Mendocino County Behavioral Health System Program Gap Analysis & Recommendations for Allocation of Measure B Revenues

Kemper Consulting Group

Lee D. Kemper
Jim Featherstone

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CONSULTING GROUP

Behavioral Health System Gap Analysis & Recommendations

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Behavioral Health System Gap Analysis & Recommendations

I. Executive Summary

Mendocino County's Measure B, the "Mental Health Treatment Act," was approved by County voters on November 7, 2017. Over the first five (5) years, Measure B will generate roughly $38 million for behavioral health facility construction and ongoing operations, services and treatment. Kemper Consulting Group was hired by Mendocino County to:

- Conduct an assessment of behavioral health facility and service needs in Mendocino County and identify current service needs in the County due to gaps in the continuums of care; and, identify projected service needs in five (5) years based upon current and anticipated needs; and,
- Present key policy and financing decisions that need to be made by the Board of Supervisors to effectuate effective and sustainable use of the Measure B revenues over time.

The *Mental Health Mission Statement* of the Mendocino County Behavioral Health Services Department (BHRS) speaks to delivering services "in the least restrictive, most accessible environment within a coordinated system of care that is respectful of a person's family, language, heritage and culture" and maximizing independent living and improving quality of life through community-based treatment. The BHRS *Substance Use Disorders Treatment Mission Statement* speaks to promoting "healthy behaviors through prevention and treatment strategies that support our community's need to address alcohol and other drug abuse, addictions and related conditions." ***Our assessment finds that the current continuums of care in Mendocino County for mental health and substance use disorder treatment fall short of achieving the goals expressed in these mission statements in a number of key service areas.***

For the current mental health continuum of care, we find the continuum is missing key services that are essential to reducing the need for inpatient psychiatric care, including but not limited to Crisis Residential Treatment, day treatment, and a robust array of community-based wellness and support services. We also find the growing level of crisis mental health assessments is placing increasing strain on local hospital Emergency Departments that serve as the primary locations for patient assessment and hold pending a determination of their psychiatric needs. Further, we find that Mendocino County's use of out-of-county inpatient psychiatric care is growing at an accelerated pace, due in large part to a lack of alternative treatment options in the County. Between FY 2016-17 and FY 2017-18, the average daily number of persons in inpatient psychiatric care increased from 11.7 to 15.1 – an increase of 29%.

Over the next five years we believe the primary principle that should drive Measure B policy-making is a commitment to developing a comprehensive mental health services continuum in Mendocino County that provides a broad range of services and supports that remediate mental health conditions at the earliest possible time and reduce the need for inpatient psychiatric utilization. With this principle, we believe

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Mendocino County can both set a goal of reducing the need for inpatient psychiatric care, while simultaneously assuring that inpatient psychiatric care is available in the County when needed. Further, we believe a goal of a 50% reduction in the use of inpatient psychiatric care within five years, by FY 2022-23, is a responsible goal. This would reduce daily hospital utilization from 15.1 persons per day to a more sustainable 7.6 persons per day.

To achieve this goal, among other things we recommend that Measure B funds be allocated to support facility construction of a Crisis Residential Treatment facility, which includes a Crisis Stabilization Unit (CSU), as currently planned but awaiting financing. We also recommend Measure B funds provide annual funding support to CSU operations. We recommend that Measure B funds be allocated to support facility construction for inpatient psychiatric care in Mendocino County, and offer alternative approaches for achieving this objective. We recommend that Measure B funds provide annual funding support for a substantial expansion of community-level support services that address mental health conditions of county residents, including those in more remote locations, at the earliest possible time and reduce the need for inpatient psychiatric care. Finally, we recommend Measure B funds be allocated to a Supportive Housing Pool for use in addressing the housing needs of persons with mental illness, including individuals that are under conservatorship with Mendocino County and placed out-of-county and persons that are homeless.

For the current SUDT continuum of care, we find the array of treatment services provides only the most basic components of a care continuum, and to a very small population. We find key services are missing, most notably community-based recovery and rehabilitation programs and a wide range of residential treatment options (low to high intensity). We note that planning for the development of SUDT services in the County is contextual to possible implementation of the Drug Medi-Cal Program's Organized Delivery System (ODS), and that discussions with Partnership Health Plan are underway regarding administration of the ODS for Mendocino County. We make no recommendations regarding implementation of the ODS, but we believe Measure B funds should be dedicated to expand access to SUDT services for county residents to expand upon the limited array of services that are currently available. Toward this end, we recommend 10% of Measure B funds be allocated to SUDT services over the first five years, subject to a proposed spending plan from the BHRS Director, and a continuation of this funding during the following five years.

More broadly, we offer the Board of Supervisors a proposed set of policies to guide the use of Measure B funds that include:

- Measure B funds are intended to ***supplement, not supplant,*** existing sources of funding for mental health and SUDT services;
- Measure B funds are intended to fund programs that address shortcomings in the service continuums for both Mental Health and Substance Use Disorder Treatment, as those continuums

evolve over time, with an emphasis on community-based services that reduce the need for higher level services;

- A Measure B Prudent Reserve should be established and funded to provide additional revenue for behavioral health programs in Years 6-10 of Measure B, when funding will be less due to the drop from 1/2-cent to 1/8-cent sales tax;
- A separate annual accounting of all Measure B revenues and expenditures should be undertaken that is distinct from standard accounting by BHRS; and,
- A 10-Year Strategic Spending Plan for Measure B revenues should be adopted that provides a framework for funding priorities over time. A proposed Spending Plan is offered for consideration.

II. Background

Kemper Consulting Group was hired by Mendocino County to conduct an assessment of behavioral health facility and service needs in Mendocino County to support program development and policy planning needed for implementation of Measure B, the "Mental Health Treatment Act," which was approved by Mendocino County voters on November 7, 2017. Measure B gives Mendocino County a unique opportunity to address mental health and substance use issues experienced by county residents today and into the future through its collection of sales tax revenue to support expanded behavioral health service delivery. As set forth in Measure B, over the first five (5) years the measure will generate roughly $38 million for facility construction and ongoing operations, services and treatment.[1] Of the revenue generated in the first five years, up to 75% of the revenue ***may be*** used for facilities and not less than 25% ***must be*** dedicated to services and treatment. Beginning with revenues collected in the sixth year and each year thereafter, 100% of new funding, estimated at nearly $2 million annually, ***must be*** used for ongoing operations, services and treatment. Among other stated purposes, Measure B is intended to achieve the following:

- Provide for assistance in the diagnosis, treatment and recovery from mental illness and addiction by developing:
  - A psychiatric facility and other behavioral health facilities;
  - A regional behavioral health training facility to be used by behavioral health professionals, public safety and other first responders; and,
- Provide for the necessary infrastructure to support and stabilize individuals with behavioral health conditions, including addiction and neurological disorders.

Kemper Consulting Group was hired by Mendocino County to conduct an assessment of behavioral health facility and service gaps in Mendocino County and produce a report that addresses all of the following:

a. Outline optimal continuums of care for mental health and substance use disorder treatment (SUDT) services in Mendocino County;
b. Identify planned additions to the existing mental health and SUDT continuums of care;
c. Identify service gaps in mental health and SUDT programming, taking planned additions into consideration;
d. Provide the following data summaries based on data provided by RQMC and BHRS:
   - Summary of current programs, services, target populations, funding sources, and expenditure amounts;
   - Summary data on numbers of persons receiving services by program component and cost of care; and, average daily census and cost of clients in inpatient care settings outside of Mendocino County;

e. Outline options for the treatment of persons with acute inpatient psychiatric needs in Mendocino County, including development of a Psychiatric Health Facility and alternatives to inpatient psychiatric care, and the projected costs of those options;
f. Present two snapshots of behavioral health service need in Mendocino County and include recommendations on both of the following:
    - Programs/services needed in the County right now due to gaps in the continuums of care;
    - Programs/services projected to be needed in five (5) years based upon current and anticipated needs; and,
g. Outline key policy decisions that need to be made by the Board of Supervisors to effectuate effective and sustainable use of the Measure B revenues over time and make recommendations on the use of Measure B funds.

Kemper Consulting Group's responsibility did not include review of a regional behavioral health training facility. Therefore, no work or recommendations regarding this matter are included in this report.

As a part of our work, KCG consultants reviewed a wide range of written documents and programmatic and fiscal data; conducted Internet research; interviewed a variety of public officials and private sector representatives outside of Mendocino County; and, conducted Key Informant interviews of Mendocino County officials, providers, and stakeholders. Sources for this work included:

- Programmatic and fiscal data supplied by RQMC and BHRS;
- California DHCS reports, budget documents, and letters;
- California EQRO reports;
- California Hospital Association reports;
- Phone interviews and email communications with Behavioral Health officials in various California counties; representatives of Psychiatric Health Facilities (PHF); and, California DHCS officials;
- Key Informant interviews with County leadership, including the CEO, Sheriff, and, HHSA and BHRS Directors; representatives of RQMC; leadership of local hospitals; community health center representatives; Behavioral Health Advisory Board members; and, Mendocino County residents that are consumers or family members of persons with mental illness (see **Appendix A** for a listing of Key Informants); and,
- Discussion with Measure B Advisory Committee at April 25, 2018 meeting; review of the Measure B Advisory Committee meeting videotape of May 23, 2018; and, review of Measure B Advisory Committee agenda and meeting materials.

III. Continuums of Care for Mental Health and Substance Use Disorder Treatment

The mission statements for Mendocino County's Health and Human Services Agency (HHSA) and Behavioral Health and Rehabilitative Services (BHRS) Department express broadly defined goals[2]. The ***HHSA Mission Statement*** speaks to supporting and empowering families and individuals to live healthy, safe, and sustainable lives in healthy environments.[3] The ***Mental Health Mission Statement*** speaks to delivering services "in the least restrictive, most accessible environment within a coordinated system of care that is respectful of a person's family, language, heritage and culture" and maximizing independent living and improving quality of life through community-based treatment.[4] The ***Substance Use Disorders Treatment Mission Statement*** speaks to promoting "healthy behaviors through prevention and treatment strategies that support our community's need to address alcohol and other drug abuse, addictions and related conditions"[5] (see **Appendix B**). These three mission statements point to the importance of providing a comprehensive continuum of care for the prevention and treatment of mental health and substance use disorder conditions.

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) outlines four overarching components[6] of an effective Continuum of Care:

- ***Promotion Strategies*** to create environments and conditions that support behavioral health and the ability of individuals to withstand challenges and to reinforce the entire continuum of behavioral health services;
- ***Prevention Strategies*** and Interventions delivered prior to the onset of a disorder that are intended to prevent or reduce the risk of developing a behavioral health problem;
- ***Treatment Strategies*** for people diagnosed with a substance use or other behavioral health disorder;
- ***Recovery Strategies and Services*** that support individuals' abilities to live productive lives in the community and can often help with abstinence.

When considering the array of services currently available through the service delivery systems in Mendocino County for mental health and substance use disorder treatment (SUD) it is important to consider them within this federal framework.

1. Mental Health Services Continuum of Care

A. Existing Service Continuum

As described by SAMHSA, there are four segments of services in an effective continuum of care: promotion, prevention, treatment, and recovery. Within this context, the Specialty Mental Health Services required under Medi-Cal for children and adults includes a set of services that fall into the categories of treatment and recovery only. Under current Medi-Cal requirements, each county's Mental Health Plan is required to

include all of the services listed in **Table 1**.

Table 1 Medi-Cal Required Specialty Mental Health Services[7]		
Service	**Children**	**Adults**
Adult Crisis Residential Services*	x	x
Adult Residential Treatment Services*	x	x
Crisis Intervention	x	x
Crisis Stabilization	x	x
Day Rehabilitation	x	x
Day Treatment Intensive	x	x
Intensive Care Coordination	x	-
Intensive Home Based Services	x	-
Medication Support	x	x
Psychiatric Health Facility Services	x	x
Psychiatric Inpatient Hospital Services	x	x
Targeted Case Management	x	x
Therapeutic Behavioral Services	x	-
Therapy and Other Service Activities	x	x
*Include children ages 18-20		

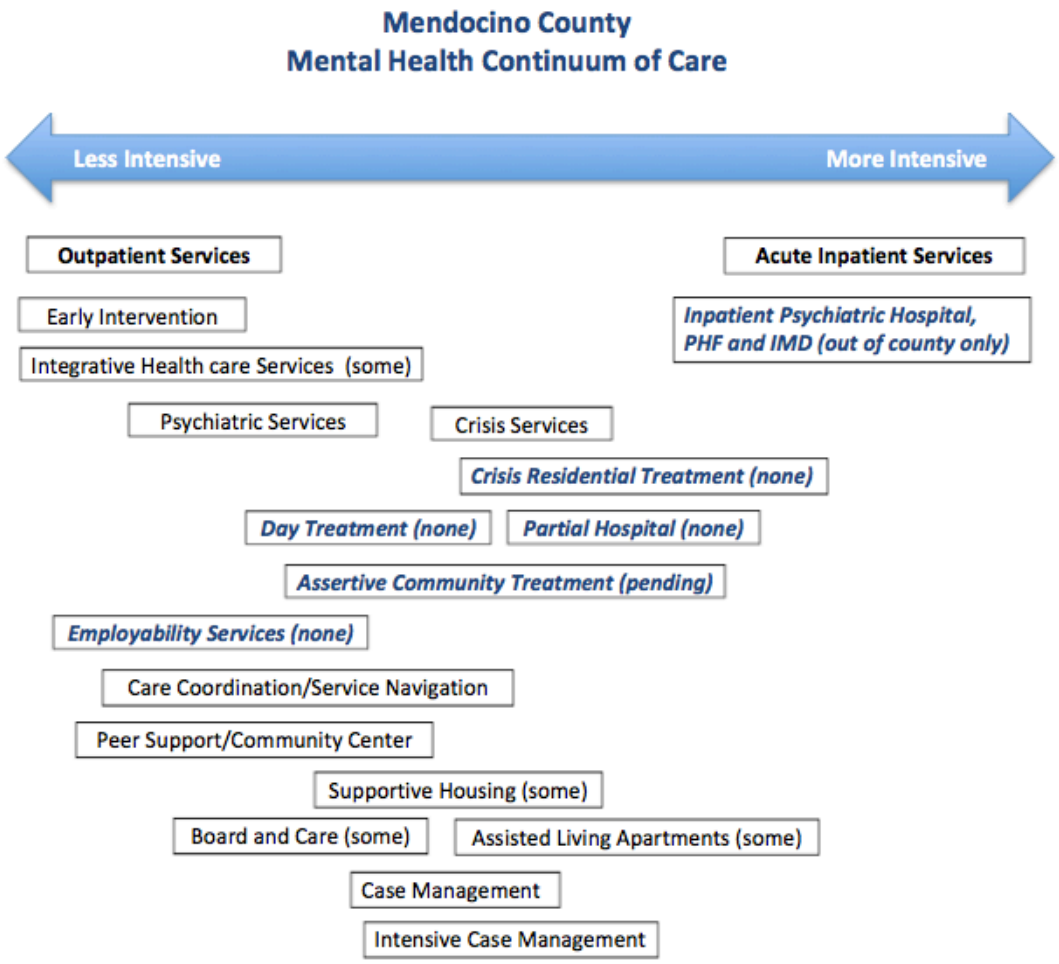
Counties utilize several sources of revenue to support the delivery of all required services, including Realignment, Medi-Cal reimbursements, Mental Health Services Act (MHSA), and county general funds. Redwood Quality Management Company (RQMC), Mendocino County's third party administrator, and its subcontractors deliver most of the mental health services provided to Medi-Cal eligible adults and children in Mendocino County. BHRS operates Mobile Outreach Team services in selected areas of the County.

As demonstrated on **Schematic 1** (following page), the current Mental Health continuum of care for both adults and children is missing a variety of key services in Mendocino County, including alternatives to inpatient psychiatric care (Day Treatment, Partial Hospital, Crisis Residential Treatment); inpatient psychiatric care (Psychiatric Health Facility, psychiatric inpatient services in an acute care hospital and IMD); and, Employability Services for adults.

B. Planned Additions to the Service Continuum

According to RQMC, there are two planned service additions partially underway. These include a Crisis Residential Treatment Center and a possible Crisis Stabilization Unit (CSU). Both components are included in a planned residential treatment campus to be located at 631 S. Orchard Street in Ukiah, California. Land at this location has been purchased, plans have been developed for both program components, and facility construction pends receipt of other funding.

SCHEMATIC 1



1. Substance Use Disorder Treatment Continuum of Care

A. Existing Service Continuum

Counties utilize several sources of revenue to support the delivery of all required Medi-Cal drug treatment services. These revenues include 2011 Realignment funding, Medi-Cal reimbursements, federal SAPT funding, and county general funds. California's Department of Health Care Services (DHCS) allocates funding for Drug Medi-Cal services to counties as a part of each county's Behavioral Health Subaccount allocation established by the 2011 Realignment law. Funds must be used exclusively for the Drug Medi-Cal Program, and to receive the funds, the county must contract with DHCS to arrange, provide, or subcontract

for the provision of services to all Medi-Cal eligible residents of the county. Mendocino County's BHRS Department is currently responsible for the provision of all Medi-Cal required services, which are:

- Outpatient drug-free treatment;
- Narcotic replacement therapy;
- Naltrexone treatment;
- Intensive Outpatient Treatment; and,
- Perinatal Residential Substance Abuse Services (excluding room and board).

The array of services currently required under Medi-Cal is limited and does not provide a comprehensive continuum of care for county residents; and, BHRS' SUDT treatment efforts focus primarily on the delivery of these five Medi-Cal services. As shown on **Table 2** (following page), there is some access to services beyond these in the County, including residential treatment, Medication Assisted Treatment, and treatment for dual diagnosis conditions, but these services are limited in availability. Furthermore, as of this writing, Mendocino County and DHCS are in discussions regarding the County's current level of compliance with Medi-Cal drug treatment requirements. Specifically, there is disagreement between DHCS and the County regarding the extent to which services are being provided and billing is taking place for Intensive Outpatient Treatment, the Narcotic Treatment Program, and Perinatal Residential Services.

B. Potential Additions to the Service Continuum

The Drug Medi-Cal program has developed an Organized Delivery System (ODS) model that is available to counties that opt-in to provide the expanded range of services. The ODS model is intended to provide a continuum of care modeled after the American Society of Addiction Medicine (ASAM) criteria for substance use disorder treatment services. Under the ODS model, counties that contract with DHCS will have expanded and more direct responsibility for assuring client access to drug treatment services and movement through the treatment system. The continuum of required services under the ODS model include: Early Intervention; Outpatient Services; Intensive Outpatient Services; Short-Term Residential Services; Withdrawal Management; Opioid/Narcotic Treatment Program Services; Recovery Services; Case Management; and, Physician Consultation. Optional additional services include: Medication Assisted Treatment (MAT); Partial Hospitalization,; and Recovery Residences. For Mendocino County to contract with DHCS and assume responsibility for operation of the ODS for Drug Medi-Cal services, the BHRS would need to address two key challenges:

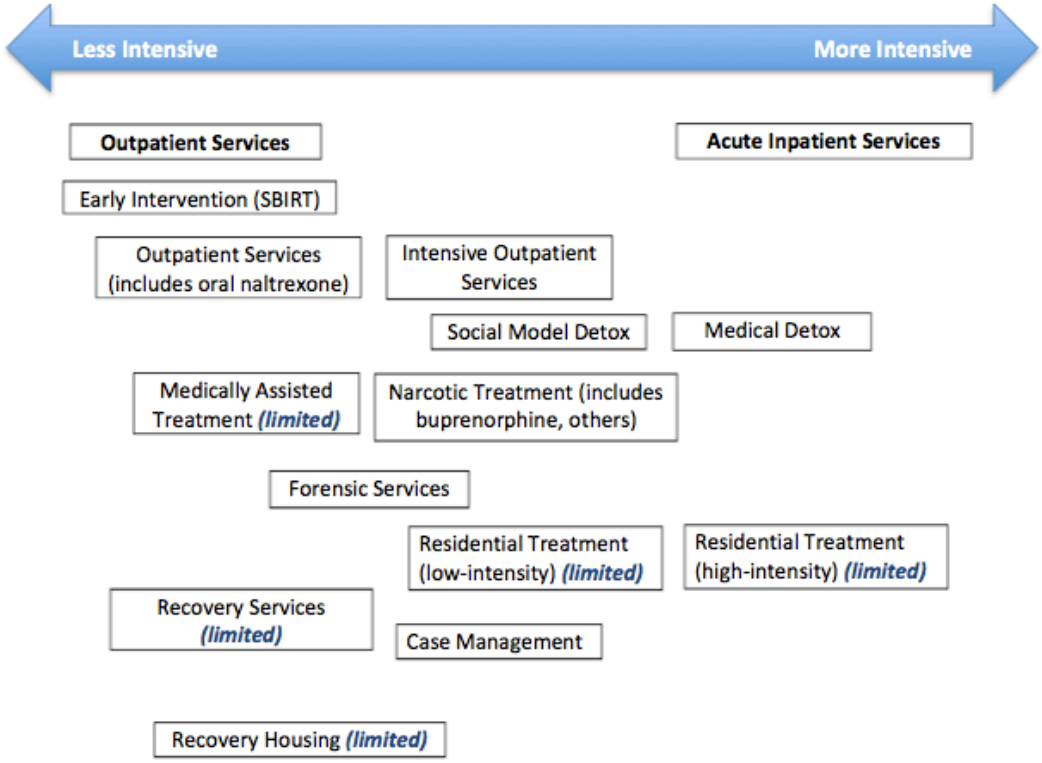
- Substantially expand administrative and program management operations to address all of the following: provider credentialing and contracting; quality assurance; compliance and service oversight; beneficiary outreach; claims processing; and policy direction; and,
- Identify and contract with an array of SUDT contractors for new service delivery.

Table 2[8] SUDT Services by Type of Service (FY 2016-17)				
Service Program	Name	Target Population	Served	Funding
Outpatient Services	BHRS	Medi-Cal	100	SAPT, Realignment, Medi-Cal
	Arbor Youth	Medi-Cal (ages 16-24)	NA*	Realignment, Medi-Cal
	Justice System/BHRS Collaboration	Dual Diagnosis	10	Realignment, Medi-Cal, MHSA
	Consolidated Tribal Health	Children, youth, adults, and seniors	NA*	MHSA, other
Perinatal Treatment	WINDO	Medi-Cal (pregnant women)	7	SAPT, Realignment, Medi-Cal
Prevention/Early Intervention	BHRS	Youth	395	SAPT, Realignment, Medi-Cal
Early Intervention	Justice System/BHRS	Adults with low-level crime	24	Fee-for-Service
Correctional Treatment	SUDT services in jail	Jail inmates	NA*	AB109
Adult Drug Court	Justice System/BHRS Collaboration	Adults with suspended state prison sentence	21	Realignment, Medi-Cal
Family Dependency Drug Court	Justice System/BHRS/CWS Collaboration	Families involved with Family/Children Services	78	Realignment, Medi-Cal, Family/Children Services
Residential Treatment	Athena House, Crossing the Jordan, Redwood Gospel Mission, Salvation Army	Individuals	32	Free (faith based)
	DAAC (Center Point), Humboldt Recovery Center	Individuals	6	Various
	Friendship House, Sierra Tribal Consortium	Individuals	5	Tribal funding
	New Life Community Services	Individuals	2	Private pay
	Ukiah Recovery Center	Individuals	1	Various
	Hilltop	Individuals	2	Various
	Progress House	Medi-Cal	23	Medi-Cal
	Health Right 360	Pregnant women/ mothers	1	Various
Medically Assisted Treatment	Santa Rosa Treatment Program, Drug Abuse Alternatives Center	Persons needing narcotic replacement therapy	NA*	Various
	Little Lakes Health Center, Long Valley Health Center, Mendocino Community Health Clinic, Mendocino Coast Medical Services	Persons needing naltrexone treatment	NA*	Various
TOTAL			707	
*Services with NA means data not provided				

Schematic 2 below presents a visual picture of the current continuum of SUDT services available to county residents.

SCHEMATIC 2

Mendocino County
Substance Use Disorder Treatment
Continuum of Care



In lieu of operating the ODS directly, Mendocino County may have the opportunity to participate in the ODS through a Regional Model for SUDT service delivery to be operated by Partnership Health Plan (PHC). Under the Regional Model, PHC is seeking to operate the ODS for eight counties participating in PHC. If PHC's plan is approved by DHCS, each of the counties would have the option to join. To participate, each county would pay PHC a single unique per-utilizer-per-month (PUPM) rate in exchange for PHC providing the required ODS services. As of this writing, the financing picture for PHC and the proposed rates for counties, including Mendocino County, are not yet finalized; and, BHRS has not made a determination regarding its approach for the ODS. ***Counties that do not operate the Drug Medi-Cal ODS directly or participate in the PHC Regional Model will not be eligible to receive Medi-Cal financing support for the expanded array of drug treatment services to Medi-Cal members.***

IV. Financing by Program

To place the revenues generated by Measure B into the broader financing context for mental health and SUDT services, we have prepared summary tables that show the array of existing programs and the amount budgeted for each program. The data provided for these tables was provided by RQMC and BHRS. Fund sources vary by program and may include Mental Health and SUDT Realignment, Medi-Cal, MHSA, and federal funds.

1. Mental Health Services

Overall funding dedicated to Mental Health Services provided through RQMC and its subcontractors in FY 2017-18 was $14,863,950. Of this amount, $8,983,950 was budgeted for services to children and $5,880,000 was budgeted for services to adults. See **Appendix C, Tables 1 and 2**, for a list of funding by program. Programs that do not exist are listed with none. Beyond the programs presented in this table, BHRS directly administers the Mobile Outreach and Prevention Services (MOPS) program, which was funded at $207,349 in FY 2017-18 (see **Appendix C, Table 3**).

2. Substance Use Disorder Treatment Services

Overall funding dedicated to Substance Use Disorder Services provided through BHRS and its contractors in FY 2017-18 was $2,096,335. Total persons served in FY 2016-17 were 707 persons. See **Appendix D** for a list of funding by program. With a population of just over 88,000 residents, current funding for SUDT services in Mendocino County is reaching only 707 people, less than 1% of the county population. The funding allocated to SUDT services is equal to roughly 14.1% of the funding allocated to mental health services.

V. Mental Health Service Utilization

1. Overall Mental Health Services Utilization

As shown in **Table 3**, a comparison of FY 2016-17 and FY 2017-18 mental health services utilization shows the following:

- More unduplicated (unique) persons received mental health services in FY 2017-18 ***– 18.4% more***
- More persons received Emergency Crisis Assessments ***– 22.8% more***
- More calls were made to the Crisis Line ***– 11.2% more***
- More unduplicated (unique) persons participated in Full Service Partnerships ***– 8.3% more***
- More inpatient psychiatric hospitalizations occurred ***– 17.3% more***

Based upon these data, three conclusions can be drawn. First, in FY 2017-18 Mendocino County's mental health system, under RQMC administration, responded to more crisis conditions, conducted more crisis assessments, and placed more people into inpatient psychiatric care than in FY 2016-17. Second, total hospitalizations reached 645, which represents a 17.3% increase in psychiatric hospitalizations over FY 2016-17. ***This is a significant increase.*** Finally, the number of Full Service Partnerships (FPP), designed to serve persons with serious mental illness, increased. However, they were provided to only a fraction of the persons that received inpatient psychiatric care. In FY 2016-17, roughly 24% received FPP support. For 2017-18, only 22.3% received FPP support.

Table 3[9]
Persons Served by Age and Type of Service
FY 2016-17 and FY 2017-18

Ages	Ages 0 to 24		Ages 25 to 65+		Total		
Fiscal Years	FY16-17	FY17-18	FY16-17	FY17-18	FY16-17	FY17-18	% Prior Year
Unique Persons Served	1280	1390	1044	1362	2324	2752	118.4%
Full Service Partnerships	43	42	90	102	133	144	108.3%
Emergency Crisis Assessments	593	661	1102	1420	1695	2081	122.8%
Inpatient Psychiatric Hospitalizations	163	225	387	420	550	645	117.3%
Crisis Line Contacts	1131	1001	4119	4837	5250	5838	111.2%

2. Persons Receiving Mental Health Services by Region

As shown in **Table 4** (following page) in both FY 2016-17 and FY 2017-18, slightly more than half of the persons that received mental health services in Mendocino County were residents of Ukiah and roughly 13% were residents of Willits. Residents of the North Coast, including Fort Bragg, composed between one-fifth and one-quarter of the service population. Residents in outlying areas, including North County,

Anderson Valley and South Coast, made up roughly 5% of the service population. Based on these data, it is evident that the primary locus for mental health services in Mendocino County is Ukiah, with a smaller emphasis on Fort Bragg and Willits, and that few services are reaching people in outlying areas.

Table 4[10]
Persons Served by Region
FY 2016-17 and FY 2017-18

Region	FY16-17	Percent	FY17-18	Percent
Ukiah	1288	55.4%	1459	53%
Willits	307	13.2%	353	12.8%
North County	64	2.7%	83	3%
Anderson Valley	27	1.2%	31	1.1%
North Coast	493	21.2%	670	24.3%
South Coast	39	1.7%	38	1.4%
OOC/OOS	106	4.6%	118	4.3%
TOTAL	2324		2752	

3. Inpatient Psychiatric Hospitalizations

To undertake our analysis, we received mental health service utilization data from RQMC for the first three-quarters of FY 2017-18 (July 2017 to March 2018). From these data, we developed various projections for the full fiscal year. Among these, we projected that 641 persons would be placed into inpatient psychiatric care in FY 2017-18. In a recent update, RQMC reported that 645 persons received inpatient psychiatric services in FY 2017-18 (as shown in **Table 3** on the prior page), but they were not able to provide complete data on utilization. Based upon the validation of our projection of 641 persons, we believe the projections presented in **Table 5** (following page) can be relied upon to assess other important measures associated with inpatient psychiatric care.

Based upon the first three-quarters of FY 2017-18, our projections show there has been significant growth in the utilization of inpatient psychiatric services between FY 2016-17 and FY 2017-18:

- Number of persons that received inpatient psychiatric services increased from 550 to 645 – ***an increase of 17.3%.***
- Total inpatient hospital days are calculated to increase from 4,300 to 5,524 – ***an increase of 28.5 %;***
- Average length of psychiatric hospital stay is calculated to increase from 7.8 days to 8.6 days – ***an increase of 8%;*** and,
- Average number of persons hospitalized each day (daily census) is calculated to increase from 11.7 to 15.1 average beds/day – ***an increase of 29%.***

Table 5[11] Inpatient Psychiatric Hospitalizations FY 2016-17 and FY 2017-18				
Data Points	**FY16-17**	**FY17-18**	**Projected**	**% Prior Year**
Unduplicated Persons Serviced	424	380	507	119.5%
Hospitalizations	550	481	645*	117.3%
Total Hospital Days	4,300	4,143	5,524	128.5%
Hospital days/Unduplicated person	10.1	10.9	109	108%
Average Hospital Days/Episode	7.8	8.6	8.6	110.2%
Average Daily Hospital Beds (Daily Census)	11.7	15.1	15.1	129%
*Reported actual for full fiscal year. All other projections based on nine months of data for FY 2017-18				

Because Mendocino County does not have inpatient psychiatric beds at any general acute care hospital in the County, or at a Psychiatric Health Facility in the County, all inpatient psychiatric placements were made out-of-county, as shown in **Table 6**. A comparison of data on inpatient psychiatric hospitalizations for both

Table 6[12] Inpatient Psychiatric Hospitalizations – Placement Locations FY 2016-17 and FY 2017-18			
Facility	**FY16-17**	**FY17-18**	**% Prior Year**
Aurora (Santa Rosa)	148	107	72.3%
Respadd (Redding/Red Bluff)	128	179	140%
St. Helena/Deer Park	137	262	190%
St. Mary's (San Francisco)	14	21	150%
John Muir	11	5	45.5%
St. Francis	8	0	0%
Marin General	15	11	73.3%
San Jose Behavioral Health	0	5	new
Woodland Memorial Hospital	0	7	new
Sierra Vista	14	0	0%
VA Hospitals	14	9	64.3%
Heritage Oaks	22	5	22.7%
Freemont	9	6	66.7%
Other Locations	30	28	93.3%
TOTAL	550	645	117.3%

fiscal years (**Tables 7 and 8** on following page) shows that not only are more unique individuals being placed into inpatient psychiatric care and there are more placements, but that a smaller proportion of high-need patients is driving utilization. In FY 2016-17, 19% of patients (82) had two or more episodes of care and utilized 44% (1,878) of total hospital days. In FY 2017-18, 18% of patients (68) had two or more episodes of care and utilized 46% (1,906) of total hospital days.

Table 7[13] Inpatient Psychiatric Hospitalizations FY 2016-17								
Number of Hospitalizations	1	2	3	4	5	7	Total	Averages*
Unduplicated Persons Served	342	54	19	4	4	1	424	10.1 days
Hospitalization Episodes	342	108	57	16	20	7	550	7.8 days
Total Hospital Days	2422	1020	483	178	139	58	4300	11.7 beds
Average Hospital Days/Episode	7.1	9.4	8.5	11.1	7.0	8.3		7.8
Average daily hospital use: 4300 hospital days/365 days = 11.7 beds per day. Average hospitalizations per unduplicated person: 4300 hospital days/550 persons = 10.1 days/episode. Average hospital days per episode: 4300 hospital days/550 hospitalizations = 7.8 days/episode ***Patients with 2+ episodes of care (82) = 1,878 hospital days***								

Table 8[14] Inpatient Psychiatric Hospitalizations FY 2017-18 (July 2017 to March 2018)								
Number of Hospitalizations	1	2	3	4	5	9	Total	Averages*
Unduplicated Persons Served	312	47	15	4	1	1	380	10.9 days
Hospitalization Episodes	312	94	45	16	5	9	481	8.6 days
Total Hospital Days	2237	1113	410	218	57	108	4143	15.1 beds
Average Hospital Days/Episode	7.2	11.8	9.1	13.6	11.4	12.0		8.6
*Based upon 9 months of reported data. ***Average daily hospital use (nine months of data): 4143 hospital days/274 days = 15.1 beds per day.*** Average hospitalizations per unduplicated person: 4143 hospital days/380 persons = 10.9 days/person. Average hospital days per episode: 4143 hospital days/481 hospitalizations = 8.6 days/episode ***Patients with 2+ episodes of care (68) = 1,906 hospital days***								

Additional data on the reasons for inpatient psychiatric care (placement criteria) and the reasons for Crisis Line Contacts can be found in **Appendix E, Tables 1 and 2.**

4. Data on Interactions with Law Enforcement

As previously shown in **Table 3** (see page 16) there were 5,838 Crisis Line contacts in FY 2017-18, for an average monthly number of 486 monthly crisis contacts. Of total calls to the Crisis Line, 402 calls were from various law enforcement agencies, including the County Sheriff, city police departments, the California Highway Patrol and the Jail, as shown in **Table 9** (following page).

Recently, the County Sheriff's Office started collecting data on the number of jail inmates that have been prescribed mental health medications. Such prescribing provides evidence of the need for mental health services by jail inmates. As shown in **Table 10** (following page), on a monthly basis, between 39% and 76% by jail inmates were prescribed mental health medications, for an average monthly rate of 62%.

Table 9 Calls from Law Enforcement to Crisis Line (FY 2017-18)[15]		
Agency	**Number**	**Percent**
County Sheriff	165	41%
Fort Bragg Police	55	13.7%
Ukiah Police	118	29.4%
Willits Police	32	8%
California Highway Patrol	9	2.2%
Jail	23	5.7%
TOTAL	402	100%

Table 10[16] Mendocino County Jail Inmates & Mental Health Conditions (CY 2018)			
Month	**Average Daily Jail Population**	**Population Receiving Medication**	**Percent Receiving Medication**
January	300	117	39%
February	301	157	52.2%
March	306	211	69%
April	299	216	72.2%
May	304	232	76.3%
Monthly Average	302	187	62%

Finally, as shown on **Table 13** (see page 27), only 18 of the 2,081 Emergency Crisis Assessments conducted in FY 2017-18 (less than 1%) were conducted at the County Jail. Most Emergency Crisis Assessments were conducted at the Crisis Center (38.4%); Ukiah Valley Medical Center (35.7%); Mendocino Coast District Hospital (13%); and, Howard Memorial Hospital (11.2%).[17] Notwithstanding where crisis assessments are conducted, many interventions leading to mental health crisis assessments involve law enforcement personnel with either the County Sheriff or one of the city policy departments.

VI. LPS Conservatorships[18]

A subset of persons that receive services from the Mental Health System is persons that are placed in conservatorships. ***For adults under conservatorship, the costs of these services are in addition to the amounts expended by RQMC for administration of the adult mental health system.*** A discussion of Conservatorships is presented in this section.

1. Background on LPS Decision Making Process

Individuals that meet Lanterman-Petris-Short (LPS) conservatorship criteria are persons that have been determined to meet criteria for grave disability; they are unable to meet basic care needs of food, clothing, and shelter to the detriment of life or limb due to a mental illness. This process is most commonly initiated through the Welfare & Institutions (W&I) Code 5150 process. An individual referred for inpatient psychiatric hospitalization under 5150 that continues to meet grave disability criteria to the point that they can't safely be returned to their home community is referred for a temporary conservatorship.

Once referred for temporary conservatorship, the County Public Guardian is notified and court hearings are held to determine whether the temporary guardianship will become permanent. On some occasions an individual is identified as gravely disabled who has not been hospitalized through the W&I 5150 process. In those cases the County Behavioral Health Director orders an evaluation/investigation of the person's grave disability, and if the result of the investigation determines the individual is gravely disabled, then a local petition for temporary conservatorship is initiated. These cases are most often initiated when the individual is in jail or cared for by family/others (basic care needs being attended to by others) and the care can't be sustained so conservatorship needs to be considered.

2. Roles and Responsibilities

Once the courts have approved and appointed guardian and conservatorship, the Public Guardian becomes responsible for the person and their estate unless indicated. The Public Guardian is responsible for psychiatric and financial decisions on the client's behalf. Psychiatric decisions, including placement, are made jointly between the Public Guardian and BHRS. The initial decision of where to place a client includes a review of the active symptoms and risk factors the client is experiencing. In situations where the client is in an inpatient psychiatric facility, the facility staff will often recommend a level of care. The Court standard is to order the least restrictive level of care necessary to meet the client's basic needs, and often an agreed upon level is determined at the hearing for permanent conservatorship. Once an individual is placed in a long-term residential care facility, the BHRS LPS Placement Coordinator and the Public Guardian jointly monitor the client's progress and needs, and the court is notified of all changes in the level of care.

LPS Conservatorships expire each year, and in order to be renewed an evaluation by two qualified clinicians

must independently determine the individual continues to remain gravely disabled. If one of the clinicians finds the individual does not meet conservatorship criteria, the conservatorship is dropped. If both find the individual continues to meet criteria, a court hearing is established. If the client contests the reappointment, a trial (judge or jury at the client's discretion) is heard to determine if the conservatorship will be reestablished. If an individual believes they are capable of caring for themselves they can also contest the conservatorship if it has been at least six months since the last court hearing. If the Public Guardian and BHRS do not feel the client continues to meet criteria the petition will not be renewed. Length of stay at facilities varies greatly depending on the severity of the individual's symptoms and individual responsiveness to treatment.

3. Types of Residential Placements

There are various types of long-term residential care placement options and there are many different scales of service within the types of care. Most placements that are targeted for long-term specialty mental health care fall in the category of Institutes for Mental Disease (IMD), and within this category of IMDs there State Hospitals, Mental Health Rehabilitation Centers (MHRC), Adult Residential Facilities (ARF), Residential Care Facilities for the Elderly (RCFE), and Skilled Nursing Facilities (SNF). Some other placement options are not targeted for specialty mental health care, but provide residential care for those with medical care needs or daily support related to aging or disability. For LPS conserved individuals that are almost ready to return to independent living and self care, there are supported living environments which are like independent homes but with staff regularly overseeing and providing support to assure the individual is eating, sleeping, taking medications, and otherwise meeting basic activities of daily living.

Residential Care Facilities that are specially designed for treating individuals with mental illness have two types of costs: board and care costs and patch rates. Payment for the board and care costs come out of the client's income (SSDI, etc.) and are paid by the Public Guardian's Office. The Public Guardian's Office facilitates obtaining income for clients that qualify when they are appointed guardian. These costs are relatively fixed across levels of placement. The patch rates are supplemental rates to cover the specialty mental health services provided in the facility. Patch rates vary considerably between placements and the type of services provided – between $60 and $1,000 per day – and are paid for by the BHRS.

County BHRS officials report there are a limited number of residential care facilities for specialty mental health issues in California, and that placements are frequently full and there is strong competition among counties for available placements. These officials also report that Mendocino County has limited in-county placements, and all of them are the lowest levels of care clients would utilize before returning to independent living from conservatorship. At this time, Mendocino County has only one specialty mental health board and care facility, and does not have any specialty Mental Health Rehabilitation Centers, Special Treatment Programs, acute psychiatric facilities, or state hospitals.

4. Data on LPS Conservatorships

As presented in **Table 11**, between FY 2015-16 and FY 2016-17, the average monthly number of clients in Conservatorship declined slightly, from 63.1 per month to 61.8 per month. While average monthly clients appear to have declined in FY 2017-18, total costs of care for FY 2017-18 are projected to equal or exceed those in FY 2016-17, at roughly $2.5 million. As shown on this table, ***roughly two-thirds of the conservatorship placements made in FY 2017-18 were made out-of-county because of the lack of suitable placement options in Mendocino County.***

Table 11
LPS Conservatorships
FY 2015-16, FY 2016-17 and FY 2017-18

Fiscal Year	Average Monthly Clients	Unduplicated Clients	Total Residential Days	Total Costs*	Placements in County	Placements out of County	Percent out of County
15-16	63.1	73	18,036	$2,640,962	24	60	71.4%
16-17	61.8	56	16,220	$2,516,904	36	41	53.2%
17-18	54.2	46	10,706	$1,909,176	17	34	66.57%

*Data provided by BHRS. Cost data reflects county costs and may not include costs that are absorbed by RQMC in serving the under 25 population.

VII. Selected Program Outcomes for Inpatient Psychiatric Care

Behavioral Health Concepts, Inc. ((BHC), a behavioral health consulting firm, serves as California's External Quality Review Organization (EQRO) for Medi-Cal Specialty Mental Health Services. We contacted BHC to obtain EQRO data on Mendocino County and comparison counties to compare overall performance on available measures. From BHC, we received selected performance data for FY 2016-17 pertaining to inpatient psychiatric care. Among other things, **Table 12** provides data on Mendocino County and comparison counties regarding:

- Percent Medi-Cal population;
- Percent of high cost clients;
- Re-hospitalization rates post hospital discharge (within 7 days and within 30 days); and,
- Provision of outpatient services post hospital discharge (within 7 days and within 30 days).

Based on these measures, in comparison with other California counties, in FY 2016-17 Mendocino County had one of the highest proportions of county residents eligible for Medi-Cal and one of the highest proportions of clients that are considered "high cost." Notwithstanding these dynamics, Mendocino County's re-hospitalization rates were less than or equal to most other counties; and, the County's provision of outpatient services was generally better than most other counties and the statewide average. ***However, based on 550 inpatient placements in FY 2016-17, these data show many clients did not receive outpatient services within 7 days (193, or 35% of clients) and many did not receive outpatient services within 30 days (143, or 26% of clients).***

Table 12[19]
EQRO Mental Health Service Outcomes (FY 2016-17)
Mendocino & Selected Comparison Counties

County	Population	Percent Medi-Cal	Percent High Cost	7-Day Re-hosp	30-Day Re-hosp	Outpatient within 7 Days	Outpatient within 30 days
Mendocino	**88,378**	**47.0%**	**4.38%**	**3%**	**9%**	**65%**	**74%**
Nevada	98,095	26.2%	5.56%	5%	10%	52%	68%
Lake	64,306	48.8%	3.08%	4%	9%	53%	71%
Sutter-Yuba	171,653	43.2%	1.79%	2%	8%	40%	72%
Napa	142,028	23.0%	2.93%	3%	3%	35%	55%
Humboldt	135,116	39.7%	2.63%	10%	22%	26%	61%
State Average	39,255,883	34.5%	2.86%	5%	15%	40%	58%

EQRO Definitions:
- High Cost: Clients with approved claims of more than $30,000 in a year
- Re-hospitalization: After discharge from an inpatient facility client goes back to an inpatient facility within 7 or 30 calendar days.
- Outpatient Follow-up: Documents whether or not a patient received an outpatient service within 7 or 30 days post discharge from an inpatient psychiatric facility (first hospitalization only, not prior or subsequent hospitalizations)

VIII. Addressing Gaps in the Mental Health Services Continuum

As discussed in Section III, there are a number of key gaps in the current continuum of mental health services in Mendocino County. This section considers alternative approaches for addressing these gaps, presents the experience of other counties, and places the approaches in the Mendocino County context.

1. Crisis Stabilization Unit (CSU)

As defined by California DHCS, "crisis stabilization services last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires a timelier response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral, and therapy."[20] A Crisis Stabilization Unit (CSU) is licensed as an outpatient mental health program for up to 23 hours and 59 minutes of crisis stabilization and observation. Clients voluntarily admit for services or are brought in on a 5150 hold by law enforcement (or other LPS designated staff based on county policy). A CSU is utilized to provide a centralized location for conducting voluntary and involuntary mental health assessments and provides an alternative to a hospital ED. A CSU typically provides:

- Crisis stabilization, with a focus on individualized interventions directed toward resolution of the presenting, psychiatric episode;
- Evaluation of clients for whom inpatient psychiatric hospitalization may be indicated;
- Admission of clients for inpatient, psychiatric hospitalization;
- Referral for drug and/or alcohol use issues; and,
- Referrals to other county and community-based agencies and services.

As of October 2017, California's DHCS reported that sixteen counties were operating a CSU, including Alameda, Contra Costa, Fresno, Humboldt, Kern, Marin, Orange, Riverside, Sacramento, San Diego, San Francisco, San Joaquin, Santa Clara, Santa Crus, Sonoma, and Solano Counties. Most of these counties are counties with larger populations.[21] Three smaller counties not referenced in DHCS report – Napa, Nevada and San Luis Obispo Counties – have recently opened CSUs. Their programs are briefly described below:

- *Nevada County.* Since October 2016 Nevada County has operated a CSU that the County calls its "Mental Health Urgent Care Center." As described by the County, this 4-bed center is a 23-hour program that provides emergency psychiatric care in a warm, welcoming environment for individuals experiencing a mental health crisis. The center is located adjacent to the Sierra Nevada Memorial Hospital Emergency Department, where all evaluations occur after CSU business hours. The center is an LPS designated facility that can accept voluntary as well as 5150 clients. The program was funded by SB 82.[22] The Urgent Care Center is contracted to Sierra Mental Health Wellness group, a community based organization. Operational costs are between $1.2 and $1.3 million annually. According to the

Nevada County Health and Human Services, the CSU currently operates at a revenue loss estimated at roughly $400,000 due to fewer savings associated with reduced inpatient hospitalization than originally anticipated. At this time, Nevada County plans to continue the program because it is considered important to the overall wellbeing of the community.[23]

- *Napa County.* Napa County received $1.998 million in SB 82 funding for development of a 4-bed Crisis Stabilization Unit (CSU) to serve individuals experiencing a mental health crisis. Grant funds were used for the construction and renovation and for purchase of furnishings, equipment, and for information technology costs. The CSU is intended to fill gaps in the County's continuum of care and will serve approximately 2,190 clients on an annual basis. This estimate includes clients needing emergency psychiatric medication services and general crisis services that may not require staying at the CSU. The CSU is designed to serve individuals that are in psychiatric crisis, including those seeking services voluntarily as well as referrals from first responders such as police, sheriff, paramedics, ambulance and hospital Emergency Departments.[24] Based on the first year of operations, Napa County officials reported a revenue shortfall of roughly $475,000.[25]

- *San Luis Obispo County.* San Luis Obispo County recently opened a new 4-bed CSU on a shared campus near the county's existing Psychiatric Health Facility. San Luis Obispo County received $971,070 in SB 82 funding for development of the facility. The County contributed $300,000 to the project, for a total cost of roughly $1.2 to $1.3 million. The 4-bed CSU is designed to provide immediate response on a short-term basis (lasting less than 24 hours) to stabilize individuals experiencing mental health crises. County officials reported they expect the new facility to relieve strain on the county's 16-bed PHF. According to local officials, annual operating costs are projected to be between $1.4 million and $1.6 million.[26]

Research shows that a centralized Crisis Stabilization Unit that provides psychiatric emergency services can reduce boarding time in the hospital Emergency Department and ED clearance and placement time.[27] While a CSU can contribute to a reduction in the placement of persons into inpatient psychiatric care, such a reduction is not assured. For example, Napa County officials reported that their early experience with their CSU has not reduced inpatient utilization, but instead has contributed to a modest increase. Furthermore, to the extent there are limited service options available that provide an alternative to inpatient psychiatric care, a CSU by itself will not reduce inpatient admissions. It does, however, provide an alternative location to hospital EDs for the provision of psychiatric emergency services, and it provides law enforcement with a location to take patients that does not require officers to remain with patients to provide security while determinations are made concerning treatment and placement.

A. Mendocino County Context

As shown in **Table 13**, the number of Emergency Crisis Assessments increased from 1,695 in FY 2016-17 to 2,081 in FY 2017-18 – ***an increase of 22.8%.*** In FY 2017-18, most assessments took place at the Crisis Center (38.3%), Ukiah Valley Medical Center (26%), Mendocino Coast District Hospital (13%), and Howard Memorial Hospital (11.2%). As presented in **Table 5** (see page 18) 550 persons were placed into inpatient psychiatric care in FY 2016-17 and 645 persons were placed in FY 2017-18. The increased volume of persons needing mental health assessment, and the increased need for placement in inpatient psychiatric care, is putting increasing strain on hospital Emergency Departments in the County and is imposing costs on these hospitals as they hold patients awaiting placement in out-of-county psychiatric facilities.

Table 13[28]
Emergency Crisis Assessments
FY 2016-17 and FY 2017-18

Location	FY16-17	%	FY17-18	%
Ukiah Valley Medical Center	708	42%	742	35.7%
Crisis Center-Walk Ins	491	29%	798	38.4%
Mendocino Coast District Hospital	235	14%	270	13%
Howard Memorial Hospital	209	12%	233	11.2%
Jail	12	<1%	18	<1%
Juvenile Hall	13	<1%	6	<1%
Schools	10	<1%	3	<1%
Community	15	<1%	11	<1%
FQHCs	2	0%	0	0%
TOTAL	1695	100%	2081	100%

At an annual rate of 2,081 mental health assessments, the average daily rate is 5.7 assessments per day. Based on the experience of other counties, it may be challenging for a CSU to be financially self-sustaining with available Medi-Cal and other third party reimbursements. However, the value of investing resources in this approach may be derived more from having a centralized assessment operation with centralized clinical operations that relieves local hospitals from the responsibility and cost of providing a secure and safe Emergency Department location for these assessments, and where local law enforcement can reliably take persons needing assessment and hand-off responsibility to responsible officials.

As referenced earlier, both Nevada County and Napa County operate CSUs and both have had difficulty making their CSU operations fully reimbursable and self-sustaining. Nevada County reported that its operating revenue (funding from various billable sources, including Med-Cal, other insurance) is roughly $400,000 below break-even. Similarly, Napa County reported that its operating revenue shortfall in FY 2017-18 is roughly $475,000. Based on this experience, we anticipate additional funding support beyond Medi-Cal and other reimbursements would be needed to support CSU operations.

It is important to note that Mendocino County's geography and the locus of most service delivery makes the utility of a CSU on the 101-corridor more impactful for the hospitals in Ukiah and Willits than for Mendocino Coast District Hospital in Fort Bragg. In our interviews with representatives of Ukiah Valley Medical Center and Howard Memorial Hospital, we learned that both hospitals hold ED beds for individuals pending 5150 determinations and placement of patients in care. Howard Memorial Hospital reported that an average of 2 beds is held each day. If a CSU were established as a part of the new Crisis Residential Treatment facility campus (already supported by SB 82 funding) there would be a relief of this responsibility for both hospitals, along with cost-savings due to these beds becoming available for other ED purposes. A separate strategy would need to be developed for the Mendocino Coast that makes the assessment processes at Mendocino Coast Hospital complementary with the CSU in Ukiah.

Based on our review of the data and current service dynamics, we believe a CSU makes sense for Mendocino County. However, prior to finalizing terms for operation of a CSU, we believe a fiscal analysis needs to be completed by RQMC, in consultation with BHRS and local hospitals, that considers all of the following:

- Projected daily and annual CSU utilization, and underlying assumptions;
- Projected CSU operational costs, and underlying assumptions;
- Identification of key revenue sources, including Medi-Cal, and projection of revenues by revenue source, and estimate of funding needed to support CSU operations; and,
- Identification and quantification of offsetting savings to local hospital EDs resulting from reduced use of hospital facilities for emergency psychiatric conditions.

It is important to state that a CSU is a crisis response strategy. It is not a strategy to prevent crises from occurring in the first place. However, as a part of post crisis follow-up, a CSU that is co-located with a Crisis Residential Treatment (CRT) program would be a practical option, because some persons in crisis could be placed into residential treatment instead of inpatient psychiatric treatment. This is the approach being taken by Bay Area Community Services (BACS), which is working to open a facility that provides an LPS designated CSU on the first floor and a second floor that will serve as a 12-16 bed CRT. It is also similar in approach to that taken in San Francisco County by the Progress Foundation, which is providing a walk-in voluntary (non-LPS designated) Urgent Care Center with a CRT program.

RECOMMENDATION: It is recommended that a CSU should be established in Mendocino County and annual operating revenue should be allocated to support the CSU from Measure B funds. This CSU should be placed in the context of a planned Crisis Residential Treatment Program, discussed later in this report.

2. Embedded Crisis Clinicians in Hospital Emergency Departments

The embedding of crisis clinicians in a hospital Emergency Department is an alternative to establishing a

CSU. With this approach, embedded clinicians provide assessment and treatment of mental health conditions in the hospital ED 24/hours per day, 7 days/week. Local law enforcement responding to persons with mental health conditions takes these persons to the hospital ED for mental health assessment and treatment. Depending on local needs and priorities, the crisis clinicians embedded at the hospital can be county employees, contracted employees, or hospital employees.

Two studies of embedding crisis clinicians in EDs showed comparable findings. One study involved embedded crisis worked from the University of Pittsburgh Medical Center-Mercy and Western Psychiatric Institute and Clinic of UPMC, who provided interventions aimed at quickly linking patients with the care and resources. With this intervention, the percentage of patients admitted to the hospital for MH or addiction matters declined.[29] A second study involved the placement of four mental health professionals that provided crisis assessments for patients in the ED in an Access Center that was added to the ED. The Access Center was staffed 24 hours a day, 7 days a week and was available to meet the mental health needs of ED patients quickly.[30]

Sutter County operates a joint county mental health plan for Sutter and Yuba Counties. Sutter County utilizes an "embedded crisis clinician" model in the Rideout Memorial Hospital ED, as described below.

- *Sutter-Yuba Counties.* The Sutter-Yuba program operates two psychiatric emergency services units. One unit embeds crisis clinicians in the Rideout Memorial Hospital ED. The second unit is a walk-in (non-LPS) crisis clinic that is on a shared campus with the county's psychiatric health facility. Clinicians with these two units conduct assessment, placement, referral to outpatient services, and some scheduling into county behavioral health services. Staffing for the two units includes a 15 crisis counselors and 4 therapists. The two units operate 24 hours/day, seven days/week.[31]

A. Mendocino County Context

In addition to staffing a Crisis Center, RQMC dispatches crisis clinicians to the three hospitals in Mendocino County: Ukiah Valley Medical Center, Howard Memorial Hospital, and Mendocino Coast District Hospital. These crisis clinicians are not embedded clinicians that stay at each facility on a 24-hour, 7-day per week basis. Rather, these clinicians are called and go to the hospital EDs as needed. Current Memoranda of Understanding between the hospitals and RQMC provide specified response times. In general, county law enforcement and hospital representatives reported that RQMC's response is reliable and timely.

In light of the current role RQMC crisis clinicians play in responding to mental health crises at Mendocino County hospitals, it is not clear how embedding crisis workers on a full-time basis in each hospital would substantially improve current dynamics. On the one hand, if the crisis clinician is "at the ready" in the local hospital, the worker is immediately ready to receive the client. On the other hand, if the time standards set in the MOUs are workable, it isn't clear what the improved outcomes would be of having embedded

workers, as the primary issue would remain placement in a locked setting. Furthermore, for the embedded crisis worker concept to succeed, local hospitals would need to allocate designated space on a full-time basis for these crisis workers. Second, the locus of crisis mental health care would continue to be local hospital EDs, and current dynamics of psychiatric patients sitting in the ED awaiting placement would likely continue, and current cost impacts to hospitals would remain.

RECOMMENDATION: The embedding of crisis mental health clinicians in local hospitals would not substantively improve local service dynamics and is not recommended for Mendocino County.

3. Crisis Residential Treatment Services

As defined by the California DHCS, adult Crisis Residential Services (CRS) "provide an alternative to acute psychiatric hospital services for beneficiaries who otherwise would require hospitalization. The CRS programs for adults provide normalized living environments, integrated into residential communities. The services follow a social rehabilitation model that integrates aspects of emergency psychiatric care, psychosocial rehabilitation, milieu therapy, case management and practical social work."[32] Crisis residential services are designed to provide a positive, temporary alternative for people experiencing an acute psychiatric episode or intense emotional distress who might otherwise face voluntary or involuntary commitment. Programs provide crisis stabilization, medication monitoring, and evaluation to determine the need for the type and intensity of additional services within a framework of peer support and trauma-informed approaches to recovery. The programs emphasize mastery of daily living skills and social development using a strength-based approach that supports recovery and wellness in homelike settings.

According to the California Mental Health Planning Council, crisis residential treatment programs "reduce unnecessary stays in psychiatric hospitals, reduce the number and expense of emergency room visits, and divert inappropriate incarcerations while producing the same, or superior outcomes to those of institutionalized care."[33] Our research found that a handful of Northern California counties have Crisis Residential Treatment programs (**Table 14**), and only Shasta County operates the program directly.

Table 14[34]
Counties with Crisis Residential Treatment Programs

County	Operated by County	Beds
Shasta	Yes	15
Butte	No	10
Placer-Sierra	No	14
Sonoma	No	20
Marin	No	10
Napa	No	8
Yolo	No	14

In our research, we also found California counties that developed hybrid models that incorporated a Crisis Residential Treatment (CRT) program. These models include the following:

- *Placer County.* Placer County combines mental health assessment of clients in the hospital ED with a CRT program. Clients that do not need inpatient placement may go to the CRT program or alternative service. Placer County employs three (3) clinicians per day, 1 of who is stationed at their busiest hospital in Roseville. The other 2 clinicians are available to respond to the other hospital ED and to the two jails for crisis evaluations. A contractor (Sierra Wellness Group) manages the afterhours and weekends portion, during which they employ 2 clinicians from 5pm to midnight, and 1 for the overnight with 1 backup/on-call. The county does have the back-up option of a PHF for inpatient placements when needed. According to county officials, this approach has provided a cost-effective alternative to inpatient hospitalization.[35]

- *San Francisco County.* San Francisco County's Progress Foundation combines a walk-in voluntary Urgent Care Center with a CRT. While the Urgent Care Center is non-LPS designated, it serves as an alternative to a CSU, and to inpatient hospitalization and it provides immediate care with the option of up to 14 days of crisis residential services.[36]

- *Bay Area Community Services (BACS).* BACS is working to open a combined CSU with a CRT to allow easy access to on-going services in Oakland. The BACS program will be done with a home they are remodeling to have the first floor provide an LPS designated CSU with a second floor that serves as a 12-16 bed CRT.[37]

A. Mendocino County Context

Mendocino County's MHSA Three Year Program and Expenditure Plan states that the County is partnering with mental health contract providers to develop a Crisis Residential Treatment (CRT) facility for adults (18 and older) to be funded, in part, by a Mental Health Wellness Grant. Operational funding for the program is expected from MHSA/CSS and Medi-Cal, and the Plan states that the program is in the development phase with intentions to open doors in FY 2018-19.

According to the MHSA Plan, "the CRT facility will be a therapeutic milieu for consumers in crisis who have a serious mental health diagnosis and may also have co-occurring substance use and/or physical health challenges to be monitored and supported through their crisis at a sub-acute level." The CRT will put an emphasis on "reducing inpatient hospitalizations when possible, reducing unnecessary emergency room visits for mental health emergencies, reducing the amount of time in the emergency room, and reducing trauma and stigma associated with out-of-county hospitalization."[38]

Mendocino County received an SB 82 grant for $500,000 that was approved for the purpose of building a 10-bed Crisis Residential Treatment (CRT) Program. As stated in the terms of the grant, the program "will provide a clinically effective and cost-efficient alternative to psychiatric hospitalization for individuals ages 18 and over experiencing a mental health crisis." Redwood Community Services (RCS), an affiliated agency of RQMC, was awarded a contract by Mendocino County to provide CRT services, as well as locate and secure a property as the County's designated grantee. RCS projects it will serve up to 800 individuals annually at the facility. SB 82 grant funds were provided to purchase real property, renovate real property, purchase furnishings, equipment, and information technology and to finance 3 months of start-up costs.[39] Land at 631 S. Orchard Street, Ukiah, was purchased with the SB 82 funding and construction of a facility, which would include a CSU on the same grounds, pends receipt of other financing. The projected cost of construction for the combined Crisis Residential Treatment facility and CSU is approximately $4.66 million, not including the land that has already been purchased.[40]

RECOMMENDATION: A Crisis Residential Treatment Program should be established in Mendocino County and capital construction of the facility (including a CSU) at 631 S. Orchard Street, Ukiah, should be funded by Measure B funds, if funding is not readily available from other sources.

4. Psychiatric Inpatient Services

As defined by the California DHCS, psychiatric inpatient hospital services "include both acute psychiatric inpatient hospital services and administrative day services. Acute psychiatric inpatient hospital services are provided to beneficiaries for whom the level of care provided in a hospital is medically necessary to diagnose or treat a covered mental illness. Administrative day services are inpatient hospital services provided to beneficiaries who were admitted to the hospital for an acute psychiatric inpatient hospital service and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services due to lack of residential placement options at non-acute residential treatment facilities that meet the needs of the beneficiary."[41]

Psychiatric inpatient hospital services are provided by Short-Doyle/Medi-Cal (SD/MC) hospitals and Fee-for-Service/Medi-Cal (FFS/MC) hospitals. County Mental Health Plans (MHP) are responsible for authorization of psychiatric inpatient hospital services reimbursed through either billing system and for payment of the non-federal share of cost for Medi-Cal beneficiaries.

As defined by DHCS, a Psychiatric Health Facility (PHF) "is a facility licensed under the provisions beginning with Section 77001 of Chapter 9, Division 5, Title 22 of the California Code of Regulations. Psychiatric Health Facility Services are therapeutic and/or rehabilitative services provided in a psychiatric health facility on an inpatient basis to beneficiaries who need acute care, and whose physical health needs can be met in an affiliated general acute care hospital or in outpatient settings."[42] A PHF is an alternative category of acute psychiatric care provided in a Psychiatric Inpatient Hospital. Under federal Medicaid law, a PHF with

16 beds or less may qualify for federal Medicaid reimbursement, subject to other state licensing requirements. County MHPs are responsible for authorization of psychiatric inpatient hospital services provided in a PHF and for payment of the non-federal share of cost for Medi-Cal beneficiaries.

The California Hospital Association (CHA) has developed data on the availability of psychiatric inpatient services in California. Using a standard of 50 beds needed for each 100,000 county residents, CHA estimates that the 13-county region presented in **Table 15** needs 776 inpatient psychiatric beds. As shown on this table, current inpatient psychiatric bed capacity in the 13-county region is 234 beds. CHA estimates that Mendocino County needs 44 inpatient psychiatric beds.

Table 15[43]
Acute Care Psychiatric Bed Distribution – Northern California

County	Population	Adult Hospital Beds	Child/Adol Hospital Beds	Gero-Psych Hospital Beds	Psych Intensive Care Beds	PHF Beds	Chem/Dep Beds
Mendocino	87,649	0	0	0	0	0	0
Colusa	21,482	0	0	0	0	0	0
Del Norte	27,254	0	0	0	0	0	0
Glenn	28,017	0	0	0	0	0	0
Humboldt	135,727	16	0	0	0	16	0
Lake	64,591	0	0	0	0	0	0
Marin	261,221	17	0	0	0	0	0
Napa	142,456	37	0	0	0	0	0
Shasta	179,533	37	0	0	0	16	0
Siskiyou	43,554	0	0	0	0	0	0
Sonoma	502,146	75	20	0	0	0	0
Tehama	63,308	0	0	0	0	0	0
Trinity	13,069	0	0	0	0	0	0
TOTALS	1,570,007	182	20	0	0	32	0

The CHA standard of 50 psychiatric beds for every 100,000 in population aligns with the standard recommended by the Treatment Advocacy Center in 2008. The Center solicited estimates of bed need from 15 experts on psychiatric care in the United States, including professionals that have run private and state psychiatric hospitals, county mental health programs, and experts on serious psychiatric disorders. A range of 40 to 60 beds per 100,000 in population was identified through this process, and a consensus of 50 beds per 100,000 in population was approved.[44]

A. Mendocino County Context

Mendocino County does not have any inpatient psychiatric beds in a general acute care hospital or a PHF in the County. Based on current inpatient psychiatric hospital utilization data, there is clear evidence of high

need for inpatient psychiatric beds. As presented in **Table 5** (see page 18), between FY 2016-17 and FY 2018 there was a 17.3% increase in inpatient psychiatric placements, and the average number of persons receiving inpatient psychiatric care increased from 11.7 to 15.1 per day, an increase of 29%.

The rate of growth in Mendocino County's utilization of inpatient psychiatric care between FY 2016-17 and FY 2017-18 should alarm public officials and the public. This high level of utilization and its associated costs are not in line with the BHRS Mental Health Department's mission to deliver services "in the least restrictive, most accessible environment within a coordinated system of care that is respectful of a person's family, language, heritage and culture." Further, the costs associated with this level of care are not sustainable over time. ***These data reveal a serious weakness in the overall composition of the County's mental health services continuum – there are no meaningful alternatives to inpatient psychiatric care, and there are insufficient front-end services that support persons with mental illness and reduce the incidence of crisis conditions.***

Further, as shown in **Table 8** (see page 19), based upon the first nine months of FY 2017-18, sixty-eight (68) unduplicated persons with two or more inpatient episodes (18% of clients) utilized 1,906 total hospital days (46% of hospital days) and 312 unduplicated persons with one inpatient episode (82% of clients) utilized 2,237 total hospital days (54%). The small multiple episode group, the so-called "frequently utilizers," followed a trajectory of placement, return to the community, and return to placement. This dynamic reveals a lack of sufficient community-based treatment support and ongoing follow up services for people that return from inpatient care. These data, along with the data referenced above, demonstrate the need for a much more robust front-end continuum of services that reduces the need for inpatient psychiatric care, including but not limited to Crisis Residential Treatment, day treatment, supported housing, and other supports.

At the same time, these data demonstrate that Mendocino County has an immediate need for inpatient psychiatric beds at either a general acute care hospital or PHF, and that unless a facility is constructed in Mendocino County to address this demand, the County will continue to compete with other California counties for limited inpatient placement opportunities out-of-county.

There are two options for Mendocino County to expand inpatient psychiatric bed capacity in the County. One option is for one of the local hospitals along the Interstate 101-corridor to build a new wing for psychiatric beds. We identify hospitals along this corridor because this is locus of most demand for services and care provided in the County. In our discussions with Ukiah Valley Medical Center and Howard Memorial Hospital officials, we found genuine interest in the concept. At the same time, we understand that in order for either hospital to make a commitment to expand hospital facilities and operations to take on this responsibility, the owner of those facilities, Adventist Health, would need to make a determination that it is in the organization's strategic business interest to take on the responsibility. Further, we understand that final decisions for such an undertaking would be made at the organization's corporate

level, not at the local hospital level. Accordingly, we cannot assess the viability or likelihood that one or both of these hospitals would want to take on this responsibility.

Alternatively, a second option is that Mendocino County could proceed to develop a 16-bed Psychiatric Health Facility that meets Medi-Cal standards for reimbursement at a suitable site in Mendocino County. For this avenue to be pursued, the Board of Supervisors would need to identify a suitable location for the facility and establish a process for determining ownership of the facility, build responsibility, and operational responsibility. Additional discussion about development of a PHF is provided in **Section IX**.

RECOMMENDATION: Expanded psychiatric inpatient hospital capacity is needed in Mendocino County. Facility construction costs for the development of this capacity should be funded by Measure B funds.

IX. Considerations for Development of a Psychiatric Health Facility

There are three options for development of a Psychiatric Health Facility (PHF) in Mendocino County:

- County owned and County operated facility;
- County owned facility and private provider operates facility under contract with the County; and,
- Privately owned and operated facility and provider contracts with the County.

For all three options a variety of decisions will need to be made by county officials, including determination of the location and ownership of the land for the PHF; build management responsibility; and, operational responsibility, including the determination of the agency or agencies that make patient admission decisions and prioritize bed availability. In the following discussion, we outline features that are common to all three options and identify features that are unique to each option.

1. Features Common to Three PHF Options

A. Construction and Clinical Licensing Requirements

The construction requirements, facility licensure requirements, and clinical staffing requirements are common to all three options. Generally, California health facility laws and regulations define the requirements for construction of a Psychiatric Health Facility (PHF). California regulations for clinical staffing for a 16-bed PHF[45] are briefly summarized below:

- Clinical Director (who may also serve as the administrator);
- On-call psychiatrist 24/7;
- 17 total staff over a 24-hour period, off which there shall be 2 licensed mental health professionals, 5 nursing staff, and 5 mental health workers;
- LCSW to oversee social services;
- RN 40 hours per week; and,
- Registered nurse, a licensed vocational nurse, or a psychiatric technician awake and on duty in the facility at all times.

B. Populations Served

Typically, Medi-Cal reimbursable clients are the primary target population for a PHF, although most PHFs take clients that have other insurance coverage when the admission is approved by the county. According to data provided by RQMC, 78% of persons receiving Emergency Crisis Assessments in FY 2017-18 were enrolled in Medi-Cal, either with Partnership Health Plan or dual Medicare/Medi-Cal enrollees.[46] Based on this statistic, it is reasonable to assume that most patients treated at the PHF will be covered by Medi-Cal.

When a local mental health system has a full continuum of services that provide support to persons with mental illness and prevent hospitalization, the reliance on inpatient psychiatric care provided by a PHF or other facility can be reduced. Assuming that Mendocino County is committed to reducing inpatient utilization and maximizing the treatment of persons with mental illness in less restrictive settings as described in the BHRS Mental Health Mission Statement, the PHF should be viewed as a resource for the provision of needed inpatient psychiatric care with the intention that committed efforts will concurrently be made to reduce utilization of that type of care. When that type of care is reduced, the PFH can continue to play an important role in the County by providing that care when it is needed; and, it can remain financially viable by accepting patients needing inpatient psychiatric care from other counties in the region. As shown on **Table 15** (see page 33), there is a dearth of available inpatient psychiatric beds in the Northern California region. This means there will be a ready supply of patients needing care that can be served by a facility in Mendocino County.

As a part of establishing a PHF, Mendocino County will need to define the terms for how priority will be given to Mendocino County patients and the conditions for placement of non-county residents. It should be possible for Mendocino County, or the PHF under contract with Mendocino County, to structure agreements with other counties that make beds available when Mendocino County needs are met and excess capacity at the facility exists. This model is currently used for Nevada County, Mariposa County, and Trinity County, all of which do not have their own facilities but instead contract with El Dorado County (as well as other facilities) to purchase beds at the PHF in El Dorado County.[47]

C. Projected Build Costs

Not including the cost of the land, the estimate for the cost of construction a new PHF facility is between $5 and $6 million. This estimated cost range is based upon interviews with representatives of Heritage Oaks Hospital and Telecare, two PHF providers in the State of California and in the Northern California region.[48] We also contacted Butte County, which owns and operates its own PHF, but county officials were unable to provide build costs because the county's building is over 20 years old.[49]

The cost of remodeling a county-owned or other building is estimated at a minimum of $300 per square foot. This estimate is based upon an interview with Restpadd, which operates PHFs in Shasta County and Tehama County.[50] It is important to note that this cost estimate of $300 per square foot is subject to volatility because it is strongly influenced by the specific conditions of a potential site, the site's compliance with current building codes and its readiness for construction, including environmental conditions. In our research, we found current PHFs range in size from 7,500 and 14,000 square feet.[51] With a square foot cost of $300, we project a cost range of $2.25 million to $4.2 million for a remodeled building.

We note that this cost projection for remodeling is considerably less than that provided by Heller & Sons,

Inc., contained in its proposal to the Howard R. Hospital Foundation to remodel the old Howard Hospital building for a psychiatric health facility on that property. That proposal contained a cost range of between $11.2 million and $14.9 million.[52] To test the relative competitiveness of these various cost estimates, a formal PHF Request for Proposals process would need to be undertaken by Mendocino County.

Taking all of the available information into consideration, for the purposes of developing a new PHF facility construction cost estimate, we have set a cost of $7.5 million as reasonable. This assumes a base cost of $6 million (top-end of $5 to $6 million range identified by PHF builder-operators) plus 25% for contingency.

D. Medi-Cal Payment Rates

According to the California DHCS, Medi-Cal Adult PHF daily rates have increased from $651.20 in FY 2012-13 to $847.90 in FY 2017-18, which reflects a 30.2% increase in the daily rate in six years. Available DHCS data also shows a 7.3% increase in FY 2018-19 for an average PHF claim of $909.58.[53] For all Medi-Cal eligible persons, 50% of the cost (non-federal share) is a county cost.

2. Features Unique to Each PHF Option

A. County Owned and County Operated PHF

With this option, the PHF would be designed, built, owned, staffed and operated entirely by the Mendocino County. Under this approach, the County would need to delegate management of construction to a designated county agency. For development and operation of the clinical program, the County would need to delegate management to a designated county department. The County would also need to authorize hiring through the usual processes and creation of new county positions that meet the licensing requirements for PHF staffing. This approach would require the most direct and ongoing County commitment to management of construction and operation of the facility.

1. Projected Annual Operating Costs

Butte County operates its own PHF. According to Butte County officials, annual operating costs include salary costs of $2.9 million per year for 23 staff, including nurses, clinicians, psychiatrists and mental health technicians who work the 24-hour schedule. In addition, there is roughly $900,000 in other administrative costs, for a total of approximately $3.8 million annually.[54] Operating costs for Sutter-Yuba County's PHF are estimated at $4.3 million dollars annually.[55] It is important to note that a county operated PHF with county employees is generally the most expensive option due to higher staff costs associated with county employees. Based upon this reported information, the range of annual operating costs for a county owned and operated PFH is between $3.8 and $4.3 million.

2. Other Considerations

For the county to build a PHF, the county will need construction management and oversight expertise. For the county to operate a PHF, the county will need clinical and operations expertise, including the ability to:

- Hire and manage numerous clinical staff, including nurses, clinicians, psychiatrists and mental health technicians that work a 24-hour schedule;
- Establish, administer and maintain a claiming process for PHF reimbursement that is reliable and secure and ensures reimbursement from all payer sources, including Medi-Cal, Medicare and private insurance;
- Assure financial viability of the PHF by maximizing bed usage and minimizing empty bed days; and,
- Contract with other counties or private insurance providers for excess bed supply and establish associated claims processes.

B. County Owned and Privately Operated PHF

With this option, the PHF facility would be designed and built to Mendocino County specifications, and the County would own the facility. For PHF operations, the County would solicit bids and select a provider to be responsible for PHF programming and provision of direct services under contract. The County could ask PHF providers to separately bid out both the construction and the operations, with the understanding that the facility would be County owned. With this approach, the County would maintain ownership control of the building and contract out PHF operations. The County could periodically place the PHF program through a competitive bid process to ensure the most competitive provider continues to provide PHF services under Mendocino County's preferred terms.

1. Projected Annual Operating Costs

Based upon our interview with Restpadd, which operates PHFs in Shasta County and Tehama County, the estimated annual cost of PHF operations at its facilities is roughly $3 million per year for staffing plus an additional 12% for administrative costs, for a total estimated cost of $3.4 million.[56] This estimated cost is roughly $400,000 to $900,000 less than the estimated cost for operation by county employees.

2. Other Considerations

For the County to build a PHF, the County will need construction management and oversight expertise. For the County to contract out operation of the PHF, the County will need appropriate clinical and management expertise to oversee the contract.

C. Privately Owned and Privately Operated PHF

With this option, the County would solicit and select a private provider to build and operate the PHF on behalf of Mendocino County, subject to specific conditions set by the County. The approved provider would then be responsible for building a suitable facility as well as the hiring and managing all staff that are required to provide PHF services.

This approach could limit the County's direct, up-front financial investment because the costs for building and operation could be negotiated over a longer period of time. Thus, this approach could make it possible for Measure B dollars to be used for other programming. However, this approach would also limit the county's control over the project as the program would be owned by a third party contractor, and the Board's contract with the provider would need to do both of the following: 1) Prioritize bed availability for Mendocino County to ensure County residents have appropriate access to placement, when needed; and, 2) Define the timeline and terms of payoff for building construction and how County building ownership rights will be handled at payoff. The County's contract with the provider would be especially important because the County would be a customer of the provider, but not the only customer.

1. Projected Build Costs

With this approach, the provider would be solely responsible for constructing a suitable facility and establishing an appropriate PHF program based on current licensing requirements. While there could be some negotiation with the County, the responsibility would remain primarily with the contracted provider. The County would be required to certify the site for Medi-Cal reimbursement. Further, the provider would be required to secure financing on its own, unless negotiation with the County provided some amount of Measure B revenue. As referenced earlier, the project facility build cost is up to $7.5 million (base estimate plus contingency).

2. Projected Annual Operating Costs

With this approach the PHF contractor would operate and provide staffing for the PHF. As referenced earlier, the estimated cost of PHF operations at similar facilities in Shasta County and Tehama County is roughly $3 million per year for staffing plus an additional 12% for administrative costs, for a total of $3.4 million.[57] We use this figure as the estimated cost for contracted out PHF operations. We contacted other PHF programs to get additional operating cost estimates, including Heritage Oaks Hospital and Telecare, but no information was available because these firms considered this information to be proprietary.

X. Current and Future Behavioral Health Service Needs

Our assessment of Mendocino County's current Mental Health service continuum is that it does not offer a robust set of alternative services that prevent crisis conditions and provide alternatives to inpatient psychiatric care. The system is heavily tilted toward responding to crisis conditions, with the primary service strategy of inpatient psychiatric care in out-of-county facilities.

Based upon our research and analysis and our discussions with Key Informants, we recommend the following program services are all needed in Mendocino County:

- PHF or other inpatient psychiatric care;
- Crisis Residential Treatment;
- Crisis Stabilization Unit (CSU);
- Expanded outreach, such as the Mobile Outreach Teams;
- Addressing service needs of outlying and remote areas of the county;
- Expansion of support programs and wellness efforts, with special attention to making these services more robust by including medication management, employment services, and other services to support families;
- Day Treatment;
- Supportive Housing;
- Partial hospital care/rehabilitative care/board and care; and,
- Expansion of substance use disorder treatment.

Among these, the need for an expanded support programs and wellness efforts – with direct services provided to individual consumers and their families – was most emphasized by consumers and family members. In our interviews, these informants shared their struggles in managing their needs, or in assisting with the care of their loved ones, and their feelings of isolation and lack of connection and support. Collectively, they pointed to a need for one-on-one coaching support for consumers to help them reach their goals for recovery and healing; more support for family members assisting their loved ones in recovery; broad based wellness efforts across the county, not just in populated areas; employment services; and, support with transportation to get to needed services.

Over the next five years we believe the primary principle that should drive Measure B policy-making is a commitment to developing a comprehensive mental health services continuum in Mendocino County that provides a broad range of services and supports that remediate mental health conditions at the earliest possible time and reduce inpatient psychiatric utilization. As a part of this, we believe policy makers should establish a policy goal of Measure B funding is to reduce the need for inpatient psychiatric care, while simultaneously assuring that inpatient psychiatric care is available in the County when needed. We believe

a goal of a 50% reduction in the use of inpatient psychiatric care within five years, by FY 2022-23, is a responsible goal. This would reduce daily hospital utilization from 15.1 persons per day to a more sustainable 7.6 persons per day.

With respect to the SUDT services continuum, as we discussed in this report, Mendocino County's current array of SUDT services is limited to a small set of services. The near-term expansion of these services hinges primarily on the County's determination of how it will proceed with the Drug Medi-Cal Organized Delivery System (ODS). If the County does not implement the new ODS, either through county administration or through Partnership Health Plan (PHC), then the expanded continuum of services will not be available to residents of the County. As of this writing, we do not know what the real viability of the PHC plan is, so we are not in the position to make a recommendation about this approach. However, we do know that county administration of the ODS would set a very high bar for the County because the County would be required to directly administer services under a managed care model that is similar in approach to that required for the County's Mental Health Plan, which the County has contracted out to a third party administrator.

In the near term, we believe it makes sense for policy makers to assess where Measure B funds can be allocated to expand access to SUDT services in the County, either through current service contracts or through new contracts with providers, so that more people can be served. As reported by BHRS, only 707 persons received SUDT services in FY 2016-17 from all funding sources. We believe this small number is far out-paced by the level of need, and an allocation of Measure B funds for an expansion of SUDT services is not only appropriate, but also essential. In addition, we believe some of these resources should be dedicated to dual treatment of SUDT and mental health conditions.

XI. Key Policy Decisions and Recommended Actions

It is recommended the Mendocino County Board of Supervisors approve the following policy approach pertaining to the use of Measure B revenues:

GUIDING PRINCIPLE: The guiding principle for the use of Measure B revenues is the development of a comprehensive mental health services continuum in Mendocino County that provides a broad range of services and supports that remediate mental health conditions at the earliest possible time and reduce the need for inpatient psychiatric utilization.

KEY POLICIES: The following policies are recommended to assist Mendocino County in meeting its goal of a comprehensive mental health services continuum:

1. Measure B funds should ***supplement, not supplant,*** existing sources of funding for mental health and SUDT services, which include Realignment, MHSA and Medi-Cal funding.
    a. Prior to considering any proposed spending of Measure B funds that would supplant an existing source of funding for behavioral health services, a programmatic and fiscal analysis of such proposed spending should be prepared for consideration by the Board of Supervisors.
2. A biannual review process of Measure B spending and its impact on the mental health and SUDT continuums of care should be undertaken and presented to the Board of Supervisors.
3. A Measure B "Prudent Reserve" should be established and funded to provide additional revenue for behavioral health programs in Years 6-10 of Measure B, when funding will be less due to the drop from 1/2-cent to 1/8-cent sales tax.
4. In addition to standard accounting of behavioral health revenues and expenditures by BHRS, a separate annual accounting of all Measure B revenues and expenditures should be undertaken that is distinct from BHRS' accounting.
    a. The Board of Supervisors would determine the public or contracted entity that will responsible for carrying out a separate accounting of Measure B revenues and expenditures; and,
    b. A biannual accounting report on Measure B revenues and expenditures should be prepared for the Board of Supervisors by the responsible entity.
5. A 10-Year Strategic Spending Plan for Measure B revenues should be adopted that addresses top priority needs in Years 1-5 of Measure B funding, establishes a Prudent Measure B Reserve for use in future years, and provides a framework for continued funding of identified priorities in Year 6-10 that provides flexibility to refine and revise spending priorities over time.
6. BHRS, RQMC and its subcontractors should be directed to restructure the manner in which data is provided to the Board of Supervisors and the public on the populations served by current and newly funded behavioral health programs so that client-level data is collected and reported by program and by region, and quarterly monitoring of utilization and service trends can be more fully evaluated.

XII. Proposed Measure B Strategic Financing Plan

To effectuate program development, it is recommended the Mendocino County Board of Supervisors approve a 10-Year Measure B Strategic Financing Plan to guide current and future use of Measure B revenues. The Financing Plan proposed in this section is designed to address the key shortcomings of the current mental health and SUDT continuums of care that Kemper Consulting Group has identified through its assessment of service gaps and future needs. The proposed Measure B Strategic Financing Plan that follows would address the following priority areas of need for mental health and substance use disorder services:

1. Create an in-county residential treatment alternative to inpatient psychiatric care by funding construction of a Crisis Residential Treatment facility (land already purchased, plans approved, construction pending financing);
2. Create a centralized system for mental health crisis assessment and intervention through annual dedicated operational funding for a Crisis Stabilization Unit (construction included as part of Crisis Residential Treatment facility), along with Medi-Cal and other reimbursements;
3. Create in-county inpatient psychiatric treatment capacity by funding construction of Psychiatric Health Facility (pending RFP process); operations to be funded from existing revenue sources, including Realignment and Medi-Cal;
4. Reach more persons with mental illness through expansion of programs and supports in communities across Mendocino County, based on a plan to be developed by BHRS. Such plan would consider all of the following: expansion of mobile outreach; expansion of wellness programs to include more robust array of services (medication management, employment services, other supports); expanded monitoring of clients engaged with the mental health system through greater intensity support services; one-on-one consumer and family support programs; and, day treatment and/or partial hospital programs.
5. Reach more persons with substance use disorders through expansion of programs and supports in communities across Mendocino County, based on a plan to be developed by BHRS.
6. Expand the reach of Full Service Partnerships to more seriously mentally ill people by dedicated annual funding (pending proposal from BHRS);
7. Expand in-county Supportive Housing opportunities for mentally ill persons, including homeless mentally ill and individuals under conservatorship, by creating a Supportive Housing Pool for alternative housing support uses, such as construction, match for state/federal financing opportunities, rental subsidies and vouchers (pending proposal from BHRS and the county housing authority); and
8. Create a Prudent Reserve that is carried forward into Years 6-10 of the initiative, when the rate of sales tax collection drops from 1/2-cent to 1/8-cent and annual revenues drop from roughly $7.5 million to $2.0 million.

Proposed Measure B Strategic Financing Plan – Years 1-5							
	% Allocation	**TOTAL**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Measure B Revenue	**-**	**$37,500,000**	**$7,500,000**	**$7,500,000**	**$7,500,000**	**$7,500,000**	**$7,500,000**
Crisis Residential Treatment (CRT)	12.7%	$4,750,000	$4,7500,000	$0	$0	$0	$0
Psychiatric Health Facility (PHF)	20%	$7,500,000	$0	$4,000,000	$3,500,000	$0	$0
Crisis Stabilization Unit (CSU)	5.3%	$2,000,000	$0	$500,000	$500,000	$500,000	$500,000
Support Services Expansion	15.3%	$5,750,000	$1,000,000	$1,000,000	$1,250,000	$1,250,000	$1,250,000
FSP Expansion	6.7%	$2,500,000	$500,000	$500,000	$500,000	$500,000	$500,000
Supportive Housing Pool	9.3%	$3,500,000	$500,000	$750,000	$750,000	$750,000	$750,000
SUDT Services Expansion	10%	$3,750,000	$750,000	$750,000	$750,000	$750,000	$750,000
Measure B Prudent Reserve	20.7%	$7,750,000*	$0	$0	$250,000	$3,750,000	$3,750,000
TOTAL	100%	$37,500,000	$7,500,000	$7,500,000	$7,500,000	$7,500,000	$7,500,000

Proposed Measure B Strategic Financing Plan – Years 6-10							
	% Allocation	**TOTAL**	**Year 6**	**Year 7**	**Year 8**	**Year 9**	**Year 10**
Annual Measure B Revenue	**-**	**$10,000,000**	**$2,000,000**	**$2,000,000**	**$2,000,000**	**$2,000,000**	**$2,000,000**
Measure B Reserve	**-**	**$5,000,000**	**$1,000,000**	**$1,000,000**	**$1,000,000**	**$1,000,000**	**$1,000,000**
Crisis Residential Treatment (CRT)	0%	$0	$0	$0	$0	$0	$0
Psychiatric Health Facility (PHF)	0%	$0	$0	$0	$0	$0	$0
Crisis Stabilization Unit (CSU)	16.7%	$2,500,000	$500,000	$500,000	$500,000	$500,000	$500,000
Supportive Services Expansion	41.6%	$6,250,000	$1,250,000	$1,250,000	$1,250,000	$1,250,000	$1,250,000
FSP Expansion	16.7%	$2,500,000	$500,000	$500,000	$500,000	$500,000	$500,000
Supportive Housing Pool	0%	$0	$0	$0	$0	$0	$0
SUDT Services Expansion	25%	$3,750,000	$750,000	$750,000	$750,000	$750,000	$750,000
TOTAL	100%	$15,000,000	$3,000,000	$3,000,000	$3,000,000	$3,000,000	$3,000,000
Net Measure B Prudent Reserve		$2,750,000*					

*Net Reserve potentially available for Regional Behavioral Health Training Facility

Taken together, the recommended policy actions and the Measure B Strategic Financing Plan would create a framework for building out the existing, limited continuums of care for both mental health and substance use disorder treatment over time. The proposed financing plan will not address all needs in all areas at the same time; and, it is assumed that service needs will be redefined over time as the services continuums are expanded. Thus, within certain categories of proposed spending, notably Support Services and Supportive Housing, it is intended that BHRS leadership, in consultation with RQMC, the Measure B Committee, the Behavioral Health Advisory Committee, and community stakeholders, further refine the areas where service expansion can be undertaken in a timely and cost-effective manner.

1. Program Development Action Steps

It is recommended the Board of Supervisors take the following steps toward implementation of the new mental health and SUDT programs recommended in the proposed Measure B Strategic Financing Plan:

1. Approve appropriation of funding of an amount up to $4.75 million from Year 1 Measure B revenues for construction of the Crisis Residential Facility/Crisis Stabilization Unit planned for the site at 631 S. Orchard Street in Ukiah, if no other funding is readily available.
2. Direct the BHRS Director, in consultation with RQMC and the Behavioral Health Advisory Board, to prepare a plan for utilization of Year 1 Measure B funds for the following service categories: expansion of specific services under the Supportive Services category; expansion of FSP services; and expansion of SUDT treatment services, including dual diagnosis treatment services.
3. Authorize the CEO to undertake a Request for Proposals (RFP) process to solicit proposals from qualified operators of Psychiatric Health Facilities (PHF) in California for construction and operation of a 16-bed PHF on land to be identified by Mendocino County. This RFP would be structured to require bids in two ways:
    a. Ownership and operation of the facility by the PHF operator under a long-term land lease agreement; and,
    b. Ownership of the facility by the County of Mendocino and operation of the PHF under a long-term Services Agreement with the PHF operator.
4. Authorize the CEO to undertake a Request for Proposals (RFP) process to solicit proposals from local hospitals in Mendocino County for construction of inpatient psychiatric beds that would be owned and operated by these hospitals, but would be committed with first priority to Mendocino County under a long-term agreement that is conditional for allocation of construction funding from Measure B.
5. Direct the BHRS Director, in consultation with the county housing authority, RQMC, the Measure B Committee, and Behavioral Health Advisory Board, to prepare a strategic plan for the development of expanded housing support programs for persons with mental illness and/or recovering from substance use. Such plan should address priorities for construction, services and vouchers or rental subsidies.

XIII. Appendix

APPENDIX A Key Informant Interview Participants		
Organization	**Informant**	**Title**
Behavioral Health Advisory Board	Jan McGourty	Chair
	Lois Lockart	Member
	Flinda Behringer	Member
	John Wetzler	Former Chair
County Behavioral Health & Rehabilitation Services Department	Jenine Miller	Director
County Executive Office	Carmel Angelo	County Executive
County Health & Human Services Agency	Anne Molgaard	Acting Director
	Tammy Moss Chandler	Director
County Sheriff	Thomas D. Allman	Sheriff
	Timothy Pearce	Captain, Jail Commander
Community Physician	Ace Barrish	MD
Community Physician	Marvin Trotter, MD	Hospital ED Physician
Community Resident	Tammy Lowe	
Community Resident	Edna McLean	
Community Resident	Stephanie O'Flaherty	
Community Resident	Josephine Silva	
Howard Memorial Hospital	Jason Wells	President
Measure B Committee*	Whole Committee	Chair and Members
Mendocino Coast Clinics	Lucrecia Renteria	Executive Director/ARCH Chair
Mendocino Community Health Centers	Carol Press	Executive Director
	Ben Anderson	Behavioral Health Manager
Redwood Quality Management Company	Camille Schraeder	Systems Officer
	Tim Schraeder	Chief Executive Officer
Therapist (Manchester, Pt. Arena)	Lorelei Hammond	LCSW
Ukiah Valley Medical Center	Gwen Matthews	CEO
*Consultants met with the Measure B Committee on April 25, 2018 and watched video of the Committee's May 23, 2018 meeting regarding Consultant's scope of work		

APPENDIX B County Agency and Department Mission Statements	
Organization	**Mission Statement**
Health and Human Services Agency	In partnership with the community, the Health and Human Services Agency will support and empower families and individuals to live healthy, safe, and sustainable lives in healthy environments, through advocacy, services and policy development.
Mental Health	Mental Health Services strives to: ▪ Deliver services in the least restrictive, most accessible environment within a coordinated system of care that is respectful of a person's family, language, heritage and culture. ▪ Educate ourselves, individuals, families and the community about mental illness and the hopeful possibilities of treatment and recovery. ▪ Maximize independent living and improve quality of life through community-based treatment. ▪ Maximize the resources available and attend to concerns for the safety of individuals and the community. ▪ Manage our fiscal resources effectively and responsibly while insuring that productivity and efficiency are important organizational values which result in maximum benefits for all concerned.
Substance Use Disorders Treatment	The Substance Use Disorders Treatment program "is committed to providing services to residents of Mendocino County of diverse backgrounds. We offer a culturally competent, gender responsive, trauma informed system of care for adults and adolescents while striving to meet linguistic challenges. Utilizing holistic, person-centered recovery, we promote healthy behaviors through prevention and treatment strategies that support our community's need to address alcohol and other drug abuse, addictions and related conditions."

APPENDIX C Table 1 Mental Health Services for Adults (FY 2017-18)[58] Administered by Redwood Quality Management Company			
Program Service Type	**Program Name**	**Population**	**FY17-18 Budget**
Early Intervention	Redwood Community Crisis Center	All Ages	$160,000
	RVIHC Yuki Trails	All Ages	$20,000
	Consolidated Tribal Health Project	All Ages	$32,000
	RVIHC Family Resource Center	15-24	$20,000
	Nuestra Alianza	18+	$55,000
	Mendocino Coast Hospitality Center	18+	$162,000
	Manzanita Services Inc.	18+	$250,000
	MCAVHN	18+	$10,000
	Costal Senior	60+	$10,000
	Redwood Coast Senior Center	60+	$45,000
	Ukiah Senior Center	60+	$30,000
	FSP Flex Funds	All Ages	$300,000
Psychiatry	Dr. John Garratt & Olga Segal	25+	$211,000
Day Treatment	***None***	***None***	-
Crisis Residential Treatment	***None (pending development)***	***None***	-
Partial Hospital	***None***	***None***	-
PHF/Hospital	Aurora	All Ages	$40,000
	St. Helena	All Ages	$10,000
	Heritage Oaks	All Ages	$40,000
	Sierra Vista	All Ages	$15,000
	Physician Fee's	All Ages	$10,000
	Restpadd Redding/Red bluff	All Ages	$1,250,000
IMD	Crestwood	All Ages	$10,000
Employability Services	***None***	***None***	-
Outpatient Services	Redwood Community Services*	All Ages	$1,500,000
	Manzanita Services	Over 18	$1,015,000
	Mendocino Coast Hospitality Center	Over 18	$505,000
	MCAVHN	Over 18	$180,000
Assertive Community Treatment	***None (pending development)***	***None***	-
TOTAL			**$5,880,000**
*Includes Crisis Services			

APPENDIX C Table 2 Mental Health Services for Children (FY 2017-18)[59] Administered by Redwood Quality Management Company			
Program Service Type	**Program Name**	**Population**	**FY17-18 Budget**
Early Intervention	Redwood Community Crisis Center	All Ages	$130,000
	Tapestry Family Services	0-24	$65,000
	Action Network	All Ages	$49,250
	Arbor Youth Resource Center	15-24	$100,000
	RCS Stepping Stones Housing	16-24	$230,000
	Laytonville Healthy Start Family Resource	6-17	$35,000
	MCYP	6-24	$125,000
	Anderson Valley Unified School District	6-17	$54,700
	FSP Flex Funds	All Ages	$10,000
Psychiatric	Dr. Rebecca Timme & Larry Aguirre	0-24	$150,000
Day Treatment	***None***	***None***	-
Crisis Residential Treatment	***None***	***None***	-
Partial Hospital	***None***	***None***	-
PHF/Hospital	Aurora	All Ages	$20,000
	Heritage Oaks	All Ages	$20,000
	Physician Fee's	All Ages	$10,000
	Restpadd Redding/Red bluff	All Ages	$145,000
IMD	Crestwood	All Ages	$10,000
Employability Services	***None***	***None***	-
Outpatient Services	Redwood Community Services*	All Ages	$5,100,000
	Tapestry Family Services	Under 25	$1,800,000
	Mendocino County Youth Project	Under 25	$600,000
Assertive Community Treatment	***None (pending development)***	***None***	-
Out-of-County Placements	Milhous	Under 18	$50,000
	Remi Vista	Under 18	$40,000
	Summitview	Under 18	$40,000
	Victor Treatment Center	Under 18	$150,000
	St. Vincent's	Under 18	$40,000
	Charis	Under 18	$10,000
TOTAL			**$8,983,950**
*Includes Crisis Services			

APPENDIX C Table 3 Mobile Outreach and Prevention Services (FY 2016-17 and FY 2017-18)[60] Administered by Behavioral Health and Rehabilitative Services Department		
	FY 2016-17	FY 2017-18
Client Served	30	52
Male	12	25
Female	18	27
Number of Contacts	282	892
Total Funding	$147,167	$207,349
Summary: Mobile Outreach and Prevention Services (MOPS) funds three mental health workers that serve the North County, South Coast, and Anderson Valley and Surrounding Ukiah area with the support of a Sheriff Services Technician. Services are not provided in Ukiah, Fort Bragg, or Willits. Program funding is provided by CHFFA and Whole Person Care (Medi-Cal).		

APPENDIX D Substance Use Disorder Treatment Services (FY 2017-18)[61] Administered by Behavioral Health and Rehabilitative Services Department				
Service Program	Name	Target Population	Served in FY 2016-17	Budget FY 2017-18
Outpatient Services	BHRS	Medi-Cal	100	$768,885*
	BHRS/Justice System	Dual Diagnosis	10	
	Arbor Youth	Medi-Cal (ages 16-24)	NA	$70,000
	Consolidated Tribal Health	Children, youth, adults, seniors	NA	$16,000
Perinatal Treatment	WINDO	Medi-Cal (pregnant women)	7	$143,508
Prevention/ Early Intervention	BHRS	Youth	395	$295,721
Correctional Treatment	SUDT services in jail	Jail inmates	NA	$54,538
Adult Drug Court	Justice System/BHRS Collaboration	Adults with suspended state prison sentence	21	$233,231
Family Drug Court	Justice System/BHRS/ CWS Collaboration	Families involved with Family/Children Services	78	$354,152
	Ukiah Recovery Center	Individuals	1	$100,300
	Hilltop	Individuals	2	$22,500
	Health Right 360	Pregnant women/ mothers	1	$37,500
TOTAL			615	$2,096,335
*Funding for Dual Diagnosis program included in total				

APPENDIX E Table 1 Inpatient Psychiatric Hospitalizations - Placement Criteria[62] FY 2016-17 and FY 2017-18				
Criteria	**FY16-17**	**Percent to Total**	**FY17-18**	**Percent to Total**
Danger to Self	316	57.4%	344	53%
Gravely Disabled	122	22.2%	153	24%
Danger to Others	17	3.1%	12	2%
Combination	95	17.2%	136	21%
TOTAL	550		645	

As shown in Appendix E, Table 1, the number of placements for the first nine months of FY 2017-18 persons that were "Gravely Disabled" and those that were "Danger to Self/Others (combination)" were almost equal with those placements for all of FY 2016-17. Further, placements due to "Danger to Self" are running 8% higher than FY 2016-17.

APPENDIX E Table 2 Crisis Line Contacts – Reason for Call[63] FY 2016-17 and FY 2017-18				
Symptom	**FY16-17**	**%**	**FY17-18**	**%**
Increase in Symptoms	1307	24.9%	1368	23.4%
Phone Support	1347	25.7%	2180	37.3%
Information Only	862	16.4%	811	13.9%
Suicidal Ideation/Threat	901	17.2%	905	15.5%
Self-injurious Behavior	125	2.4%	96	1.6%
Access to Services	309	5.9%	282	4.8%
Aggression toward Others	178	3.4%	78	1.3%
Resources/Linkage	221	4.2%	118	2%
TOTAL	5250		5838	

As shown in Appendix E, Table 2, for the first nine months of FY 2017-18, the total number of Crisis Line Contacts is running ahead of the prior year. If the pace continues, the number of Crisis Line Contacts will be nearly 5,800 by the end of the fiscal year. Most contacts are made to address increased symptoms and for phone support.

XIV. Endnotes

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