Alameda County Mental Health Board

Annual Report
2002-2003

April 13, 2004

The Honorable Board of Supervisors
County of Alameda
Administration
1221 Oak Street
Oakland, CA 94612

On behalf of the Alameda County Mental Health Board I am submitting the Mental Health Board Annual Report for FY 2002-2003.

It was my privilege to serve as the Chair for the Mental Health Board for two years. It was a pleasure to work with Board Members who were dedicated and want to ensure the continued high standard of care in this County for those who suffer with mental health issues.

Our primary focus was to advance the work of Behavioral Health Care Services and to improve the system of care for patients. We have had a number of new members and are working on training to insure the continued quality of service by our Board. The continued evaluation of needs and services that are provided to consumers in the system of care in Alameda County are critical to assure local needs in our community.

I am placing this report and attachments on the website for review. This site can be accessed on http://bhcs.co.alameda.ca.us click on Mental Health Board.

Respectfully submitted by:

Karen D. Bridges,
2002-2003 Chairperson, Mental Health Board

Attachments:
Annual Report
Membership Roster
Bylaws
Committees
10 Key Questions & Review (Appendix A)
FY Work Plans (Appendix B)

Annual Report

2002-2003

"Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it's the only thing that ever has." - Margaret Mead

This report is being submitted for the Board of Supervisors review along with additional Appendix's that can be examination for a more in-depth evaluation.

The Alameda County Mental Health Board (ACMHB) has a commitment to ensure that the county's Behavioral Health Care Services provides quality care, in treating members of our diverse community with dignity, courtesy, and respect. This shall be accomplished through advocacy, education, review and evaluation of the Alameda County's mental health needs.

The Mental Health Board of Alameda County is currently active however we have had a number of openings with members being termed out this year. Each of the Board of Supervisors makes three individual appointments. The categories of membership include Consumers, Family Members, Public Interest, Mental Health Professional, and Board of Supervisor member Gail Steel.

The ACMHB is charged with reviewing and evaluating the mental health needs, services, and facilities and are mandated to report to the Board of Supervisors on performance and needs.

The duties of the Board members are to:

- Attend the Mental Health Board meeting on the third Wednesday of the month
- Service on MHB Committees
- Participate in other activities such as the CALMHB/C meeting and training.
- Reviews and approves the PATH Grant and SAMSHA Grant in support of our mission.
- We support and are involved in a number of activities e.g. the May is Mental Health Month.

Director, Marye L. Thomas M.D. and the Behavior Health Care Staff have provided exceptional programs for the Mentally Ill in Alameda County as well as addressing crisis areas and reviewing opportunities for enhanced programs and services. Due to the current economic situation and serous budget restraints the funds for a number of these programs have been scaled back or eliminated. The current financial situation at John George Hospital is of critical concern to the Board and Behavioral Health Care Staff. The impact of the Medical Center and its expenses has also created much discussion and concern.

Board members are appreciative of the quality of our meeting minutes, agendas, facilities and board packets. We are meeting in Hayward with Executive Board meetings being held in Oakland. With new Board Membership we anticipate an increase in participation.

Membership Roster

ALAMEDA COUNTY MENTAL HEALTH BOARD

Chair, Mental Health Board	Anthony Hare
Vice Chair	Karen Bridges
Secretary	
Administrative Liaison	Thomas Walker

District One Alameda County Board of Supervisors Member Scott Haggerty Mental Heath Board Appointees 1 - Open Seat Karen Bridges Marsha McInnis	District Two Alameda County Board of Supervisors Member Gail Steele, President Mental Health Board Appointees David Androff Bernard Flusche Jr. Javier Esquivel
District Three Alameda County Board of Supervisors Member Alice Lai-Bitker **Mental Heath Board Appointees** 2 - Open Seats Anthony Hare	District Four Alameda County Board of Supervisors Member Nate Miley **Mental Heath Board Appointees** 2 - Open Seats Lucas Daumont
District Five Alameda County Board of Supervisors Member Keith Carson **Mental Heath Board Appointees** **1 - Open Seat** Bielle Moore Hal Zawacki	Thomas Walker Senior Program Specialist Alameda County Behavioral Health Care Services MHB Administrative Liaison

Mental Health Board Members can be reached at:
Alameda County Behavioral Health Care Services
2000 Embarcadero Cove, Suite 400
Oakland, CA 94606
Ph (510) 567-8100 Fax (510) 567-8130

Bylaws

BYLAWS

ALAMEDA COUNTY MENTAL HEALTH BOARD

ARTICLE I

Section I NAME

The name of this organization shall be the Alameda County Mental Health Board.

Section II DEFINITION AND PURPOSE (Welfare & Institutions Code, Section 5604)

a. Review and evaluate the Alameda County mental health needs, facilities, services and special problems.

b. Advise the County Board of Supervisors on any aspect of the local mental health programs.

c. Advise the Alameda County Local Mental Health Director on any aspect of the local mental health program.

d. Review any county agreements or contracts entered into pursuant to Section 5650 of the Welfare and Institutions Code.

e. Submit an annual report to the County Board of Supervisors on the needs and performance of the county's mental health system.

f. Review and approve the procedures used to insure citizen and professional involvement in all stages of the planning process.

g. Review and comment on the county's performance outcome data and communicate its findings to the California Mental Health Planning Council.

h. Review and make recommendations on applications for the appointment of a local director of mental health to the County Board of Supervisors. The Mental Health Board shall be included in the Selection process prior to the vote of the Governing Body (Welfare and Institutions Code 5604.2a (6).

i. The Mental Health Board shall assess the impact of the realignment of services from the state to the county, on services delivered to clients and the local community.

j. Perform any other duties requested by the County Board of Supervisors.

k. The Mental Health Board shall develop bylaws to be approved by the Board of Supervisor in accordance with Welfare and Institutions Code Section 5604.5.

Section III RELATIONSHIP TO COUNTY BOARD OF SUPERVISORS

The Mental Health Board will be formalized by County ordinance. It is anticipated that the County Board of Supervisors, by virtue of ordinance and appointment, shall rely on the individual and collective judgment of the board and its members for input on all mental health related issues.

Section IV MEMBERSHIP (Welfare and Institutions Code, Section 5604)

a. The membership of the Mental Health Board shall be determined by the County Board of Supervisors and established by ordinance. The Alameda County Mental Health Board will have 16 members, one of whom shall be a member of the County Board of Supervisors.

b. There shall be an equal number of appointees by each member of the Board of Supervisors. Nothing in this section shall be construed to limit the ability of the governing body to increase the number of members. Local mental health boards may recommend appointees to the county supervisors. Counties are encouraged to appoint individuals who have experience and knowledge of the mental health system. The Mental Health Board membership should reflect the ethnic and cultural diversity of the client population in the county.

c. Fifty percent of the Mental Health Board membership shall be consumers or the parents, spouse, sibling, or adult children of consumers, who are receiving or have received mental health services (8). At least twenty percent of the membership shall be consumers (at least 3), and at least twenty percent shall be families of consumers (at least 3).

d. The Term of each member of the Mental Health Board shall be for three years. The governing board shall equitably stagger the appointments so that approximately one-third of the appointments expire in each year.

e. Each Board member shall serve no more than three consecutive full three-year appointed terms. If appointed to a vacant term, the total service shall not exceed 10 years. Mental Health Board staff shall keep a record of appointment for each board member.

f. No member of the board or his or her spouse shall be a full-time employee or part time county employee of a county mental health service, an employee of the State Department of Mental Health, or an employee of, or paid member of the governing body of a mental health contract agency.

g. Members of the board shall abstain from voting on any issues in which the member has financial interest as defined in Section 87103 of the Government Code (Conflict of Interest).

Section V MEETINGS (Welfare and Institutions Code, Section 56050)

Mental Health Boards shall be subject to the provisions of Chapter 9 (commencing with Section 54950) of Part I of Division 2 of Title 5 of the Government Code, relating to meeting of local agencies (The Brown Act).

In addition:

a. Regular meetings shall be held at least 10 times each year. Regular meetings are currently scheduled for the third Wednesday of the month at Eden Area Multi Service Center, 24100 Amador Street, Hayward, CA from 5:30-8p.m. A change of meeting site will be posted according to the Brown Act.

b. Special meetings shall be convened in the following matter:

1) Upon call of the Chair;

2) In accordance with Government Code section 54956, the Brown Act.

Section VI OFFICERS

a. At the time of election of a Chair there shall also be elected a Vice-Chair, and Secretary.

b. The Chair, Vice Chair, Secretary and Chairs of other committees or their Mental Health Board Designee shall constitute the Executive Committee. These meetings should be attended by appropriate Mental Health Administration staff.

c. The officers shall serve on a yearly basis and be subject to election in June of each year.

Section VII ELECTION OF OFFICERS

a. A Nominating Committee shall be appointed by the Chair in May of each year to consist of no less than two members of the Mental Health Board.

b. The Chair, and Vice-Chair, and Secretary shall not sit as Ex-Officio members of the Nominating Committee.

c. The Nominating Committee shall:

1) Select a slate of officers for the coming year.

2) Secure the verbal consent to serve of those selected.

3) Report back to the full Board in June with a slate of officers for the coming (fiscal—July through June) year.

4) The Chair of the Nominating Committee shall assume the Mental Health Board Chair to accept further nominations and conduct the election of officers during the June meeting of the year.

Section VIII TERMS OF OFFICE

New Officers shall begin their terms in July and serve for one year. No member shall hold more than three consecutive one year terms in the same office.

Section IX VACANCIES IN OFFICE

The Mental Health Board shall hold an election to fill any vacancy occurring in any elective office for the unexpired term.

Section X POWERS & RESPONSIBILITIES OF OFFICERS

a. The Chair shall be the principal executive officer. He/she shall carry out the policies of this organization, its Executive Committee and its general body. He/she shall do everything necessary to carry into effect the purposes of this organization including consultation with the local mental health director (5604.5(d).

b. The Vice-Chair shall do everything necessary to assist the Chair in the performance of his/her duties. In the event of absence of the Chair, the Vice-Chair shall exercise all the powers of the Chair.

c. The Secretary shall take the minutes of the Executive Committee meetings, review the minutes of the Mental Health Board prior to public distribution and assist the Chair and Vice-Chair in the performance of their duties.

Section XI REMOVAL OF OFFICERS

a. An officer may be removed from office, for cause by the majority vote of all members casting secret ballots at an official Board meeting.

b. Adequate formal notice, in writing and person, must be given to any officer of such an impending removal action.

Section XII VACANCIES

When a vacancy occurs, board staff shall contact the appropriate Governing Board member to determine if she/he has a candidate for the vacancy and/or if the member would consider recommendations from the Mental Health Board.

Section XIII QUORUM

A quorum is one person more than one-half of the appointed members.

Section XIV COMMITTEES

a. Committees shall be created as needed to do work of the Board. Standing Committees will meet on a regular basis and to develop and

implement their work plans which shall reflect current board goals and priorities.

Each member of the Mental Health Board will serve on at least one committee, task force, and/or serve as a liaison to another entity or organization.

b. The existing standing committee is the Executive Committee which plans the Board agenda and can act on behalf of the full board under unusual circumstances. The Executive Committee is composed of the Chair, Vice-Chair and Chairs of all other committees or their Mental Health Board designee. Any board member may attend the Executive Committee meetings. Other standing committees shall be approved by the Board to conduct its business in accordance to it's legal responsibilities and corresponding to the current membership of the Board. Each standing Committee shall be chaired by a Mental Health Board member.

c. Ad Hoc Committees shall be set up to reflect the interest and responsibilities of the board.

d. Current liaison responsibilities shall be set up to reflect the interest and responsibilities of the Mental Health Board.

e. The Chair of the Mental Health Board shall appoint the chair of each committee. Board members may choose upon which committee they wish to serve, or may be appointed to a committee or liaison role by the board chair.

f. Committees shall develop annual work plans which will be reviewed by the full board. Any action recommended by a committee shall be acted on by the full board.

Section XV <u>REMOVAL FROM THE BOARD</u>

a. Absence at three consecutive board and/or committee meetings, without just cause and advance notice of such cause prior to the meeting to be missed, shall be grounds to ask the governing board of member's removal.

b. Section 5-19.06 of the Alameda County Administrative Code states: "In cases of misconduct, inability of willful neglect in the performance of his duties, any member may be removed by the affirmative vote of four members of the Alameda County Board of Supervisors. Such member sought to be removed shall be given an opportunity to be heard in his own defense at a public hearing, and shall have the right to appear by counsel and to have process issues to compel the attendance of witnesses , who shall be required to give testimony, if such member of the Board so requests. A full and complete statement of the reasons for such removal, if such member be removed, together with the findings of fact made by the Alameda County Board of Supervisors, with the County Clerk and made a matter of public record."

Section XVI CONFLICT OF INTEREST

Appointments will be subject to State and Federal conflict of interest laws.

Section XVII RULES OF ORDER

Meetings of this organization shall be governed by the authority of the Brown Act and Roberts Rules of Order modified to allow open participation of the Chair, who may also set discussion time limits as appropriate.

Section XVIII EXPENSES

The Board of Supervisors may pay from any available funds the actual and necessary expenses of the members of the mental health board of a community mental health service incurred incident to the performance of their official duties and functions. The expenses of board members may include travel, lodging, child care, and meals for themselves while on official business as approved by the Mental Health Director and the Mental Health Board. A yearly finance report shall be presented to the Mental Health Board so that expenses can be reviewed.

ARTICLE II

SECTION I AMENDMENTS

These bylaws may be amended at any meeting of this organization by a two-thirds vote of the appointed membership of the Alameda County Mental Health Board. These bylaws shall be reviewed periodically to insure compliance with State Law.

SECTION II EFFECTIVE DATE

These bylaws shall go into effect and become effective immediately upon their adoption, and shall be submitted to the Board of Supervisors for their approval and final adoption.

These articles were ratified by the Mental Health Board on February 21, 1996. They were then reviewed by County Counsel and the proposed revisions adopted on October 16th, 1996. The final draft was reviewed and endorsed by the Mental Health Board on November 19, 1997, and submitted for ratification by the Health Committee of the County Board of Supervisors. They were ratified by the Alameda County Board of Supervisors on _____, 1997.

Signed: _____
Myrla Raymundo, Chair, Alameda County Mental Health Board

Alane Friedrich, Chair Emertis, Alameda County Mental Health Board

_____
Keith Carson, Chair, Alameda County Board of Supervisors

Revision of 8/20002 included

Committees

Highlights and Crisis Areas addressed during 2002-2003

Adult Services

Review Committee
Ten Key Questions– Focus on review of the issues for ongoing use and evaluation of the system of care. (Appendix A)

John George Hospital & the Medical Center
Our Board as acted as a vehicle for communication between John George Hospital and BHCS. We created dialogue to address critical issues with Hospital Administrator and staff to help assure the quality of care of patients. One of the problems that the MHB has attempted to address is insufficient affordable housing options resulted in more expensive levels of care and high administrative costs at John George Hospital. John George has experienced a number of other problems that are currently being addressed.

Housing Committee–To improve the Housing situation for individuals with Psychiatric Disabilities in Alameda County, steps to improve the situation are needed. Housing works on ways to provide available, affordable and accessible housing in safe neighborhoods for our cliental with the able assistance of Thomas Walker Housing Coordinator for BHCS.

Front Door Committee- System of Care
Continue to work with the Behavior Health Care Services to see that a quality system of health care is maintained. Budget constraints have impacted recommendations for quality of care.

Children's Services

Support the continue diversion of children in life threatening crises from John George to a more appropriate treatment setting at Children's Hospital.

Awards Committee

The goal of this committee is to improve awareness of the MHB mission along with providing recognition for those in the community who serve in assisting those with mental health issues. We honor individuals and groups for their work on mental health issues.
This program presented at the County Board of Supervisors meeting helps to inform the BOS about the local mental health programs and current issues. For the first time we held the reception at the Museum to honor the recipients of the awards. The Public Awareness Award was given to Michael Epps who produced the award presentation film "City of Hope".

Public Awareness

The Mental Health Board instituted the Public Awareness Committee (PAC) in June 2000. The committee with Dr. Karen Kramer has worked to combat stigma and discrimination for mental health clients and consumers. Meetings are held twice a month. The committee spent the last year developing and training for the Speaker's Bureau and launching the program. Mike Lippitt, from BHCS contributed significantly in these trainings. Several presentations have been made of the Power Point presentation covering the myths and realities about mental health/illness. The big thrust will be in getting speaking engagements and having enough trained participants to complete the mission set for the Bureau. The team consists of three representing the consumer, family and professional perspectives.

Further work is planned to make the Power Point presentation more ethnic specific e.g. addressing the special needs of the Asian community.

The committee is one of the most successful committees in terms of participation from the outside community. They have experienced a great expansion of the public awareness.

Front Door Committee

The Front Door Ad Hoc Committee was created in 1999 to examine a study on how individuals enter and received Psychiatric emergency, crisis and information and referral services that are the entry points into Behavioral Health Care Services. The purpose was to review the study and put together recommendations for changes from the diverse perspectives of the stakeholders.

In 2002-2003 the Front Door Committee's purpose continued to inquire into the current overcrowding situation at John George; examine issues which affect hospitalization and discharge; and provide input into the plans for short and long term crisis stabilization. The committee works to enhance relationships and communication between the department and the community. Currently we are working on administrative options and updating of the recommendations.

Criminal Justice Oversight Committee

Reports on criminal justice issues that affect mentally ill inmates. A Criminal Justice representative reports on behalf the MHA Board and the California Mental Health Association Board.

Appendix A

Ten Key Questions

ALAMEDA COUNTY
MENTAL HEALTH BOARD

TEN KEY REVIEW QUESTIONS
FY 2000-2001

PREPARED BY GARY SPICER
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
OFFICE OF MANAGEMENT SERVICES

FOR THE
ALAMEDA COUNTY MENTAL HEALTH BOARD
ADULT COMMITTEE

MISSION STATEMENTS

Alameda County Behavioral Health Care Services…

Mental Health Services – ***To provide a comprehensive network of integrated programs and services for all people with serious psychiatric disabilities, regardless of age, ethnicity, language or geographic location, in order to minimize hospitalization, stabilize and manage psychiatric symptoms and help such persons achieve the highest possible level of successful functioning in their community of choice; and to provide mental health crisis and recovery services for the general population following major disasters.***

Alameda County Mental Health Board…

The Alameda County Mental Health Board ***has a commitment to ensure that the county's Behavioral Health Care Services provide quality care, while treating members of diverse communities with dignity, courtesy and respect. This shall be accomplished through advocacy, education, review and evaluation of Alameda County's mental health needs.***

The Population To Be Served…

Alameda county is a largely urbanized county of approximately 1.4 million persons. According to population prevalence rates (adult and child) as reported in the U.S. Surgeon General's Report, December, 1999, nearly 365,000 persons in Alameda county may be suffering from the symptoms of mental illness in any given year. Symptoms may range from mild disturbances to serious and persistent mental illness. Persons in this latter group have constituted the 'target group' of county-provided mental health services under the Realignment Act of 1991. Others have been served through the Fee For Service system, which was brought into a single, county-provider system under MediCAL consolidation in 1997.

MENTAL HEALTH BOARD

TEN KEY REVIEW QUESTIONS

The purpose of these key questions is to focus Mental Health Board review on a standard set of issues for ongoing consideration. This will enable the Board to gain a sense of continuity over time, and will allow administration to focus its reports to the Board on a predictable and pre-defined set of issues.

1. Describe your system of care and highlight any changes in the past year.

2. What has happened to the number of acute and sub-acute beds by category? Explain any changes.

3. Describe any changes in availability and utilization of outpatient services by type of service?

4. Describe housing availability for the mentally ill in Alameda county.
   a. Identify and describe the major housing resources and any changes in housing availability.
   b. Describe any changes undertaken to increase access to housing and improve vacancy and housing resource management.

5. Have there been significant changes in resources that affect the flow of funds and/or referrals?
   a. Explain the strategies for dealing with any changes?

6. What priority groups have been identified for services and how are they being served?

7. Did actual revenue meet or exceed the budget?
   a. Explain status of any savings.

8. Have there been significant changes in the needs for and/or availability of services to persons in each of the three major age categories? (under 18, 18-59, 60+)

9. Present a summary of the past fiscal year's accomplishments.

10. Present a summary of future challenges.

KEY QUESTION #1

Describe your system of care and highlight any changes in the past year.

The system of care is comprised of Mental Health Services and Alcohol and Other Drug (AOD) Services. Broadly, these services may be further categorized as 'mandated services' and 'discretionary services'. Among mandated services, we include all services specified under AB 1288 and related California realignment legislation:: Psychiatric crisis or emergency care; inpatient care; outpatient/day care; case management; conservator services; administration and evaluation.

Medi-Cal consolidation requires that Alameda County Behavioral Health Care Services, as the Local Mental Health Plan, provide the full range of mental health services to any Alameda County Medi-Cal beneficiary in need of those services. This mandate covers the range of mental disorders customarily the domain of 'specialty mental health' less those diagnoses specifically excluded under requirements of the plan for consolidation of Medi-Cal specialty mental health outpatient services. These services are no longer limited to a 'Target Population', but covers all Alameda county residents meeting 'Medi-Cal necessity' criteria.

Alcohol and other Drug Services are determined by State and Federal regulation/statute. Local needs and priorities are given primary focus, with Federal and State requirements supporting prevention activities, services for parolees and perinatal women, as well as HIV/AIDS and tuberculosis services. The full range of AOD services includes: Residential, outpatient, day treatment, prevention, 'driving under the influence', and drug diversion programs.

Discretionary funding from the County General Fund provides additional services such as:

- Services to inmates in county jails and juvenile hall
- People with organic brain disease and traumatic brain injuries
- Housing support for the mentally ill/substance abusing population
- Expanded alcohol and other drug services
- Children in group homes/out of home placements
- School-aged children in school-based programs

Major Service Areas: Mental Health Services (for year ending June 30, 2001)

	Year 1999	**Year 2000**	**Year 2001**
State hospitals:			
Napa Adult, individuals served	20	24	24
Local hospitals			
providers	11	14	10
individuals served	3,142	2,707	2,682
Skilled Nursing Facilities			
Providers	7	7	7
individuals served	713	666	621
Residential programs			
Providers	4	4	5
Individuals served	245	238	77

	Year 1999	Year 2000	Year 2001
Day Treatment			
Providers (Adult)	3	3	3
adult individuals served	197	187	113
providers(Child)	10	12	11
child individuals served	755	687	776
Emergency Services			
Providers	5	5	5
individuals served	5,213	5,341	5,579
Community Clinics/Service Teams			
Providers (Adult)	15	16	16
individuals served	4,813	4,599	4,572
Providers (Child)	10	9	9
individuals served	948	999	1,009
Other Mental Health Services (Outpatient)			
Providers (Adult)	12	11	12
Individuals served	1,103	990	1,209
Providers (Child)	25	31	38
Individuals served	1,646	1,836	2,253

Service delivery is enhanced through the use of Centralized Access Services for both adults and children, which screens clients' information, determines appropriate referrals, performs assessments, and provides short-term clinical services.

The continuum of services is complemented by a Pharmacy Benefit System, which now includes all new psychotropic medications, client compliance support, industry-supported programs for the Medi-Cally indigent, and pharmaceutical cost benefit analyses. The Pharmacy Benefit Program covered pharmacy costs of about $1.2 million for approximately 1,600 clients.

A S.T.A.G.E.S. (Strides Toward Acquiring Geriatric Empowerment and Success) provides intensive community support and service (in vivo) for selected older adults. The program provides 24-hour, 7-day services directed toward maintaining mentally ill older adults' community resident status. The program served thirty-nine individuals in 2000-2001 of whom 28 were ranked as high cost mental health service consumers.

In November, 1997, Alameda County became one of the first counties to implement the consolidation of Fee For Service and Short-Doyle Medi-Cal outpatient services. This consolidation gives ACBHS, as the 'Local Mental Health Plan', responsibility for all Medically-necessary mental health specialty services for county Medi-Cal beneficiaries. Implementation of the plan expanded the ACBHS client base by about 8,100 clients for 1998-99. This number has risen to approximately 8,700 clients for the year ending June 30, 2001. Those clients received approximately $3.2 million in mental health services paid for by Medi-Cal in Fiscal Year 2000-2001. The expanded services demand on ACBHCS resulted in an addition of approximately 300 individual providers, including MFCC's and LCSW's, and approximately 40 organizational providers throughout Alameda County.

KEY QUESTION #2

What has happened to the number of acute and subacute beds by category?

Bed Type	**Year**				
State Hospital	96/97	97/98	98/99	99/00	00/01
Adult	36	24	17	18	18
Children	11	0*	0	0	0
Sub Acute Beds	96/97	97/98	98/99	99/00	00/01
Garfield	45	55	30	30	30
Gladman	68	51	53	53	53
Highview**	60	0	**		
Medi-Cal Hill**	0	30	**		
Mort Bakar**	82 IMD	62 IMD	**		
Stars*	0		20 neurobehavior 16 sub-acute 32 residential	16	same same
Villa Fairmont	89	89	89	89	same

** These facilities were combined in a consortium providing beds to several counties with Alameda County contracting for ten beds to come from any combination of facilities: Two beds for the Medi-Cal Center and eight beds for Behavioral Health Care.

** Highview provided sixty beds for the provision of neurobehavioral services. Ten of these beds were used by Alameda County, with eight of the ten used by Behavioral Care. Highview was closed largely due to community pressures. Upon Highview's closure, patients were transferred

These changes in bed capacity reflect the continuing goal of providing the least-restrictive services in accordance with the needs of clients in their community of choice in order that they may achieve the highest level of successful functioning.

KEY QUESTION # 3

Have there been any changes in availability and utilization by type of service?

Utilization Changes (Highlights)

Local Hospitals: Utilization declined from 2,707 unique clients to 2,682 clients (virtually no change).

Total days of hospitalization was reduced from 40,827 to 39,153, indicating a shorter average number of days for hospitalized clients.

Skilled Nursing Facilities, IMD's

Adults: Number of clients placed in year remained dropped from 666 to 621. Client contacts (days, services) remained roughly the same at 109,201 compared to 108,398 from the year before.

Day Treatment:

Adult: Day treatment services declined considerably in 2001, with a reduction in client contacts from 13,953 days to 6,666 days—over 50%. This reduction culminated in the closing of the Gladman Day Treatment Program.

Children: Day treatment services to children were provided to 953 clients in 2001 compared to 687 in the year 2000, a 39% increase in clients served. Service counts showed an increase for the year from 64,000 to over 84,000, a nearly 1/3 increase. This increase in day treatment services reflects an increasing priority on placing mental health programs at school sites through counseling enriched day treatment programs.

Other Programs For Children: General mental health specialty programs for children, including medication support and mental health services also showed significant increases in clietns served and direct client contacts. In 2000, 31 different specialty service programs for children served 1,836 clients. In 2001, 40 programs (25% increase) served approximately 2,512 children (a 38% increase in clients served).

Vocational Workshop: dropped by 20% from 3,994 to 3,189 client contacts, while the number of clients served declined to 44 from the previous year's 75—a 40% decline. However, vocational-related mental health services' clients increased by 40% from 387 in 2000 to 542 in 2001.

Methadone Maintenance: Approximate 5% reduction in the number of clients served, from 2,125 to 2,082, following a 10% increase in clients the year before.

Outpatient Drug Free Services were provided to about 4,328 clients, down from 4,424, which was a reduction from approximately 4,800 clients served in 1999.

Substance Abuse Day Treatment services were provided to the same number of clients in 2001 as in 2000—372 persons.

Substance abuse residential services clients declined by about 30% from 1,607 to 1,163, except in the BASN (state parolee program) where served clients declined by about 7% to 615 clients after an increase of 83% from 381 clients in 1999 to 660 clients in 2000.

KEY QUESTION #4

Describe housing availability for the mentally ill in Alameda County.

a. Identify and describe the major housing resources and any changes in housing availability

b. Describe any changes undertaken to increase access to housing and improve vacancy and housing resource management/development.

According to the Community Care Licensing Directory Report, the following data describe the number of facilities and beds at several points in time. The data count only homes that have indicated a preference to work with "mentally disabled adults."

It is difficult to determine actual capacity of housing resources available to Alameda county residents with a diagnosed mental illness. Such data as is available comes from Community Care Licensing. These data reflect only the annual submissions by board and care home operators to Community Care Licensing. Changes in capacity may occur during the year and go unreported. The State Of California does not report the vacancy rate in these homes, which varies considerably from time to time.

Housing for the mentally ill may be found in several categories:

Family and friends
Private accommodations in private homes
Unlicensed board & care homes
Single room occupancy hotels (residential hotels)
Institutional (long term SNF's and convalescent homes)
Licensed board & care homes
Individually secured apartments (with and without support services)

In addition, in **2000-2001,** twenty of these board and care homes, with approximately 300 beds in all, participated in the ACBHCS Supplemental Rate Program, which provides enhanced services to mentally ill residents.

Current funding levels do not support the use of all 300 beds for SRP services. The 1999-2000 budget for SRP is approximately $950,000 out of the $1.5 million needed to fund all 300 beds for SRP services. With this $950,000, approximately 193 beds are funded. The occupancy rate of these beds is very close to 100%, since SRP beds are at a premium and are usually filled from a waiting list.

The above data reflects the capacity of licensed board and care homes. There may be many unlicensed homes providing domicile services for mentally ill adults and children. It should not be inferred that a measure of capacity indicates levels of demand. It is our understanding that the need for housing for mentally ill persons exceeds available resources. No systematic effort has thus far been undertaken to determine what actual need is.

The impact of gentrification, rising owner occupancy rates, and increased conversions to higher revenue alternatives among board and care homes have served to reduce housing availability for mentally ill persons. Aside from the absolute decline of housing units at rents within the limited budgets of disabled persons, the process of finding vacancies that do exist is very difficult. Landlords and housing providers have many more applicants to choose from to fill any vacancies. When vacancies do occur, they are filled very quickly. Move-in cash requirements may exceed the immediate resources of mentally ill persons, who tend to have fixed and/or low incomes.

Alameda Behavioral Health Services is actively engaged with a number of other agencies in a strategy to improve access to housing for the mentally ill. Among these efforts are:

1. A supportive housing program providing mental health services to mentally ill clients at risk of homelessness.

2. A web-site for board and care home operators for listing vacancies and conditions of occupancy

3. Partnerships with housing developers to 'set aside' housing for the mentally ill in new developments

4. Block purchases from SRO operators.

5. Development of a strong 'housing advocacy' voice in county and state decision-making.

These efforts have resulted in a housing participation allocation of fourteen beds in the Alameda Point Housing Collaboration and another ten beds in West Oakland. These allocations are specifically directed to the needs of Alameda county's mentally ill adults. Consumers occupying these set asides are provided with specialized 'mental health case management' services in order to mitigate against potential occupancy problems.

In addition, BHCS staff, Thomas Walker, meet regularly with operators of Board & Care Homes for the mentally ill in Alameda county. These meetings and discussions provide ongoing support and contact with Board & Care Home operators in an effort to address emerging problems that may be encountered by consumers in those settings, provide a resource and contact point for operators, and ensure continuity of care and policy applications to support the maintenance of these housing resources.

KEY QUESTION #5

Have there been significant changes in resources that affect the flow of funds and/or referrals? Explain the strategies for dealing with any changes.

I. CHANGES IN FUNDING:

Welfare Reform – CalWORKS

Recent efforts to reduce welfare rolls in favor of employment for recipients of AFDC have resulted in significant demands for behavioral health care services for individuals attempting to secure and maintain regular employment. In a cooperative agreement between BHCS and Alameda County Social Services, BHCS has developed a system for outreach, identification, and referral to appropriate services for AFDC/TANNF clients. These services become part of the clients' required Welfare To Work Plan.

Initial estimates suggested that up to 25,000 Alameda County residents may participate in the CalWORKS program. Services that may be required by some of these participants will include social support groups, individual therapy, substance abuse services, as well as evaluation and assessments for appropriate services.

In 1999-2000, Behavioral Health Care Services and Alameda County Social Services Agency began a collaborative effort to identify and refer appropriate clients from among AFDC/TANNF recipients who could benefit from substance abuse and/or mental health services in their transition from welfare to work. For 2000-01, this inter-agency collaboration supports a CalWORKS Oversight Committee and a fully staffed outreach services program, specifically charged with promoting behavioral health care services, facilitating behavioral health care referrals, and training staff at community agencies regarding resources available to clients of 'Welfare to Work'.

Medi-Cal Consolidation / Managed Care

The most major change that has affected both the flow of funds and referrals is Medi-Cal Consolidation, the first two steps of a three step implementation of Medi-Cal Managed Care. Counties were offered the first right of refusal to serve as 'Local Mental Health Plans'. If they declined, they would have relinquished their Short-Doyle Medi-Cal Program.

Alameda County implemented phase II of Medi-Cal consolidation on November 1, 1997. This consolidation gave Alameda county full risk and responsibility for all Medically necessary mental health specialty services for Medi-Cal beneficiaries in Alameda County.

In order to deal with this change, Alameda County greatly expanded its service delivery capacity by adding nearly 300 individual providers and 40 agency providers. This expansion should allow for the additional client load of about 9,000 clients coming with phase II consolidation.

In 1998 integrated agency services through the children's system of care, including identification of contracting entities as lead agencies were developed. MOU's were developed with Social Services, Probation, and the Alameda Health Care Alliance.

In 1999-2000, BHCS Systems became more strategic in the development of the Level Three provider panel, seeking to expand the range of cost-effective services through targeted identification of providers where increased referrals could shift some of the service demand away from Level One providers. Specifically, a need was seen to increase the availability of medication support and primary health care services for BHCS clients. A contract was developed with a primary care physician organization to provide Medi-Cal services, including medication monitoring and support.

Analyses indicated that only about 60% of the Level Three provider panel actually provided services to clients of ACBHCS. Many of these smaller providers were not taking new referrals. Therefore, it was seen that the most likely strategy for developing provider capacity is for ACBHCS to work with 'organizational providers', where the provider can develop additional capacity for referrals without creating additional overhead costs at either the provider level or at ACBHCS.

Development of services to CalWORKS clients has emphasized the availability of substance abuse services. This priority has led to reconsideration of the relationship between the mental health and substance abuse portions of the ACBHCS System, including access, referrals, budget allocations, and accommodation of dually diagnosed clients.

In 2000-2001, BHCS has sought to meet increasing mandates from State auditors for compliance with Medi-Cal standards around the provision of services to Medi-Cal clients. These standards include the use of performance outcomes data, cultural competency planning, and a decentralized protocol for utilization review.

Increasingly applicable to the allocation of state grants and funds will be the ability of the County to meet evaluation and outcomes measurement and reporting requirements.

Medi-Care Funding

Over the past few years there has been an emphasis on Social Security at the Federal level. While there is cause for concern regarding the long-term viability of the Social Security program, there has been more immediate activity toward curtailment of costs. One of these efforts has been labeled "Medi-Care Fraud Prevention". One result of the increased auditing and claims control pursuant to fraud prevention has been a dramatic increase in the requirements for successful claims to be submitted by providers. The paperwork has increased. Verifications have been required where none had existed before. Inevitably, more claims have been rejected for payment under Medi-Care. The more stringent claiming procedures have also required additional expenditures by providers for infrastructure to deal with increased verifications and claim processing demands. So, while costs went up, successful claims went down. Thus, providers began to question the cost-effectiveness of participating in Medi-Care reimbursable services. The impact of this concern about meeting stringent Medi-Care, while meeting Medi-Care cost reduction targets, has undoubtedly resulted in an overall reduction of funds available to pay for services. The decline in provider capacity available through Medi-Care has tended to shift demand to Medi-Cal providers.

Tobacco Settlement

In 1999-2000, the results of the broad, class-action civil suits brought by states against tobacco companies produced settlements that would pay funds to states and local jurisdictions that could be used to provide additional health care services. While the actual distribution of these funds was left to states, in California the mandate was for local initiatives to determine spending priorities. Alameda county has identified behavioral health care services among its local needs to be addressed through tobacco settlement funds.

In 1999, ACBHCS engaged Mercer Associates to work with in-house staff in developing a comprehensive assessment of the likely demand, cost, and infrastructure requirements that could be expected to occur were ACBHCS to provide a behavioral health care coverage plan comparable to Medi-Cal for indigent county residents.

In 2001, BHCS presented an Indigent Care Plan to the Board of Supervisors that will provide indigent county residents meeting certain utilization history criteria with behavioral health care services comparable to those services funded by MediCal and subject to the same medical necessity criteria. The intent is for the coverage to be funded by Tobacco Settlement Funds and to 'follow the client', like an insurance plan.

A comprehensive behavioral care plan for indigents would cost approximately $11 million in Alameda county. It is expected that $2 to $3 million may become available to fund such services. In order to use such limited funding effectively, it will be necessary to structure an indigent care plan so as not to incur more than the actual costs of services. That is, infrastructure will be minimized. Priority decisions will have to be made regarding the covered population and eligibility for services. Since $3 million will not provide a scope of services comparable to Medi-Cal, such funding as will be available must be directed toward already identified gaps in care for indigent clients. For instance, it might be more cost-effective to provide additional outpatient services for indigent clients who are hospitalized, since hospitalization costs are already covered for indigent clients as mandated by the Realignment Act of 1991, but there have been no prior funding sources for outpatient services that could keep indigent clients out of hospitals.

II. CHANGES IN REFERRALS

These changes in funding also influence referrals. In the Fee For Service Medi-Cal Program, approximately 9,000 individuals with "included diagnoses" have been served in non-hospital services each year. About 5,800 of these individuals (65%) have serious and persistent mental disorders. Some of these beneficiaries (2,655 or 28%) have also been receiving services in the County's Short-Doyle Medi-Cal Program. However, most of these individuals will be new to this Department.

In addition to the expanded referrals resulting from Medi-Cal consolidation, ACBHCS has positioned itself as the local provider of mental health and substance abuse specialty services. This strategy has resulted in the development of several new avenues for county residents to gain access to behavioral care services. Examples include a Memorandum Of Agreement (MOU) between BHCS and Social Services for the provision of services to children in foster home placements. This MOU produces approximately 70% of the referrals to Children's Access Services.

A new Outreach Program and expanded community level counseling programs for 'Welfare to Work' clients will require additional resource allocations from Social Services to Behavioral HealthCare to provide mental health and substance abuse services.

In 1999-2000, increased emphasis has been placed on 'early childhood' development, including mental health services for expectant mothers and newborns. Known as "Pre-To-Three", these programs are funded directly through earmarked funds. In Alameda county, a program has been designed, funded, and implemented to provide training to childcare workers and other community/neighborhood resources having direct contact with mothers and children. This training helps the early identification and treatment of a myriad of mental and adjustment problems recognized as best treated in early childhood.

In 2000-2001 the identification of appropriate resources to meet client needs has been enhanced through the development of outreach services, particularly those outreach services directed toward CalWORKS clients and children. Of notable import, is the development of training programs to assist childcare workers in identify early mental health needs among children.

5A. STRATEGIES FOR DEALING WITH THESE CHANGES

Phase II Provider Network: Prior to Consolidation, outpatient mental health services in the Fee For Service Medi-Cal Program were provided by 1,200 unique providers, mostly psychiatrists and psychologists. When the Department assumed Phase II responsibility for the thousands of individuals with mild to moderate mental health problems, we assembled a Provider Network to continue to make these services available. These services will be available to beneficiaries who do not need the intensive, comprehensive support of a Service Team and System of Care.

Interagency Planning and Oversight: With the expanded demands of early childhood services, Welfare To Work, and targeted services for the mentally ill homeless, ACBHCS has found both resources and policy considerations extending across multiple agencies and funding sources. In order to deal effectively with issues requiring the coordination of inter-agency resources, it has been necessary to develop specific strategies and mechanisms for ensuring multiple agency involvement and access to decision making. Thus, BHCS Systems, Alameda County Social Services, Public Health, Probation, and the Sheriff's department have frequently come together through regular and ad hoc committees to discuss mutual interests and opportunities for collaboration. This has been true for the Children's System of Care, adolescent services, day treatment programs in schools, mental health programs at Youth Probation, and mental health programs directed toward AFDC/TANNF clients.

ACCESS: A centralized point of intake provides referrals for all Service Teams. This unit is designed to accomplish several purposes:

- Intake decisions are made on a uniform, equitable basis County-wide
- Intake decisions are made by staff with specialized expertise in differential diagnosis, risk assessment and triage
- Staff time at Community Support Centers does not need to be diverted into "on duty" intake coverage and away from the primary focus of work

Because ACCESS receives many calls from individuals who do not require Service Team or System of Care services, the Provider Network will offer a suitable resource to serve these county residents.

Risk Sharing Strategies: This Department, like many others throughout the country, is continuing to explore ways of sharing fiscal risk and service delivery responsibility with other service organizations. The incentives provided by such arrangements appear to benefit the clients served because community social supports are emphasized in order to stabilize clients' daily lives in order to prevent decompensation that leads to expensive institutionalization. It also benefits persons in need who otherwise would have to go without service because the savings from institutionalization cost reductions may become available for an expansion of community based services.

Infrastructure Development: Behavioral Health Care has found that the implementation of new strategies to deal with increased caseloads and expanded diversity of funding sources has placed new demand on its infrastructure, including management, policy development, planning, contract monitoring, reporting, and MIS. As system strains are identified, resources must be developed to cope with service requirements. Such responses have included additional staff at operations levels, solicitation of state level grants to implement new programs, enhanced cost-accounting to ensure appropriate pass-through costs are identified and claimed, and a comprehensive planning process to address current and future MIS needs.

Management by Performance Indicators

With capped funding, the Department needs to assure optimal effectiveness and efficiency. Performance outcome measures have become crucial to management decisions as managed care has increased the risk assumed by local mental health authorities. Although this Department has long used measures of productivity and revenue, the list of measures has expanded to include those involving other performance outcomes.

Performance measures have taken two forms, **Process Measures** and **Treatment Outcome Measures.**

- **Process measures** at ACBHCS include client satisfaction, access to services by defined 'target group' clients, system cost control, consumer complaint resolution, continuity of care, and staff productivity.
- **Treatment outcome measures** have been historically more difficult to establish, in part due to the dynamic nature of mental health treatment methodologies. Outcome measures at ACBHCS include reduced client recidivism to institutional care, hospital utilization reduction, total system wide cost reduction, movement of clients through a 'system of care' appropriate to levels of acuity, and consumer satisfaction with outcome.

Implementation of any new programs, such as STAGES (noted above), or significant system restructuring is now accompanied by a program evaluation component, such as Service Team Caseload, Workload, and Productivity Reports. This data informs managers on a monthly basis regarding any program changes and their impact on performance. It will also provided a database for subsequent analysis of the 'system' impact of the restructured efforts. These analyses will be integrated with the adopted elements of the Utilization Management Committee's outcome measures recommendations.

ACBHCS has also participated in the State Department of Mental Health Performance Outcome Studies for adults and children. Despite a state sampling error in its first implementation, the adult outcome study has provided the base from which ACBHCS has begun to develop a systematic approach to measurable system, process and treatment outcomes in the following areas:

- Access to services
- System cost
- Continuum of care
- Consumer satisfaction
- Consumer-community education
- Treatment outcomes
- Legal compliance

The ACBHCS Adult System Of Care has replaced the "client stability ranking" which assisted managers in monitoring and managing caseload profiles within the system and at specific providers with the data available through the Adult Performance Outcomes system.

In 1999, ACBHCS adopted the Adult Performance Outcomes measures that have been mandated statewide by the California Mental Health Planning Council and California Department of Mental Health. These outcomes measures include a battery of standardized instruments designed to collect client demographic, status (housing, employment, clinical), and satisfaction data. As this new system has begun to produce data, the client stability rankings have been reduced to twice yearly collections instead of every two months.

EPSDT

In 2000-2001 a new direction for EPSDT funded programs has been identified. This direction will assist school based programs in funding interventions for students in convenient, on-campus settings. In addition, there is growing interest in developing programs that focus on the 'preventive' promise of early screening and diagnoses. That is, perhaps funding can be allocated to programs that specialize in mental health prevention, rather than treatment of problems.

Early Periodic Screening Diagnosis and Treatment (EPSDT) is a federally mandated health program that was expanded by the Omnibus Health Care Act (OBRA '89) to include both mental health and drug treatment services. Three years ago a law suit forced the State Health Care Agency to seek new partners in implementing this expanded care.

New programs provide a broad range of services to youth not previously eligible to receive mental health services. This is possible because the definition of Medi-Cal necessity for EPSDT eligible youth is much less stringent. This funding played a role in the provision of mental health services to dependent children and wards of the court placed in the community. The funds also encourage innovative programming strategies for serving 'transitionally at risk youth', who may be returning to the community from residential placements or are at risk of out of home placement.

Cost Containment Strategies

Efficient resource management has always been necessary due to capped funding in the Short-Doyle and Realignment Programs. The need is even greater now with prepaid service delivery obligations under Consolidation and Managed Care.

In 1999, ACBHCS has continued to identify opportunities to more accurately match the clinical needs of clients with appropriate levels of service. For instance, a new service team directed toward clients with the problems of persistent homelessness should allow earlier and more appropriate intervention for clients who might otherwise become hospitalized as a result of mental health conditions with and without substance abuse complications.

A comprehensive study (Front Door) was undertaken in 1999, to identify the uses, efficiencies, and service impact of the ACBHCS Psychiatric Emergency Services. Among the questions asked in the study were: Who uses the PES service, are there appropriate and more cost-effective alternatives, are clients being inadequately served by the continuum of care that starts with a PES visit?

In 1999-2000, a broad coalition of interested persons, under the leadership of the Mental Health Board, reviewed and prioritized a number of recommendations derived from the Front Door Study. These recommendations included considerations for expanded housing resources, crisis housing, medication support, crisis services for the dually diagnosed, and expanded capacities among service teams serving clients with substance abuse disorders.

MediCare Claiming:

ACBHCS has responded to the difficulty experience by programs in claiming MediCare reimbursements by providing technical assistance, participating in statewide technical upgrades, and shifting services toward organizational providers with the in-place infrastructure necessary to successfully process MediCare claims.

Institutional (IMD) Bed Management

With implementation of the Realignment legislation in 1991/92, Alameda County Mental Health Services assumed full responsibility for the funding and management of all IMD resources, including Napa State Hospital and locked Skilled Nursing Facilities (SNF). This major change has allowed for strategic redirection of these resources from highly restrictive and costly settings, to less restrictive, local, community-based supportive and clinical services. Napa beds alone have gone from 168 in 1991 to 30 this fiscal year. Since FY 91/92, total beds have been reduced from 444 to 282.

The dollars that had been used to purchase these beds have been used primarily to offset the County deficit experienced over the past several years, thereby saving the local, community services. However, some of the IMD dollars have been reinvested in the System of Care to enhance the supportive and clinical services, including many of those described here.

Adolescent Sub-Acute Facility (STARS)

The Adolescent Sub-Acute facility opened in July, 1997. The forty-eight bed facility has been planned over the last four years and under construction for the last 18 months. The facility includes a locked 16 bed Psychiatric Health Facility (PHF), four cottages that house eight residents each, and a seven classroom school house. The site includes administrative offices, dining commons and activity areas both indoor and out. In 2000-01, about 90 youth were served in the STARS Day Treatment program and 81 adolescents were served at the inpatient facility (Psychiatric Health Facility).

Detoxification Program (Vida Nueva)

The purpose of the Detoxification Program is to reduce the unnecessary and inappropriate inpatient utilization of adults in our system.

Behavioral Health Care Services is contracting with Telecare Corporation to operate a 10 bed Social Model Detoxification Facility. This three to five day residential program will be augmented by the provision of a differential diagnosis evaluation component to be provided by the Gladman Day Treatment Program.

The Social Model Detoxification Program takes referrals from acute inpatient programs, primarily John George Pavilion. Services will focus on stabilizing the resident and providing linkages to appropriate treatment services and housing in the community. Persons who can benefit from receiving a differential diagnosis evaluation can request and/or may be referred to the differential diagnosis component at Gladman Day Treatment. Residents participating in the differential diagnosis evaluation will remain in the recovery facility until the completion of the evaluation, an estimated average length of 14 days.

Because of developing lower-cost alternatives and a need for greater flexibility, the Vida Nueva Program will be phased out in 2000-01 in favor of increased outpatient services with aggressive engagement strategies through a program to be called CHANGES.

Contract with John George Psychiatric Pavilion

Behavioral Health Care Services (BHCS) and Alameda County Medi-Cal Center (ACMC) continued a Memorandum of Understanding (MOU) for inpatient services provided by John George Pavilion (JGP). The MOU provides the opportunity for BHCS to manage its $22M JGP Inpatient budget efficiently. The MOU is structured on three performance/reimbursement levels.

At the first level, BHCS will bill and collect revenues from Medi-Cal, Medicare, Insurance and Patient Fees. These revenues are built into the BHCS budget base. JGP will be reimbursed by BHCS based on all authorized inpatient services. JGP will be at financial risk for baseline performance objectives set forth in the BHCS budget.

At the second level, JGP will be reimbursed for authorized inpatient services provided above the baseline performance objectives outlined in the BHCS budget. These services will reflect a shift from private hospitals to JGP, and will be reimbursed at a rate comparable to the private hospital rate under Inpatient Consolidation.

At the third level, the MOU provides for the sharing of system wide acute care psychiatric hospital cost savings. BHCS will reimburse ACMC for 50% of net system savings achieved through additional efforts by JGP. These net system savings will be a reduction, not just redirection of costs/savings as mentioned in Level II. These savings can be achieved through an integrated management system of both JGP beds and inpatient consolidation beds, and through the development of an integrated service delivery system with JGP psychiatric emergency services, inpatient services, BHCS crisis and outreach programs.

The next step in developing a financial agreement based on managed care principles between BHCS and ACMC is reimbursement for emergency services. Currently, the MOU allows BHCS to continue reimbursing ACMC for emergency services based on the BHCS budget amount. But both BHCS and ACMC have agreed to work toward this goal of a fully integrated psychiatric emergency service.

KEY QUESTION #6

What priority groups have been identified for services and how are they being served?

Populations having been identified as appropriate target groups for special service strategies by Alameda County Behavioral Health Care include:

Vocational clients
Children in foster care
Mono-lingual non-English speakers
Welfare to work clients
Dually diagnosed clients
Incarcerated clients
High cost/ high utilizers of institutional services
Adolescents at risk of out of home placement
Elderly clients, over the age of 65
Pre-school age children
Peri-natal clients
Homeless clients
Frequent users of crisis services
Transition-age youth (ages 18 through 25)
Juvenile Justice clients
Medically Indigent clients, Working Poor

Service programs have responded to the special needs of identified target groups with a variety of programming developments.

- Management by Priorities; focus on clearly defined priority and target populations.
- Access Unit with centralized case assignment.
- Case management services responsive to centralized case assignment.
- Out of office services to clients in their natural community settings.
- Integration of former Fee For Service Hospitals into a System of Care.
- Dual diagnosis program design and staff training.
- Service teams with a single point of responsibility and 7 day, 24 hour availability.
- Crisis Residential Facility (Woodrow House, operated by BACS).
- Managed bed utilization through the Bed Control Committee.
- Capitated full risk service program (STRIDES).
- Children and Youth Crisis Team.
- Children and Youth Sub-Acute Facility (STARS).
- Development of a continuity program of case management for STARS graduates.
- Guidance Clinic program provides brief therapy and crisis services.
- Support groups for employment seekers and the newly employed.
- Language resources and AT&T Translation services.
- Jobs Now Program.
- Provision of medication/pharmacy benefits to indigent clients.
- Provision of Medi-Cal matched services to children, regardless of Medi-Cal status.

Current strategies include:

Developing protocols for meeting service delivery obligations
- Multiple providers
- Expanded provider network
- Identification of 'best source' of services
  - Cost effective
  - Available
  - Culturally competent
- Participation in ASO (inter-county Administrative Services Organization)
- Development of interagency joint services agreements
- Developing provider agreements guaranteeing priority access for Medi-Cal clients

Assess and monitor levels of risk.
- Funding compared to utilization
- Demand for higher levels of care
- Recidivism to higher levels of care
- Clinical outcomes.

Improved data management and analyses.
- Enhances risk management
- Supports required reporting (internal and external)
- Supports fiscal claiming and management
- Allows tracking of 'special populations'
  - Service characteristics
  - Subject to MOU's
  - Sources of funds
  - Multi-agency accountabililty

System-wide identification of indigent clients eligible for Pharmacy Benefits Program of Indigent care developed through pharmaceutical public service programs.

Referral of Level 3 (outpatient/medication support) clients under age 18 to outpatient provider network as 'county pay', when not covered by Medi-Cal.

Outreach, screening for benefits and service needs, advocacy, placement, and support are provided to county residents with persistent mental illnesses who are homeless or at risk of becoming homeless. In 2001, these services are provided through a demonstration program for supportive housing, begun in September, 1999.

An 'early childhood' program serving young and expected children and their families provides education, counselling, and support. In addition, the program provides workshops, strategies, and tools for the development of appropriate mental health skills among child-care workers.

Planned System Changes:

Through analysis of the data collected in the "Front Door Project, service system access points that may contribute to system performance have been identified. For instance, PES is a major service system entry point, at which we may wish to adopt protocols which are suitable to effectively match between client needs and services provided. Referrals from PES may be expanded and modified to ensure adequate immediate access to crisis services, but allow for appropriate discharges to reduce 'recycling' of clients through PES and inpatient services. A systematic strategy of identifying dually diagnosed clients who frequently use PES and directing these clients to substance abuse programs could significantly reduce the load on an over-taxed emergency care system.

Another potential system change will occur through enhanced clinical level data collection, specifically in connection with Youth and Adult Performance Outcomes. This data will be collected on all clients open to the system for at least sixty days. Clinicians will have the data available for individual treatment plan development. On a system-wide basis, the client outcome data will support analyses of service utilization for client profiles based on clinical as well as historic utilization data.

Anomalies between treatment plans and client outcomes can provide a basis for evaluating program changes and identifying risk factors.

Service delivery is enhanced through the use of Centralized Access Services for both adults and children, which screens clients' information, determines appropriate referrals, performs assessments, and provides short-term clinical services. Community support clinics are organized around the 'assertive community outreach' model, providing in vivo services to clients in order to maintain clients in community resident status. The outreach model for BHCS community services consists of our single, well-known '800' telephone number with language diversity capacity and trained clinical staff answering calls. These staff are trained to screen callers, identify problems, triage client needs, and make appropriate referrals both within and outside the BHCS system of care.

It should be noted that the use of centralized access services impacts the caseload of providers. On the one hand, consumers are more likely to be directed to providers near their homes. Consumers are likely to find services more compatible with their own ethnic and linguistic characteristics. Providers, on the other hand, will do little case-finding on their own. Providers will also be 'assigned' cases according to more consistent policy and service parameters. Centralized access services will require a flow of clients through the system in order to facilitate additional referrals. In order to do this, a more consistent emphasis on providing services at the least restrictive level of care will be required. The continuum of services to ensure appropriate service levels for all clients at a cost and clinically effective level becomes crucial.

The Children's System of Care Project has developed protocols for the coordination of services among children's services providers: Education, probation, social services, mental health services. Strategically, the multi-agency coordination brings together a variety of services targeted to the comprehensive needs of youth at risk of out of home placement.

A refined system for service cost-accounting that includes true cost impact for expanded services must be developed. Such true cost accounting must include variable overhead, staff, management, MIS, direct, and indirect costs with a mechanism for apportioning such costs at a unit level to facilitate reimbursement claiming.

KEY QUESTION #7

Did actual revenue meet or exceed the budget?
Explain the status of any savings.

The 1999-00 approved budget included revenues totalling $114,700,917 with a Net County cost of $18.6 million. Mid-year adjustments resulted in an increase in revenue to $118,359,568, approximately a 3% increase.

A maintenance of effort budget submission will include this 3% increase and identify an increase in service and supply costs of 4.35%, which will increase the Net County Cost from $18.6 million in 1999-00 to $20,85 million in 2000-01.

KEY QUESTION #8

Have there been significant changes in the needs for and/or availability of services to persons in major age categories (i.e. 0-17, 18-59, 60+)?

Consumer Age Demographics:

The age group distribution of clients served by ACBHCS has been fairly consistent, except for children.

Year	*1997*	*1998*	*1999*	*2000*	*2001*
Age Group					
Under 18	**3,094**	**3,227**	**3,809**	**5,123**	**4,235**
Ages 18 – 59	**11,961**	**11,363**	**10,621**	**14,224**	**11,413**
Over age 60	**1,133**	**1,092**	**1,016**	**1,074**	**965**

Managed Care:

The prepaid, capped funding and prepaid service obligations of managed care require special attention to efficiency and effectiveness in service delivery. In preparation for managed care there have been many refinements to services currently being provided by Behavioral Care Services which have resulted in more timely access, better case management, better follow-up and continuity in services

Welfare Reform

The general decline in numbers of individuals on public assistance results in decreasing numbers of individuals with Medi-Cal coverage. Additional agreements with other agencies, such as Social Services could produce an expanded user-base of behavioral care services. The agreement to provide services to Cal-Works clients produces a 'case-finding' effect for mental health. This could lead to increased numbers of individuals publicly identified as being "mental health clients," with an increased number of referrals for service from agencies and professionals in the community. With time-limited benefits and increasing pressures to reduce clients reliance of welfare assistance, the stress and anxiety aroused by the loss of a secure income may precipitate psychiatric symptoms, with a resulting increased demand for service.

Outcomes Measurement

The required measurement and reporting of system performance outcomes is expanding to clinical outcomes through the implementation of statewide outcomes programs at the children's, adult, and older adult levels. Measurement of these outcomes produces a heightened sense of cost-benefit ratios, adherence to treatment plans, and stricter utilization review procedures. There remains a concern about the impact of these responses to outcomes measurement and the potential impact on clients' length of stay with treatment providers. Efforts must be made to ensure that systems do not over-react and unnecessarily attenuate positive therapeutic relationships.

The 0 to 17 age group.

EPSDT Funding:

EPSDT funding has created over $1 million in new programs for children in Alameda County. About five-hundred children who have not received services before are now receiving their mental health services through EPSDT contracted services.

System of Care Funding:

A three year grant for SOC funding from the State Department of Mental Health supports further development of interagency collaboration and the creation of several new collaborative service programs jointly administered by key children's services agencies, including Behavioral Care, Public Health, Child & Family Services, Probation Services and the County Office of Education.

The program targets seriously emotionally disturbed youth at risk for out of home placement or in out of home placements. SOC planing emphasizes the partnership of county agencies with contract providers, family members and consumers in the planing and development of new programs and the distribution of future funding in county children's services.

A multi-agency team meets weekly to discuss placement access, review treatment plans and jointly plan care for youth in high-end residential, acute hospital and state hospital placements.

Healthy Families

Recent statewide initiatives will make health insurance available to families with income above the Medi-Cal cutoff but below 200% of the Federal poverty guidelines. The health benefits provided under these plans may be used to cover some limited mental health services. It is estimated that up to 25,000 Alameda County children may be eligible for these benefits.

Ages 18 through 59

Novel Antipsychotics

The availability of effective "novel antipsychotics" (e.g. Clozaril) reduces the need for institutional care, thereby increasing the community tenure for many previously institutionalized, seriously mentally ill individuals. This increases the need for medication monitoring, case management, and assertive outreach team services in the community.

Welfare Reform

Cal-Works' Welfare to Work program seeks to identify clients who have barriers to employment. Many of these barriers may be addressed through individualized treatment for mental health conditions. Welfare To Work will require welfare beneficiaries to participate in job-seeking or job-readiness development. While it is not required that any welfare beneficiary seek treatment

of any kind, participation in a treatment program may be beneficial to some clients with mental health conditions and may be counted toward participation requirements by Welfare To Work.

Ages 60+

Aging of the Population

The most dramatic issue affecting persons in this age range is the increasing numbers of persons and proportions of the population who are in this age range. This "aging of the population" is a demographic trend that is expected to continue for several decades. The prevalence of the following two problems is likely to increase throughout this period.

Organic Brain Syndromes

Although public mental health services have not been funded to assume responsibility for the Medi-Cal needs of these individuals, the absence of an adequate community service system means that many such individuals will turn to this department (as well as other health care agencies) to seek service.

Even though this department does not have primary responsibility for this population, an increasing prevalence of OBS will have at least two direct effects.

First, OBS can develop in a person who has had a life long serious mental illness such as schizophrenia or bipolar disorder. Even if adequate community services were available for care of OBS patients, the presence of OBS as a co-occurring disability will complicate the provision of services to these aging seriously mentally ill individuals.

Second, even though this department does not have general responsibility for OBS services, the department is obligated to pay for acute psychiatric hospitalizations for OBS patients who require hospitalization due to associated mood symptoms or psychotic symptoms. Again, the aging of the population will lead to a greater demand on these service obligations.

Medi-Cal Complications

Just as there is likely to be an increase in co-occurring OBS with mental illness as the population ages, there is also likely to be an increase in co-occurring Medi-Cal problems with mental illness. As this occurs our services will need to be supplemented and better coordinated with other health care resources in the community.

KEY QUESTION #9

Present a summary of the past fiscal year's accomplishments.

Accomplishments for FY 2000/01 primarily rested on continued system building and the development of formal agreements between local public agencies and Behavioral Health Care as the specialty mental health care provider.

Highlights of those accomplishments are summarized below:

Continued refinement of Provider Services Network. Recent efforts have focused on identifying providers able to dedicate capacity to BHCS referrals and able to meet BHCS quality assurance and documentation needs while serving clients cost-effectively.

Mandated managed care organization infrastructure that provides out-patient authorization, a client grievance and appeal process, credentialing for providers, provider appeal, provider relations, negotiation of rates/contracts, expanded billing/payment system, and expanded data collection reporting process.

Provided for Client /Consumer Involvement and Empowerment through the **"Jobs Now Project"** that of establishes mechanisms to train and hire clients, either in BHCS, directly or at provider sites (county operated and contract).

Refined contracting process for AOD services.

- Used system values and planning principles in contract negotiations
- Restructured contracts to reflect priorities related to populations served, priority of access, expectations regarding revenue generation capability/capacity, efficiency, cost effectiveness, etc.
- Developed a contract monitoring process for AOD services reflective of these changes.

Increased supported housing availability for clients through a model housing advocacy and assistance grant.

Developed a Cultural Competency Plan for conducting surveys and identifying opportunities for enhancement and cultural competency training for staff. Surveys of staff training needs were conducted at four program agencies with results tabulated and serving as the basis for a series of recommendations regarding cultural competency:

Enhanced contact between mental health providers and other neighborhood based services with common populations.

Enhanced identification of career opportunities among minority populations.

Enhance use of visual décor, bulletin boards, posters, etc. in promoting cultural awareness.

Development of clinician forums on topics of cultural competency on a systemwide basis.

KEY QUESTION #10

Present a summary of ongoing challenges and unmet needs.

- Develop a plan to make BHCS more 'Family Friendly'.
  Increased family involvement in treatment planning.
  Adequate privacy safeguards
  Family-client training and orientation/education regarding mental health issues and services
  Increased mental health service outreach to the community

- Develop protocols and guidelines on 'paperwork control', recognizing that time and infrastructure requirements may erode capacity for providing an expanded range of services to residents, in particular in programs that might offer 'drop in' services.

- Ensure that savings that result from deinstitutionalization, service coordination, improved service delivery models, and other program improvements **are reinvested into the System of Care.** As California's economy adjusts to a contraction cycle following its prolonged growth, the ability to apply reinvested savings within BHCS will be challenged by local government deficits.

- Continue implementation of state mandated outcome measures at county and contract provider sites. Become an active participant in determining appropriate outcomes measures to be applied on a statewide basis.

- Develop a local strategy for identification of and measurement of meaningful outcomes of services and resource allocations. Evidence based treatment (EBT) is becoming a reality in public service provision. State mandated outcomes will address only part of the impact of services, limited to measures common to all counties in the state. The ability to apply measures and outcomes analyses to the local service strategy will support increased data driven decision making and more consistent system performance in a limited-resource environment.

- Improve Cultural Competency of BHCS Systems
  Assess cultural competency levels of staff
  Provide cultural competency training

- Develop more housing alternatives for BHCS clients, including housing partnerships, grants, in vivo support programs, and private provider incentives. Expand system support for the continuation and expansion of those resources including: Case management services, planning assistance for operators, housing liaison services, and advocacy.

- Improve access to and management of clinical and fiscal data.
  Complete MIS strategic plan for updating current Management Information System.
  Network MIS system to provider sites for improved access to shared data and communication.

- Implement CalTOPS pilot of outcomes measurement and enhanced service planning for substance abuse programs. Develop training resources and implementation plan for

expanding CalTOPS outcomes measures to comprehensive system of substance abuse treatment.

- Identify range and parameters of 'detox' services necessary to support effective system of substance abuse services, while meeting needs of consumers, and supporting a cost-effective and appropriate level of service.

- Develop a more viable and appropriate crisis/assessment service for children in Alameda County.

- Expand services to inmates of county jails, including medication support and transition services to released inmates to reduce re-arrests.

- Improve and expand services to 'transitional' age youth who are 'aging out' of service eligibility in our Children's Services Programs but still need case management and other support services to achieve stability in the community.

- Implement a program of substance abuse services directed toward meeting the mandate of Proposition 36 as passed by the voters in November, 2000. This Proposition mandates and funds the provision of substance abuse services to persons convicted of non-violent drug offenses.

- MOU's with county-sites that are performance based, outcome driven, with incentives for enhanced performance.

- Continue to collaborate with Probation Department to provide enhanced services to Juvenile Hall Population., i.e., develop 'revised' mission for mental health services at Guidance Clinic/Juvenile Hall, that addresses client need for service and the Probation Department's responsibility for providing for a safe, humane environment for all 'in custody' youngsters. Areas of concern to be addressed and more clearly defined include defining and prioritizing:
    - In custody/probation populations to be served
    - Service to clients and/or reports to Courts, services to mental health's state mandated target population and substance using/abusing youngsters
    - Services to youth (not eligible for MH services through the state mandated MH target population definition) with problematic behaviors that pose hazards for themselves and/or custodial staff.
    - Explore and develop alternative funding streams for these enhanced services.

Continue with strategic planning and implementation of recommendations arising from the Front Door Project, including diversification of system access points and appropriate services for meeting determined needs of county residents presenting for mental health services. This may include satellite mental health services, integration with county social services, facilitated application for medi-Cal benefits, etc.

Identify and meet the mental health needs of those residents of Alameda county with special physical needs, including the disabled.

Glossary:

24 Hour Services: Acute Inpatient Services, residential and skilled nursing facilities providing round the clock service.

ACBHCS: Alameda County Behavioral Health Care Services

AFDC/TANNF: Aid to Families with Dependent Children, a welfare cash support program

AOD: Alcohol and Other Drug Services

APO: Adult Performance Outcomes (statewide measures of service system performance)

CalWORKS: California's Welfare To Work Plan

CBO: A Community Based Organization providing services under contract with the county.

Day Treatment: Rehabilitative services available to clients at least 3 hours/day with a staff to client ratio of either 1:8 or 1:10.

EPSDT: Early Periodic Screening Diagnosis and Treatment (A Medi-Cal funding program to improve access to services for children**.**

IMD: an Institute of Mental Disease, a skilled nursing facility serving serverely mentally ill clients between 18 and 65.

LCSW: Licensed Clinical Social Worker

Medi-Cal: California's implementation of Federal Medicaid Program, provides medical insurance-like coverage for qualified low-income persons.

Mental Health Specialty: Services deemed to be best provided through practitioners of the healing arts specializing in mental health.

MFCC: Master in Family and Child Counseling (a clinical license designation)

MHS: Mental Health Services: Outpatient Clinic Counseling, Case Management

OBS: Organic Brain Syndrome

PES: Psychiatric Emergency Services

Phase II: The second phase of county government being responsible for all required mental health specialty services for Medi-Cal eligible persons residing in the county. Phase I applied to hospitalization, Phase II to outpatient services.

SRO: Single Room Occupancy (residential)

Sub-acute: A 24-hour service with care intensity below that of hospitalization, e.g. skilled nursing facility.

Appendix B

FY Work Plans

Priority Areas in the work plans of the Committees:

We did not have our yearly retreat. However, this is a tool that enables the Board to establish priorities and goals for the year. We will have a number of new Board Members to replace those who have left and a retreat should be held this next year.

Board Members - A number of our highly qualified Board Members will be leaving due to conflicts of interest and ineligibility to serve. There appears to be an issue with the Welfare and Institutions Code. Some who have applied will not be eligible for appointment. We need to work on having competent Board Members appointed. We consistently have vacancies that need to be filled.

Budget – We worked with staff on priorities of various programs due to lack of funds. This will be an on going consideration in the next year.

System of Care – Work on maintaining the current level of programs and care given the financial crisis. The system appears to be stretched to the limit of its ability to deliver services with the funds available.

Aging Problems and Mental Health Disabilities - Work with multicultural communities and addressing the needs of the aging population.