reviewed at six months for new clients and every twelve months thereafter.**

| **Level III** | **Adult** |
|---|---|
| **Description** | Adults who present a significant risk to self or others and who cannot be maintained in the community without multiple services of high intensity. |
| **Admission Criteria** | **General Admission Criteria are met**<br><br>**AND**<br>• GAF score of 40 and below<br>**AND**<br>**At least one of the following**:<br>• Significant impairment in more than two important areas of life functioning (home, work, peer relationships)<br>• Combined impact of diagnoses, symptoms and functioning leading to highly complex treatment needs<br>• Presents potential risk to self, caregivers, and/or community as demonstrated by suicide attempts and/or very destructive behaviors<br>**AND**<br>**At least one of the following:**<br>• Severe personality disorder (severe affective issues, sexual identity issues, self mutilation)<br>• Severely psychotic (delusional, manic, command hallucinations), rapid cycling<br>• Significant history, duration and/or intensity of impairment in sleeping, eating<br>• Chronic inability to meet basic needs for food, clothing, shelter (grave disability)<br>• History of serious, violent crime<br>• History of ongoing substance abuse which contributes to significant impairment<br>• History of avoiding contact with and use of treatment resources<br>• Behaviors/symptoms that are unresponsive to current psychiatric medications<br>• History of inpatient mental health admissions or at risk for admission |
| **Expected Outcomes** | • Reduce the need for more intensive services such as inpatient treatment or IMD placement, AND/OR<br>• The beneficiary will have a stable residential setting, AND/OR<br>• The beneficiary will have the benefits necessary to support stability, AND/OR<br>• The beneficiary, caregivers, and/or referring system will find the services offered to be satisfactory, AND/OR<br>• Functioning will be improved as demonstrated by changes in the BASIS 32 or TL-30S, AND/OR<br>• Symptoms will be improved with the beneficiary having gained skills regarding symptom self management (including the used of prescribed medications), AND/OR<br>• Linkage will be made to medical care and appropriate aftercare services, AND/OR<br>• Linkage will be made to community supports in consideration of life domain issues (life domains include the spiritual/emotional), AND/OR<br>• The beneficiary and/or caregivers will have an improved ability to use community support services. |
| **Range of Hours** | **71-120 Standardized Service Hours for one year. Service plan to be reviewed at three** |

| | |
|---|---|
| **and Expected Service Duration** | **months for new clients and every six months thereafter.** |

| **Level IV** | **Adult** |
|---|---|
| **Description** | Adults who present very high risk to themselves, caregivers and/or the community and who cannot be maintained in the community, requiring intensive residential services in order to reduce need for inpatient treatment and work for improvement sufficient to allow for treatment in a less restrictive treatment setting<br>**General Admission Criteria are met**<br>**AND**<br>• GAF score of 30 or below<br>**AND**<br>• Chronic inability to meet basic needs for food, clothing, shelter (grave disability)<br>**AND**<br>**At least two of the following:**<br>• Significant impairment in more than two important areas of life functioning (home, work, peer relationships)<br>• Severe personality disorder (severe affective issues, sexual identity issues, self mutilation)<br>• Severely psychotic (delusional, manic, command hallucinations), rapid cycling<br>• Behaviors/symptoms that are unresponsive to current psychiatric medications<br>• Serious risk to self, caregivers, and/or community as demonstrated by suicide attempts and/or assaultive or very destructive behaviors<br>• History of avoiding contact with and use of treatment resources<br>• History of serious, violent crime<br>• History of multiple inpatient mental health admissions or at risk for admission |
| **Expected Outcomes** | • Reduce the need for more intensive services and return to the community , AND/OR<br>• The beneficiary will have a stable residential setting, AND/OR<br>• The beneficiary will have the benefits necessary to support stability, /OR<br>• The beneficiary, caregivers, and/or referring system will find the services offered to be satisfactory, AND/OR<br>• Functioning will be improved as demonstrated by changes in the BASIS 32or TL-30S, AND/OR<br>• Symptoms will be improved with the beneficiary having gained skills regarding symptom self management (including the used of prescribed medications), AND/OR<br>• Linkage will be made to medical care and appropriate aftercare services, AND/OR<br>• Linkage will be made to community supports in consideration of life domain issues (life domains include the spiritual/emotional), AND/OR<br>• The beneficiary and/or caregivers will have an improved ability to use community support services. |
| **Range of Hours and Expected Service Duration** | **Services associated with being served in the facility itself are included in facility costs. In addition, 1-10 Standardized Service Hours for one year (for psychiatric services) are provided through a Level IV authorization. Service plan to be reviewed at twelve months.** |

## Levels of Care Criteria – Older Adults

| | |
|---|---|
| **Assessment Tools for Baseline, Outcomes and Periodic Service Review** | **BASIS 32 (completed by client or with peer assistance)**<br>**TL-30S, if adopted by the state (completed by client or with peer assistance)**<br>The San Diego Domain Scale (completed by clinician and client together) is a possible future tool to quantify functioning in domains. However, significant development and testing would be required over a |

period of at least a year before a valid and reliable tool would be appropriate for use in establishing Service Benefit Categories.

**Context for Utilization of Criteria**

**A clinical interview, psychosocial history and mental status examination has been performed, using DSM-IV, resulting in a clinical assessment, diagnosis, and GAF score. Within this process, information is gathered about strengths and needs in various life domains and about precipitating events in the recent past.** (It is desirable to establish both the current GAF and the highest in the last 12 months.)

**Role of the Client**

**The client is an active participant in the assessment process, and whenever possible, information from and/or participation of the client's support system is highly desirable.**

**General Admission Criteria**

**A DSM-IV diagnosis exists and is the focus of the intervention provided.**

**Included diagnoses:**

- Pervasive Developmental Disorders, except Autistic Disorders
- Disruptive Behavior and Attention Deficit Disorders
- Feeding and Eating Disorders of Infancy and Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia and other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorder
- Eating Disorders
- Impulse Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders related to other included diagnoses

**Excluded diagnoses:**

- Mental Retardation (when this is the only psychiatric diagnosis)
- Learning Disorders
- Motor Skills Disorder
- Communication Disorder
- Tic Disorders
- Delirium, Dementia, and Amnestic and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance Abuse and Substance Dependence Disorders (when this is the only psychiatric diagnosis)
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorder (when this is the only psychiatric diagnosis)
- Other Conditions That May Be A Focus Of Clinical Attention, except Medication Induced Movement Disorders which are included

**A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present.**

- Mental Retardation, Delirium and Dementia, Disorders Due to a General Medical Condition, and Head Trauma conditions that are accompanied by behaviors that require the specialty services of psychiatry or behavioral services are included.
- Substance induced disorders are included.

**AND All of the following:**

- The condition, while meeting the criteria for a specific level services, cannot be safely and effectively serviced at a lower level of care, AND
- The focus of the proposed intervention is to address the impairment and/or symptoms identified above, AND
- It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment or preventing significant deterioration in an important area of life functioning, AND
- The condition would not be responsive to physical healthcare based treatment.

**Factors Unique in the Older Adult Population**

- **Co-morbidity with physical health issues**
- **Recent medical hospitalizations**
- **Multiple medications**
- **End of life issues**
- **Loss of support systems**
- **Lack of social services**
- **Isolation**
- **Transportation needs**
- **Dependence on care givers**
- **Loss of care giver**
- **Financial management**
- **Day- to-day management**
- **Memory impairment**
- **Dementia**
- **Security concerns**
- **Anxiety related to increased vulnerability**
- **Fear of being institutionalized**
- **Fear of costs of care**
- **Decrease in income**
- **Sensory deprivation(s)**
- **Decrease in functional ability**
- **Nutrition problems**
- **Resistance to treatment (medical and mental health)**
- **No resources at age 55-65**
- **Long Term Care Issues**
- **Housing Options**
- **Crisis Residential Treatment**

| Level I | Older Adult |
|---|---|
| **Description** | Older adults who:<br>• Require brief services of moderate intensity, or<br>• Have been treated previously and who require ongoing treatment of low intensity to preserve gains achieved, or<br>• Require brief or ongoing treatment of low intensity to prevent development of serious symptoms and/or functional impairment<br><br>Clients receiving this Service Benefit Category have the following characteristics:<br><br>• a good support system<br>• resources to meet basic needs as defined and available by and for client<br>• an understanding of their difficulties<br>• not a danger to self or others<br>• actively involved in recovery. |
| **Admission Criteria** | **General Admission Criteria outlined are met**<br><br>**AND**<br>• GAF score of 51-70<br>**AND**<br>• Functional impairment in at least one domain or at risk of developing functional impairment in at least one domain because of characteristics unique to older adults.<br>• Significant impairment in sleeping, eating<br>• Significant impairment created by mood changes and/or other symptoms of anxiety or depression<br>• A chronic low risk pattern of threats to self or others with no imminent risk<br>**OR**<br>**At least one of the following**:<br>• Documented past history of high risk to self or others<br>• Documented past history of a higher level of care |
| **Expected Outcomes** | • The beneficiary will maintain gains achieved in previous treatment, preventing the need for more intensive services such as inpatient treatment or IMD placement, AND/OR<br>• The beneficiary will have a stable residential setting, AND/OR<br>• The beneficiary, caregivers, and/or referring system will find the services offered to be satisfactory, AND/OR<br>• Functioning will be improved as demonstrated by changes in the BASIS 32 or TL-30S, AND/OR<br>• Symptoms will be improved with the beneficiary having gained skills regarding symptom self management (including the used of prescribed medications), AND/OR<br>• Linkage will be made to medical care and appropriate aftercare services, AND/OR<br>• Linkage will be made to community supports in consideration of life domain issues (life domains include the spiritual/emotional), AND/OR<br>• The beneficiary and/or caregivers will have an improved ability to use community support services. |
| **Range of Hours and Expected Service Duration** | **0-10 Standardized Service Hours for one year. Service plan to be reviewed every 12 months** |

| Level II | Older Adult |
|---|---|
| **Description** | Older adults whose age-related vulnerability combined with a serious mental condition creates a need for multiple services of moderate to high intensity in order to address potential danger to self/others, significant functional impairment and/or need for care coordination. |
| **Admission Criteria** | **General Admission Criteria outlined are met**<br><br>**AND**<br>• GAF score of 41-50<br>**AND**<br>At least one of the following<br>Potential danger to self/others as shown by one of the following in the past 12 months:<br>  • A serious suicide attempt/gesture/ideation<br>  • Documented recent history of violence due to mental illness<br>• Functional impairment with at least one of the following:<br>  • Documented deterioration in daily living activities<br>  • Disruption in activities due to symptoms which respond to mental health intervention<br>  • Symptoms manifested by a thought, mood, memory or perception disorder which require ongoing mental health treatment<br>• Combined impact of diagnoses, symptoms and functioning leading to complex treatment needs<br>• Services are part of a planned program of aftercare services following high intensity treatment<br>• Requires service- coordination to gain or maintain basic life needs, such as housing, transportation, basic health care, food, etc.<br>• Functional impairment resulting from at least <u>two</u> of the following:<br>  • Physical illness<br>  • Safety issues (housing, personal well being)<br>  • Dementia<br>  • Sensory impairment<br>  • Lack/level of supports<br>  • Inability to meet minimal nutritional, financial or personal care needs |
| **Expected Outcomes** | • The beneficiary will be maintained in the least restrictive setting possible, preventing the need for more intensive services such as inpatient treatment or IMD placement , AND/OR<br>• Substance abuse recovery will be initiated, AND/OR<br>• The beneficiary will be in a stable residential setting, AND/OR<br>• The beneficiary, caregivers, and/or referring system will find the services offered to be satisfactory, AND/OR<br>• Functioning will be improved as demonstrated by changes in the BASIS 32 or TL-30S, AND/OR<br>• Symptoms will be improved with the beneficiary having gained skills regarding symptom self management (including the used of prescribed medications), AND/OR<br>• Linkage will be made to medical care and appropriate aftercare services, AND/OR<br>• Linkage will be made to community supports in consideration of life domain issues (life domains include the spiritual/emotional), AND/OR<br>• The beneficiary and/or caregivers will have an improved ability to use community support services. |
| **Range of Hours and Expected** | **11-70 Standardized Service Hours for one year. Service plan to be reviewed at six months for new clients and every twelve months thereafter.** |

**Service Duration**

| **Level III** | **Older Adult** |
|---|---|
| **Description** | Older adults who present a significant risk to self or others and who cannot be maintained in the community without multiple services of high intensity. |
| **Admission Criteria** | **General Admission Criteria outlined are met**<br>**AND**<br>• GAF score of 40 or below<br>**AND**<br>**At least one of the following**:<br>• Significant impairment in one or more important areas of life functioning (home, work, peer relationships)<br>• Combined impact of diagnoses, symptoms and functioning leading to highly complex treatment needs<br>• Presents significant risk to self, caregivers, and/or community as demonstrated by suicide attempts and/or assaultive or very destructive behaviors<br>**AND**<br>**(a) at least one of the following:**<br>• Severe personality disorder (severe affective issues, sexual identity issues, self mutilation)<br>• Severely psychotic (delusional, manic, command hallucinations), rapid cycling<br>• Significant history, duration and/or intensity of impairment in sleeping, eating<br>• Chronic inability to meet basic needs for food, clothing, shelter (grave disability)<br>• History of serious, violent crime<br>• History of ongoing substance abuse which contributes to significant impairment<br>• History of avoiding contact with and use of treatment resources<br>• Behaviors/symptoms that are unresponsive to current psychiatric medications<br>• History of multiple inpatient mental health admissions<br>**OR**<br>**(b) at least two of the following:**<br>• Physical illness, causing increased impairment<br>• Significant safety issues (housing, personal well being)<br>• Dementia<br>• Sensory and/or motor impairment |
| **Expected Outcomes** | • Reduce the need for more intensive services such as inpatient treatment or IMD placement, AND/OR<br>• The beneficiary will have a stable residential setting, AND/OR<br>• The beneficiary will have the benefits necessary to support stability, AND/OR<br>• The beneficiary, caregivers, and/or referring system will find the services offered to be satisfactory, AND/OR<br>• Functioning will be improved as demonstrated by changes in the BASIS 32 or TL-30S, AND/OR<br>• Symptoms will be improved with the beneficiary having gained skills regarding symptom self management (including the used of prescribed medications), AND/OR<br>• Linkage will be made to medical care and appropriate aftercare services, AND/OR<br>• Linkage will be made to community supports in consideration of life domain issues (life domains include the spiritual/emotional), AND/OR<br>• The beneficiary and/or caregivers will have an improved ability to use community support services. |
| **Range of Hours and Expected** | **71-120 Standardized Service Hours for one year. Service plan to be reviewed at three months for new clients and every six months thereafter.** |

**Service Duration**

| Level IV | Older Adult |
|---|---|
| **Description** | Older adults who present very high risk to themselves, caregivers and/or the community and who cannot be maintained in the community, requiring intensive residential services in order to reduce need for inpatient treatment and work for improvement sufficient to allow for treatment in a less restrictive setting. |
| **Admission Criteria** | **General Admission Criteria outlined are met**<br>**AND**<br>• GAF score of 30 or below<br>**AND**<br>**at least one of the following**:<br>• Significant impairment in more than two important areas of life functioning (home, work, peer relationships)<br>• Combined impact of diagnoses, symptoms and functioning leading to highly complex treatment needs<br>• Presents significant risk to self, caregivers, and/or community as demonstrated by suicide attempts and/or assaultive or very destructive behaviors<br>**AND**<br>**At least one of the following:**<br>• Needs but lacks permanent in-home 24 hour caregiver<br>• Severe personality disorder (severe affective issues, sexual identity issues, self mutilation)<br>• Severely psychotic (delusional, manic, command hallucinations), rapid cycling<br>• Behaviors/symptoms that are unresponsive to current psychiatric medications<br>• Chronic inability to meet basic needs for food, clothing, shelter (grave disability)<br>• History of avoiding contact with and use of treatment resources<br>• History of ongoing substance abuse which contributes to significant impairment<br>• History of serious, violent crime<br>• History of inpatient mental health admissions or at risk for admission<br>**AND**<br>**At least one of the following**:<br>• Physical illness causing increased impairment<br>• Significant safety issues (housing, personal well being)<br>• Dementia<br>• Sensory and/or motor impairment |
| **Expected outcomes** | • Reduce the need for more intensive services and return to the community, AND/OR<br>• The beneficiary will have a stable residential setting, AND/OR<br>• The beneficiary will have the benefits necessary to support stability, AND/OR<br>• The beneficiary, caregivers, and/or referring system will find the services offered to be satisfactory, AND/OR<br>• Functioning will be improved as demonstrated by changes in the BASIS 32 or TL-30S, AND/OR<br>• Symptoms will be improved with the beneficiary having gained skills regarding symptom self management (including the used of prescribed medications), AND/OR<br>• Linkage will be made to medical care and appropriate aftercare services, AND/OR<br>• Linkage will be made to community supports in consideration of life domain issues (life domains include the spiritual/emotional), AND/OR<br>• The beneficiary and/or caregivers will have an improved ability to use community support services. |

| | |
|---|---|
| **Range of Hours and Expected Service Duration** | Services associated with being served in the facility itself are included in facility costs. In addition, 1-10 Standardized Service Hours for one year (for psychiatric services) are provided from a Level IV authorization. Service plan to be reviewed at twelve months. |

# APPENDIX IV: TIMELINE FOR SRI COMPONENT PLANS/RECOMMENDATIONS

| Component | Description | Assigned Lead | Completion Date |
|---|---|---|---|
| **Non-hospital Utilization Management** | • Completing the policy and protocol for non-hospital utilization management<br>• Finalizing procedures and forms to be used | Agency/MHS Adult-Older Adult Clinical Work Group | August 15, 1999 |
| **Youth Transitioning into Adult-Older Adult Mental Health System** | • Reviewing the issues and problems encountered by youth and families during transition to adult mental health services<br>• Developing principles and standards for transition<br>• Proposing programs, activities and procedures to facilitate a successful and seamless transition | Agency/MHS Adult-Older Adult Clinical Work Group with Child, Youth, and Family Committee | October 1, 1999 |
| **SRI Performance Outcome Protocol** | • Review potential measure to be included in outcome protocol<br>• Research implementation issues and concerns associated with the measures<br>• Propose performance and process measures to be included in the first round of the RISS core service procurements<br>• Develop process for implementation of State Department of Mental Health protocol | Agency/MHS Adult Quality Improvement Work Group Performance Outcome Sub-Committee | October 1, 1999 |
| **Dual-diagnosis (substance abuse/mental illness) Program Planning** | • Reviewing the issues and concerns related to serving individuals with co-occurring substance abuse and mental illness<br>• Proposing programs and services for this population<br>• Suggesting sources of funding for program | Agency/MHS Adult-Older Adult Clinical Work Group | February 15, 2000 |

| Component | Description | Assigned Lead | Completion Date |
|---|---|---|---|
| | development, including blended funding<br>• Recommending Memoranda of Agreement and joint program efforts to be developed | | |
| **Expanding Fee-for-Service (FFS) Network** | • Reviewing issues and concerns related to FFS network expansion to include disciplines beyond those in currently in system<br>• Researching experience in other California counties related to this matter<br>• Estimating financial and programmatic impact of expanding FFS network<br>• Recommending future action, procedures, and time line | Agency/MHS Adult Clinical Work Group | March 15, 2000 |
| **Referral of Level I Realignment-funded Clients to FFS Providers** | • Reviewing issue and concerns related to referral of Level I Realignment-funded clients to FFS network providers<br>• Developing methodology and procedures for process<br>• Recommending action and time line | Agency/MHS Adult Administrative Work Group | April1, 2000 |
| **Case Management Program** | • Proposal for developing current case management system into integrated, coordinated delivery<br>• Identifying potential sources for funding expansion of case management services<br>• Developing standards for the way case managers are assigned to clients<br>• Recommending types and amount of outreach services needed to enhance case management<br>• Proposing ways that case management will embody psychosocial rehabilitation principles | Agency/MHS Adult Case Management Lead Person | September 15, 1999 |

| Component | Description | Assigned Lead | Completion Date |
|---|---|---|---|
| | • Developing the method for giving input to the case management procurement process | | |
| **Long Term Care Plan** | • Proposing a process for gate-keeping and monitoring long term care services<br>• Developing priorities for locally based long term care programs<br>• Recommending how case management should be provided to clients in long term care<br>• Proposing monitoring and performance outcome protocols for long term care<br>• Developing the plan for transitioning long term care clients into local outpatient and residential programs | Agency/MHS Clinical Work Group with UBH Key Staff | October 1, 1999 |
| **Services to Older Adults** | • Reviewing issues and concerns related to treatment, care and programming for older adults<br>• Reviewing past and current planning efforts<br>• Recommending service continuum and potential sources of funding | Agency/MHS Clinical Work Group | January 15, 2000 |
| **Continuing Training for System Redesign Implementation** | • Assessing training needs across providers and programs<br>• Developing standards for meeting training needs<br>• Proposing curriculum, time line, potential trainers, and resources | Agency/MHS Adult Quality Management Committee with Agency Staff Development and UBH Key Staff | March 15, 2000 |

# APPENDIX V: PERFORMANCE OUTCOME MEASURES

## Potential Performance Outcome and Process Measures for System Redesign Implementation

### Process Measures

- Average number of standardized hours or funding per client to be maintained in system
- 24-hour acute mental health service utilization levels, including readmission rates at 30, 60, and 90 days after discharge from a hospital or crisis residence
- Medi-Cal-eligible clients being served as compared to national and statewide averages
- Number of unduplicated clients being served compared to national and statewide averages and *SRI Plan* projections
- Penetration Rate: Percent of San Diego County population receiving services
- RISS core service units compared to projections
- Overhead expenses
- Average cost per case and per standardized service hour
- Ratio of direct service delivery costs to total costs
- Number of client grievances and percent resolved within established guidelines
- Number of State Fair Hearing initiated
- Number of provider complaints and percent resolved within established guidelines
- Number of clients on waiting list for services and length of time from request to receiving first unit of service
- Percent of clients by ethnic background served in comparison with percentages in County population
- Percent of clients who are non-English speaking who receive services from an appropriate bilingual clinician
- Number of trainings for system redesign implementation completed

### Performance Outcomes

#### *System*

- Average length of time between discharge from a 24-hour level of care and completed connection with needed mental health resources as compared to standard established
- Success in implementing psychosocial rehabilitation programming and other services related to system redesign implementation
- Programs meeting revenue targets
- Revenue production by type compared to revenue projections
- Percent of clients competitively employed directly as a result of participation in an Agency/MHS program that are in supported and/or sheltered employment as compared to established standard
- Percent of clients living in the community compared to national benchmarks
- Number of expanded housing alternatives
- Increase in transportation options
- Percent of clients previously homeless in stable housing directly as a result of Agency/MHS housing efforts

- Percent of clients successfully diverted from hospitalization to other appropriate resources after being seen in local hospital emergency rooms

### Client Specific

Improvement in level of functioning

- Current clients:
- _____% of clients satisfied with access to services
- _____% of clients satisfied with services they are receiving
- _____% of clients reporting perceived improvement in presenting situation and/or condition
- Client report of progress toward their goals as specified in treatment plan

- Clients cases closed within specified period of time
- _____% of clients satisfied with services received
- _____% of clients reporting improvement in presenting situation and/or condition
- Client report about reduction in symptoms or condition at time of discharge
- Client report of progress toward their goals as specified in the treatment plan
- Client report about improvement maintained

# APPENDIX VI: FISCAL YEAR 1997-1998 EXPENDITURES BY REGION AND TYPE

# SAN DIEGO COUNTY

## Adult & Older Adult Mental Health Services
## Programs by Region and Type
## Fiscal Year 97-98 Expenditures

| REGION | CONTRACT/ CONTY OPERATED | PROGRAM | 24-HOUR SVCS. | CASE MGMT. | WRAP-AROUND SVCS. | DAY TREATMENT | OUTPATIENT | | | | | OUTREACH | EXPENDED |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | MEDICATION | MHS | CRI. INTERV. | CM Brkg. | MAA | | |
| | | | | | | | | | | | | | |
| **Central** | Contract Operated | Adult Protective Svcs. | | $355,147 | | | | | | | | | $355,147 |
| | | Areta Crowell Center | $108,204 | | | $126,206 | $167,953 | $204,320 | $8,273 | $60,491 | $1,246 | | $676,693 |
| | | Central Adult Mental Health | | | | $370,470 | $68,042 | $30,008 | $3,546 | $1,896 | $446 | | $474,408 |
| | | Jay Barreto Crisis Center | $713,483 | | | | | | | | | | $713,483 |
| | | New Vistas | $807,019 | | | | | | | | | | $807,019 |
| | | Vista Balboa | $939,476 | | | | | | | | | | $939,476 |
| | | Friend to Friend | | | $141,570 | | | | | | | | $141,570 |
| | | The Meeting Place | | | $102,600 | | | | | | | | $102,600 |
| | | Project Enable | | | | $521,366 | $635,781 | $33,635 | $443 | $18,948 | $26 | | $1,210,199 |
| | | Downtown Mental Health Center | | | | | | $703,960 | | | | | $703,960 |
| | | UPAC Counseling & Treatment Center | | | | | | $518,302 | | | | $35,028 | $553,330 |
| | | Gifford Clinic | | | | | $869,618 | $848,068 | $5,760 | | | | $1,723,446 |
| | | Owen Clinic | | | | | | | | | | $85,000 | $85,000 |
| | | Central (Contracts) Subtotal | $2,568,182 | $355,147 | $244,170 | $1,018,042 | $1,741,394 | $2,338,293 | $18,022 | $81,335 | $1,718 | $120,028 | $8,486,331 |
| | County Operated | Central Region Mental Health | | | | | $99,588 | $118,655 | $3,658 | $17,451 | | $363,598 | $602,950 |
| | Subtotal (Contracts/County) | | $2,568,182 | $355,147 | $244,170 | $1,018,042 | $1,840,982 | $2,456,948 | $21,680 | $98,786 | $1,718 | $483,626 | $9,089,281 |
| | Managed Care Outpatient (Adult)[2] | | | | | | | $1,111,247 | | | | | $1,111,247 |
| | Total Central Region | | $2,568,182 | $355,147 | $244,170 | $1,018,042 | $1,840,982 | $3,568,195 | $21,680 | $98,786 | $1,718 | $483,626 | $10,200,528 |

[1] Budgeted appropriations by low org.
[2] Estimate based on Fiscal Year 1996-1997 data

Source: Contract Operated Programs – United Behavioral Health, Contract Gross Costs, Fiscal Year 1997-1998
County Operated Programs – ARMS Report AF110002, Period 14, FY 1997-98

**REVISED TO REFLECT HHSA REGIONS**

| REGION | CONTRACT/ CONTY OPERATED | PROGRAM | 24-HOUR SVCS. | CASE MGMT. | WRAP-AROUND SVCS. | DAY TREATMENT | OUTPATIENT | | | | | OUTREACH | EXPENDED |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | MEDICATION | MHS | CRI. INTERV. | CM Brkg. | MAA | | |
| **No. Central** | Contract Operated | Douglas Young Clinic | | | | | $166,445 | $142,539 | $3,644 | $2,383 | $446 | | $315,457 |
| | | Project Payee | | $60,003 | | | | | | | | | $60,003 |
| | | SD Alliance for Mentally Ill | | | | | | $88,589 | | | | $128,722 | $217,311 |
| | | Partial Hospital Program | | | | $800,641 | $61,255 | | | | | | $861,896 |
| | | Telecare Managed Care | | $1,063,327 | | | | | | | | | $1,063,327 |
| | | East Wind Socialization Ctr | | | $111,906 | | | | | | | | $111,906 |
| | | No. Central Subtotal | $0 | $1,123,330 | $111,906 | $800,641 | $227,700 | $231,128 | $3,644 | $2,383 | $446 | $128,722 | $2,629,900 |
| | | | | | | | | | | | | | |
| | County Operated | No. Central Region Mental Health | | | | | $1,918,086 | $139,742 | $44,123 | $13,519 | | $356,792 | $2,472,262 |
| | Subtotal (Contracts/County) | | $0 | $1,123,330 | $111,906 | $800,641 | $2,145,786 | $370,870 | $47,767 | $15,902 | $446 | $485,514 | $5,102,162 |
| | Managed Care Outpatient (Adult)[2] | | | | | | | $589,085 | | | | | $589,085 |
| | Total No. Central Region | | $0 | $1,123,330 | $111,906 | $800,641 | $2,145,786 | $959,955 | $47,767 | $15,902 | $446 | $485.514 | $5,691,247 |

| REGION | CONTRACT/ CONTY OPERATED | PROGRAM | 24-HOUR SVCS. | CASE MGMT. | WRAP-AROUND SVCS. | DAY TREATMENT | OUTPATIENT | | | | | OUTREACH | EXPENDED |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | MEDICATION | MHS | CRI. INTERV. | CM Brkg. | MAA | | |
| **No. Coastal** | Contract Operated | Casa Pacifica | $164,441 | | | | | | | | $317 | | $164,758 |
| | | Turning Point Crisis Center | $742,798 | | | | | | | | | | $742,798 |
| | | Safe Haven | $51,521 | | | | | | | | | | $51,521 |
| | | Aliso Creek | | | $493,823 | | | | | | | | $493,823 |
| | | Pegasus West | | | | $178,556 | | $26,319 | $3,957 | | | | $208,832 |
| | | Psychiatric & Counseling Svcs. | | | | | $111,334 | $166,724 | $287 | $2,022 | | | $280,367 |
| | | No. Coastal Subtotal | $958,760 | $0 | $493,823 | $178,556 | $111,334 | $193,043 | $4,244 | $2,022 | $317 | $0 | $1,942,099 |
| | | | | | | | | | | | | | |
| | County Operated | No. Coastal Region Mental Health | | | | | $1,329,917 | $324,133 | $2,287 | | | $269,905 | $1,926,242 |
| | Subtotal (Contracts/County) | | $958,760 | $0 | $493,823 | $178,556 | $1,441,251 | $517,176 | $6,531 | $2,022 | $317 | $269,905 | $3,868,341 |
| | Managed Care Outpatient (Adult) [2] | | | | | | | $173,213 | | | | | $173,213 |
| | Total No. Coastal Region | | $958,760 | $0 | $493,823 | $178,556 | $1,441,251 | $690,389 | $6,531 | $2,022 | $317 | $269,905 | $4,041,554 |

[1] Budgeted appropriations by low org.
[2] Estimate based on Fiscal Year 1996-1997 data

Sources: Contract Operated Programs – United Behavioral Health, Contract Gross Costs, Fiscal Year 1997-1998
County Operated Programs – ARMS Report AF110002, Period 14, FY 1997-98

**REVISED TO REFLECT HHSA REGION**

| REGION | CONTRACT/ CONTY OPERATED | PROGRAM | 24-HOUR SVCS. | CASE MGMT. | WRAP-AROUND SVCS. | DAY TREATMENT | OUTPATIENT | | | | | OUTREACH | EXPENDED |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | MEDICATION | MHS | CRI. INTERV. | CM Brkg. | MAA | | |
| **No. Inland** | Contract Operated | MHS Case Management | | $353,565 | | | | | | | | | $353,565 |
| | | Kinesis North | | | | $346,711 | $145,142 | $64,165 | $4,287 | | | | $560,305 |
| | | No. Inland Subtotal | $0 | $353,565 | $0 | $346,711 | $145,142 | $64,165 | $4,287 | $0 | $0 | $0 | $913,870 |
| | | | | | | | | | | | | | |
| | County Operated | No. Inland Region Mental Health | | | | | $926,180 | $328,172 | $176 | $10,655 | | $226,058 | $1,419,241 |
| | Subtotal (Contracts/County) | | $0 | $353,565 | $0 | $346,711 | $1,071,322 | $392,337 | $4,463 | $10,655 | $0 | $226,058 | $2,405,111 |
| | Managed Care Outpatient (Adult) [2] | | | | | | | $178,761 | | | | | $178,761 |
| | Total No. Inland Region | | $0 | $353,565 | $0 | $346,711 | $1,071,322 | $571,098 | $4,463 | $10,655 | $0 | $226,058 | $2,583,872 |

| REGION | CONTRACT/ CONTY OPERATED | PROGRAM | 24-HOUR SVCS. | CASE MGMT. | WRAP-AROUND SVCS. | DAY TREATMENT | OUTPATIENT | | | | | OUTREACH | EXPENDED |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | MEDICATIO N | MHS | CRI. INTERV. | CM Brkg. | MAA | | |
| **East** | Contract Operated | Halycon Center | $706,404 | | | | | | | | | | $706,404 |
| | | Heartland Adult Mental Health | | | | $309,213 | $82,390 | $20,357 | $2,253 | $5,044 | $1,110 | | $420,367 |
| | | Rural Family Counseling | | | | | $1,899 | $54,749 | $3,078 | | | | $59,726 |
| | | East County Clubhouse | | | | | | | | | | | |
| | | Pegasus East CCTC | | | | $298,188 | $170,954 | $8,771 | $2,655 | | | | $480,568 |
| | | East Region Subotal | $706,404 | $0 | | $607,401 | $255,243 | $83,877 | $7,986 | $5,044 | $1,110 | $0 | $1,667,065 |
| | | | | | | | | | | | | | |
| | County Operated | East Region Mental Health | | | | | $1,949,083 | $331,722 | $11,030 | $32,764 | | $37,285 | $2,361,884 |
| | Subtotal (Contracts/County) | | $706,404 | $0 | $0 | $607,401 | $2,204,326 | $415,599 | $19,016 | $37,808 | $1,110 | $37,285 | $4,028,949 |
| | Managed Care Outpatient (Adult) [2] | | | | | | | $665,242 | | | | | $665,242 |
| | Total East Region | | $706,404 | $0 | $0 | $607,401 | $2,204,326 | $1,080,841 | $19,016 | $37,808 | $1,110 | $37,285 | $4,694,191 |

| REGION | CONTRACT/ CONTY OPERATED | PROGRAM | 24-HOUR SVCS. | CASE MGMT. | WRAP-AROUND SVCS. | DAY TREATMENT | OUTPATIENT | | | | | OUTREACH | EXPENDED |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | MEDICATION | MHS | CRI. INTERV. | CM Brkg. | MAA | | |
| **South** | Contract Operated | Isis Center | $686,108 | | | | | | | | | | $686,108 |
| | | South Bay Guidance Center | | | | | $338,734 | $299,670 | $3,717 | $12,309 | $5,905 | | $660,335 |
| | | Kinesis South | | | | $219,870 | $102,423 | | | | | | $322,293 |
| | | San Ysidro Mental Health | | | | $198,861 | | $701,727 | | | | | $900,588 |
| | | South Region Subtotal | $686,108 | $0 | $0 | $418,731 | $441,157 | $1,001,397 | $3,717 | $12,309 | $5,905 | $0 | $2,569,324 |
| | | | | | | | | | | | | | |
| | County Operated | South Region Mental Health | | | | | | | | | | | |
| | Subtotal (Contracts/County) | | $686,108 | $0 | $0 | $418,731 | $441,157 | $1,001,397 | $3,717 | $12,309 | $5,905 | $0 | $2,569,324 |
| | Managed Care Outpatient (Adult)[2] | | | | | | | $291,316 | | | | | $291,316 |
| | Total | | $686,108 | $0 | $0 | $418,731 | $441,157 | $1,292,713 | $3,717 | $12,309 | $5,905 | $0 | $2,860,640 |

| REGION | CONTRACT/ CONTY OPERATED | PROGRAM | 24-HOUR SVCS. | CASE MGMT. | WRAP-AROUND SVCS. | DAY TREATMENT | OUTPATIENT | | | | | OUTREACH | EXPENDED |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | MEDICATION | MHS | CRI. INTERV. | CM Brkg. | MAA | | |
| **Centralized Services** | Contract Operated | Telecare CHOICES | $3,066,336 | | | | | | | | | | $3,066,336 |
| | | Alpine Convalescent Center | $3,442,922 | | | | | | | | | | $3,442,922 |
| | | Cresta Loma | $4,484,695 | | | | | | | | | | $4,484,695 |
| | | State Hospital | $1,259,900 | | | | | | | | | | $1,259,900 |
| | | Alternative to State Hospital | $840,079 | | | | | | | | | | $840,079 |
| | | Managed Care Inpatient | $7,820,234 | | | | | | | | | | $7,820,234 |
| | | Supplemental Rate Program | $773,434 | | | | | | | | | | $773,434 |
| | | Out-of-County IMD's | $91,790 | | | | | | | | | | $91,790 |
| | | Emergency Shelter Beds | $185,761 | | | | | | | | | | $185,761 |
| | | Respite Care | $29,163 | | | | | | | | | | $29,163 |
| | | Patient Advocate | | | | | | $370,000 | | | | | $370,000 |
| | | Centralized Services – Contract Subtotal | $21,994,314 | $0 | $0 | $0 | $0 | $370,000 | $0 | $0 | $0 | $0 | $22,364,314 |
| | | | | | | | | | | | | | |
| | County Operated | SD Psychiatric Hospital (PERT) | | | | | $18,669 | $15,971 | $131,833 | | | | $166,473 |
| | | Case Management[3] | | $3,627,592 | | | | | | | | | $3,627,592 |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Public Conservatorship Services[3] | | $1,368,242 | | | | | | | | | $1,368,242 |
| | | San Diego Col. Psychiatric Hosp. | $6,343,248 | | | $502,901 | $1,804,865 | $3,307 | $1,607,555 | $109,765 | | $392,602 | $10,764,243 |
| | | Central Svcs. – County Subtotal | $6,343,248 | $4,995,834 | $0 | $502,901 | $1,823,534 | $19,278 | $1,739,388 | $109,765 | $0 | $392,602 | $15,926,550 |
| | Subtotal (Contracts/County) | | $28,337,562 | $4,995,834 | $0 | $502,901 | $1,823,534 | $389,278 | $1,739,388 | $109,765 | $0 | $392,602 | $38,290,864 |
| | Managed Care Outpatient (Adult)[2] | | | | | | | $58,300 | | | | | $58,300 |
| | Total Centralized Services | | $28,337,562 | $4,995,834 | $0 | $502,901 | $1,823,534 | $447,578 | $1,739,388 | $109,765 | $0 | $392,602 | $38,349,164 |

[1]Budgeted appropriations by low org.
[2]Estimate based on Fiscal Year 1996-1997 data
[3]To be distributed regionally

Sources: Contract Operated Programs – United Behavioral Health, Contract Gross Costs, Fiscal Year 1997-1998
County Operated Programs – ARMS Report AF110002, Period 14, FY 1997-98

**REVISED TO REFLECT HHSA REGION**

| REGION | CONTRACT/ CONTY OPERATED | PROGRAM | 24-HOUR SVCS. | CASE MGMT. | WRAP-AROUND SVCS. | DAY TREATMENT | OUTPATIENT | | | | | OUTREACH | EXPENDED |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | MEDICATION | MHS | CRI. INTERV. | CM Brkg. | MAA | | |
| TOTAL MENTAL HEALTH SERVICES | | | | | | | | | | | | | |
| Subtotal (Contracts/County) | | | $33,257,016 | $6,827,876 | $849,899 | $3,872,983 | $10,968,358 | $5,543,605 | $1,842,562 | $287,247 | $9,496 | $1,894,990 | $65,354,032 |
| Managed Care Outpatient (Adult)[2] | | | | | | | | $3,067,164 | | | | | $3,067,164 |
| Total Mental Health Services | | | $33,257,016 | $6,827,876 | $849,899 | $3,872,983 | $10,968,358 | $8,610,769 | $1,842,562 | $287,247 | $9,496 | $1,894,990 | $68,421,196 |

[2] Estimate based on Fiscal Year 1996-1997 data

Sources: Contract Operated Programs – United Behavioral Health, Contract Gross Costs, Fiscal Year 1997-1998
County Operated Programs – ARMS Report AF110002, Period 14, FY 1997-98

**REVISED TO REFLECT HHSA REGION**

# FY 1997-1998 EXPENDITURES

## SUMMARY AND DESCRIPTION OF SERVICES

### County-operated Direct Services

County-operated direct services include the San Diego County Psychiatric Hospital, Psychiatric Emergency Response Team (PERT), public conservatorship, case management, and regional clinics. As the Summary sheet indicates, the total amount expended for these County-operated services in Fiscal Year (FY) 1997-1998 was $24,781,129.

### Contracted Services

Contracted service expenditures for FY 1997-1998 totaled $40,572,903. These programs include 24-hour services, case management, day treatment, outpatient, and outreach. On the regional breakdowns, there is a further analysis of the different types of service, including expenditures for expanded rehabilitation services that will be part of system redesign as well as a breakout of outpatient service modalities.

### Managed Care Services

Expenditures for Managed Care inpatient services in FY 1997-1998 are shown in the "Centralized Services" detail for contracted services at $7,820,235. Managed Care Phase II Consolidation outpatient services have been allocated by region, based on a historical analysis for FY 1996-1997 and are summarized under "All Regions" as $3,067,164. In addition to these funds, the County will be receiving additional monies for mental health services "carved out" from Health Maintenance Organizations (HMOs). These funds, when they are received, will be allocated to each of the regions based on estimates of utilization. They have been estimated at $861,000.

### Long Term Care and State Hospital

Long term care expenditures for FY 1997-1998 are based on costs for Institutions for Mental Diseases (IMD) services (Choices, Alpine, Cresta Loma), state hospital, alternatives to state hospital, supplemental rate for board and care beds, and out-of-county IMDs. Long term care services are shown in the details for "Centralized Services," though there is no specific subtotal shown. The total long term care projected expenditures are $13,959,156.

# APPENDIX VII. SUMMARY OF FISCAL YEAR 1999-2000 PROJECTIONS FOR REGIONAL AND COUNTY-OPERATED PROGRAMS

SAN DIEGO COUNTY OF SAN DIEGO
Adult & Older Adult Mental Health Services
Regional Contracted and County Operated Programs by Region for Selected Services
Summary of Fiscal Year 99-00 Projections

| | BUDGET | | | | |
|---|---|---|---|---|---|
| | CONTRACT OPERATED | | | COUNTY OPERATED | Total Day Treatment & Outpatient/Outreach |
| Region | Day Treatment | Outpatient/Outreach | Sub-Total | Outpatient/Outreach | |
| Central | $ 1.1 M | $ 4.8 M | $ 5.8 M | $ 0.6 M | $ 6.5 M |
| No. Central | $ 0.8 M | $ 0.6 M | $ 1.4 M | $ 2.0 M | $ 3.4 M |
| No. Coastal | $ 0.2 M | $ 0.4 M | $ 0.6 M | $ 1.4 M | $ 1.9 M |
| No. Inland | $ 0.4 M | $ 0.2 M | $ 0.6 M | $ 1.2 M | $ 1.8 M |
| East | $ 0.7 M | $ 0.4 M | $ 1.1 M | $ 2.0 M | $ 3.1 M |
| South | $ 0.4 M | $ 1.9 M | $ 2.3 M | $0.09. M | $ 2.4 M |
| **GRAND TOTAL** | **$ 3.6 M** | **$ 8.3 M** | **$ 11.8 M** | **$7.3 M** | **$19.2M** |

NOTES:

1. County operated Programs are projected at FY 99-00 budgeted expenditure levels and Contracts are projected at the FY 99-00 contract maximum amount.
2. County operated programs medication costs ($2,365,193) are excluded because they have been pooled for FY 99-00.
3. County operated clinic expenditures are based on the six Health & Human Services Agency Region of program location for FY 99-00.

Sources: Contract Operated Programs – United Behavioral Health, Contract Gross Costs, Fiscal Year 1999-00
County Operated Programs – BRASS Proposed Budged (UBH) by low org.. Run date: 6-1-99

# APPENDIX VIII: HISTORICAL CLIENTS AND UTILIZATION FOR FISCAL YEAR 1998-1999

## San Diego Mental Health Budget Analysis

Input Screen: **Historical Clients and Utilization – Fiscal Year 1998/1999** (based on client zip code)

| | TOTAL | CENTRAL | EAST | NORTH CENTRAL | NORTH COASTAL | NORTH INLAND | SOUTH | UNKNOWN | OUT OF AREA |
|---|---|---|---|---|---|---|---|---|---|
| **Annualized Estimates** | | | | | | | | | |
| **1. Unduplicated Clients** | | | | | | | | | |
| FFS MediCal | 8,569 | 1,134 | 1,250 | 333 | 148 | 212 | 426 | 5,017 | 49 |
| SD MediCal | 8,031 | 2,664 | 1,541 | 750 | 683 | 664 | 999 | 631 | 100 |
| SD Non MediCal | 11,949 | 3,290 | 1,737 | 2,009 | 1,180 | 939 | 1,100 | 1,450 | 244 |
| SD Total | 19,980 | 5,954 | 3,278 | 2,759 | 1,863 | 1,603 | 2,099 | 2,081 | 344 |
| Total All | 28,549 | 7,088 | 4,528 | 3,092 | 2,011 | 1,815 | 2,525 | 7,098 | 393 |
| Ratio (All) | 100.00% | 24.83% | 15.86% | 10.83% | 7.04% | 6.36% | 8.84% | 24.86% | 1.38% |
| Ratio (6 Regions only) | 100.00% | 33.66% | 21.50% | 14.68% | 9.55% | 8.62% | 11.99% | | |
| % of MediCal Clients | 41.85% | 46.42% | 38.36% | 64.97% | 58.68% | 51.75% | 43.57% | 20.43% | 62.10% |
| % of Non-Medical Clients | 58.15% | 53.58% | 61.64% | 35.03% | 41.32% | 48.25% | 56.43% | 79.57% | 37.90% |
| TOTAL | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% |
| | | | | | | | | | |
| **2.. Standard Hours** | | | | | | | | | |
| FFS MediCal | 57,018 | 8,417 | 12,047 | 2,544 | 1,340 | 1,813 | 3,254 | 27,181 | 141 |
| SD MediCal | 399,710 | 95,284 | 126,952 | 23,708 | 28,413 | 47,947 | 62,130 | 11,768 | 141 |
| SD Non MediCal | 213,673 | 54,615 | 37,750 | 24,345 | 19,769 | 17,398 | 49,780 | 8,285 | 141 |
| SD Total SD | 613,383 | 149,899 | 164,702 | 48,053 | 48,182 | 65,345 | 111,910 | 20,052 | 281 |
| All Total | 670,401 | 158,317 | 176,750 | 50,597 | 49,522 | 67,158 | 115,164 | 47,234 | 422 |
| | | | | | | | | | |
| **3. Total Costs by Provider Type** | | | | | | | | | |
| FFS Providers | $3,109,770 | $467,433 | $663,888 | $139,404 | $75,531 | $102,714 | $182,910 | $1,455,135 | $22,755 |
| Contractor Case Mgmt. Programs | $2,423,045 | $884,425 | $481,788 | $208,989 | $251,757 | $285,461 | $195,497 | $100,885 | $14,241 |

| | TOTAL | CENTRAL | EAST | NORTH CENTRAL | NORTH COASTAL | NORTH INLAND | SOUTH | UNKNOWN | OUT OF AREA |
|---|---|---|---|---|---|---|---|---|---|
| Co. Case Mgmt. Programs | $4,087,667 | $1,322,217 | $1,887,667 | $180,488 | $128,615 | $232,311 | $230,133 | $25,713 | $80,523 |
| Total Case Management Prog. | $6,510,712 | $2,206,643 | $2,369,455 | $389,477 | $380,372 | $517,772 | $425,631 | $126,599 | $94,764 |
| Contractor OP/Day Service Programs | $11,056,817 | $4,312,640 | $1,678,325 | $1,043,096 | $580,300 | $576,220 | $2,165,280 | $600,404 | $100,552 |
| County OP/Day Service Programs | $10,864,172 | $967,575 | $2,940,143 | $2,057,859 | $2,384,409 | $2,013,659 | $175,857 | $258,993 | $65,677 |
| Total OP/Day Service Programs | $21,920,989 | $5,280,215 | $4,618,468 | $3,100,955 | $2,964,709 | $2,589,879 | $2,341,137 | $859,397 | $166,229 |
| Total Cs Mgmt/OP/ Day Services | $28,431,701 | $7,486,857 | $6,987,923 | $3,490,432 | $3,345,081 | $3,107,651 | $2,766,768 | $985,996 | $260,993 |
| Total FFS+SD Costs | $31,541,471 | $7,954,290 | $7,651,811 | $3,629,836 | $3,420,612 | $3,210,365 | $2,949,678 | $2,441,131 | $283,748 |
| Ratio (All) | 100.0% | 25.2% | 24.3% | 11.5% | 10.8% | 10.2% | 9.4% | 7.7% | 0.9% |
| Ratio (6 Regions only) | 100.0% | 27.6% | 26.6% | 12.6% | 11.9% | 11.1% | 10.2% | | |
| | | | | | | | | | |
| **4. Total Costs by Client Type** | | | | | | | | | |
| Fee for Service MediCal | $3,109,770 | 467,433 | 663,888 | 139,404 | 75,531 | 102,714 | 182,910 | 1,455,135 | $22,755 |
| Short Doyle MediCal | $14,576,944 | 4,355,657 | 3,857,008 | 1,234,860 | 1,473,360 | 1,426,340 | 1,548,983 | 503,129 | $177,607 |
| Subtotal MediCal | $17,686,714 | 4,823,090 | 4,823,090 | $1,374,264 | 1,548,891 | $1,529,054 | $1,731,893 | $1,958,264 | $200,362 |
| Short Doyle Indigent | $13,854,757 | 3,131,200 | 3,131,200 | 2,255,572 | 1,871,721 | 1,681,311 | 482,867 | - | $1,301,172 |
| TOTAL | $31,541,471 | 7,954,290 | $7,954,290 | 3,629,836 | 3,420,612 | $3,210,365 | $2,214,759 | $1,958,264 | $1,501,534 |
| MediCal % | 56% | 61% | 59% | 38% | 45% | 48% | 78% | 100% | 13% |
| Non MediCal % | 44% | 41% | 41% | 62% | 55% | 52% | 22% | 0% | 87% |
| TOTAL | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | | | | | | | | |
| **5. OP/Day Service Modality Report** | | | | | | | | | |
| SD Case | $454,439 | $241,545 | $83,904 | $29,800 | $8,388 | $11,360 | $50,776 | $26,653 | $2,012 |

| | TOTAL | CENTRAL | EAST | NORTH CENTRAL | NORTH COASTAL | NORTH INLAND | SOUTH | UNKNOWN | OUT OF AREA |
|---|---|---|---|---|---|---|---|---|---|
| Management | | | | | | | | | |
| SD Crisis | $610,059 | $182,135 | $172,583 | $130,985 | $20,708 | $22,765 | $41,659 | $31,540 | $7,684 |
| SD Day Treatment | $3,942,461 | $1,225,527 | $1,047,455 | $233,821 | $292,589 | $225,383 | $716,659 | $149,215 | $51,813 |
| SD Medication | $12,606,852 | $2,470,552 | $2,554,896 | $2,230,673 | $2,105,977 | $1,833,015 | $882,481 | $455,963 | $73,295 |
| SD Mental Health Services | $4,307.179 | $1,160,456 | $759,631 | $475,675 | $537,047 | $497,356 | $649,563 | $196,027 | $31,425 |
| SD Total | $21,920,989 | $5,280,215 | $4,618,468 | $3,100,955 | $2,964,709 | $2,589,879 | $2,341,137 | $859,397 | $166,229 |
| | | | | | | | | | |
| **6. Average Costs per Case** | | | | | | | | | |
| FFS Clients | $363 | $412 | $531 | $419 | $510 | $484 | $430 | $290 | $466 |
| SD Clients | $1,097 | $887 | $1,409 | $1,124 | $1,592 | $1,616 | $1,115 | $413 | $483 |
| All Clients | $996 | $1,056 | 1,543 | $1,129 | $1,664 | $1,712 | $1,096 | $139 | $664 |