Invitation - Vocational/MH Services Teleconference 7/30 10 am - Please Share!

Teleconference Invitation
July 30, 2021, 10:00 am - 11:30 am
Registration Link
(There is no fee to register.)

We invite you to join us for presentations and discussion regarding:

Vocational / Mental Health Services: Integrating Evidence-Based Programs

Employment is a major therapeutic tool, improving the quality of life and reducing symptoms in individuals with mild to moderate to severe mental illness.

Opening Remarks

- Department of Rehabilitation (DOR), *Joe Xavier, Director*
- Department of Health Care Services (DHCS), *Jim Kooler, Dr.P.H., Assistant Deputy Director, Behavioral Health*
- Mental Health Services Oversight & Accountability Commission (MHSOAC)

Speaker Panel

- Alameda County Behavioral Health Care Vocational Services: *Chris Lorente, Individual Placement & Support (IPS) Trainer; Dawn Hanson, Rehabilitation Supervisor*
- Solano County Behavioral Health and Caminar, Inc.: *Emery Cówan, LPCC, LMHC and Yazmin Robledo, IPS Supervisor*
- Calaveras County Mental Health Services, *Betty Johnson, Employment Services Case Manager and Wendy Alt, LMFT, Deputy Director Behavioral Health*

Discussion

Registration Link
(There is no fee to register.)
CA Association of Local Behavioral Health Boards & Commissions (CALBHB/C) supports the work of CA's 59 local mental and behavioral health boards and commissions.

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DEPARTMENT OF MENTAL HEALTH
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October 29, 2019

TO: Supervisor Janice Hahn, Chair
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Kathryn Barger

FROM: Jonathan E. Sherin, M.D., Ph.D.
Director

SUBJECT: **REPORT RESPONSE TO ADDRESSING THE SHORTAGE OF MENTAL HEALTH HOSPITAL BEDS (ITEM 8, AGENDA OF JANUARY 22, 2019)**

On January 22, 2019, the Board of Supervisors (Board) directed the Department of Mental Health (DMH), in coordination with Chief Executive Office (CEO), the Sheriff's Department, and the Health Departments, to assess how to address the shortage of mental health hospital beds in Los Angeles County. DMH was directed to provide the Board with a report to include the following information:

a. A plan for the creation of mental health hospital beds to include potential sites, funding options, patient population, and all other pertinent details;
b. The current and future need for mental health hospital beds that support the jail population;
c. An assessment of all contracted mental health hospital beds and make recommendations that allow the County to maintain and/or increase the number of beds available; and
d. An assessment of the current and future need for stepdown mental health beds and services, and draft a plan for the creation of both directly operated and contracted stepdown beds and services.

The attached report "Addressing the Shortage of Mental Health Hospital Beds" serves to fulfill the directives of the Board. In addition, we have attached a separate relevant report developed by an outside consultant, Mercer Health & Benefits LLC. This Mercer report assesses needs in Los Angeles County's mental health and substance use disorder

system of care, with a particular focus on inpatient and residential treatment, and offers recommendations on filling these needs.

If you have any question or need additional information, please contact me, or staff may contact Gregory Polk, Chief Deputy Director, Administrative Operations, at (213) 738-4601 or gpolk@dmh.lacounty.gov.

JES:GP:jfs

Attachments

c: Executive Office, Board of Supervisors
Chief Executive Office
County Counsel
Department of Public Health
Department of Health Services
Los Angeles County Superior Court

County of Los Angeles
Department of Mental Health

Addressing the Shortage of Mental Health Hospital Beds: Board of Supervisors Motion Response

Jonathan E. Sherin. M.D., Ph.D.
Director
Department of Mental Health

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Executive Summary

We need to improve the mental health beds and related services in our public mental health care system in LA County. Beyond just acute hospital beds, we also especially need to improve the availability and quality of subacute and residential treatment services for clients with longer-term intensive needs, as well as our services to treat clients in crisis and provide alternatives to hospitalization and/or incarceration. To accomplish this, we must develop bed capacity and improve services throughout the continuum of care. Doing so will minimize client flow into hospitals, improve client flow out, and provide higher quality client care overall.

Recommended System Changes

Improving Mental Health Pre-Hospital Services (Client Flow In)

1. Develop more behavioral health urgent care centers
2. Continue to develop crisis residential treatment and similar programs
3. Continue to develop a more robust network of mobile crisis response services
4. Continue to improve the quality and coordination of pre-hospital services for clients in crisis
5. Develop options for intensive outpatient and partial hospitalization programs for clients in crisis
6. Continue to develop supportive and holistic pre-hospital services for clients who are on or may need a mental health (LPS) conservatorship
7. Continue to improve diversion services and programs that serve as alternatives to incarceration for justice-involved clients in crisis

Improving Mental Health Post-Hospital Services (Client Flow Out)

1. Develop more subacute beds and services
2. Develop more residential treatment beds and services which provide longer-term care
3. Continue to improve quality of care and client transitions across subacute and residential treatment beds and services
4. Support efforts to relax or eliminate the federal Medicaid SMI/SED IMD exclusion
5. Continue investing in supportive housing units and services, including board and cares
6. Develop intensive outpatient and/or partial hospitalization programs as a treatment option for individuals transitioning out of mental health beds
7. Continue to improve Full Service Partnerships as a post-hospital service
8. Develop better post-hospital services for clients on a mental health (LPS) conservatorship
9. Conduct further analyses of the system of care to refine estimates of additional needed post-hospital beds and services

Improving Mental Health Hospital Services

1. Develop more acute hospital beds for children
2. Develop more acute hospital beds which can serve clients diverted out of the jail
3. Increase the proportion of acute hospital beds available exclusively to DMH clients
4. Continue to improve quality of care and client transitions across hospital settings
5. Address the shortage of psychiatrists in the system

Recommended Actions for the Board of Supervisors

To help us move quickly to begin implementing the recommended system changes detailed throughout this report, the Department of Mental Health (DMH) is recommending that the Board of Supervisors take the following actions:

1. Authorize the Director of the Department of Mental Health (DMH), or his designee, to conduct a pilot to expand mental health bed capacity and improve existing capacity in the DMH network, within the following parameters:
    a. The pilot will last for two years from the date of Board approval; and
    b. DMH will seek to procure up to 500 State-licensed, approved, or exempt mental health beds of whichever type and mix will help meet the needs of the DMH network, derived through contracting for additional beds using DMH available ongoing funding.

2. For purposes of the pilot implementation and subject to all state and federal laws, prior review and approval as to form by County Counsel, and ten-day written notification to the Board and Chief Executive Officer (CEO), delegate authority to the DMH Director to negotiate, execute, and/or amend contracts with State-licensed, approved, or exempt facilities as needed, with up to a five year initial term and up to two one-year optional extensions, to increase the existing mental health bed capacity, including to:
    a. Revise, modify, or replace existing statement(s) of work;
    b. Reflect federal, State, or County regulatory and/or policy changes;
    c. Add or revise any negotiated supplemental rate(s) or any applicable State established rates; and
    d. Terminate any such contracts in accordance with the County's standard contract termination provisions, including termination for convenience.

3. Delegate authority to the DMH Director, or his designee, to retain a consultant on a temporary and/or intermittent basis to help design and execute an integrated plan for the pilot, develop statements of work for contracts, and assist with other activities as part of the pilot build out, as needed, with a maximum contract amount of $500,000 using DMH available one-time funds.

4. Direct the DMH Director to provide an annual status report to the Board of Supervisors with the first report due in January 2021 to include the following information and analysis:
    a. The number, type, and cost of beds contracted through the pilot;
    b. A projection of the amount of remaining DMH funding available to procure additional beds up to the pilot's 500 bed target;
    c. The impact of the additional contracted beds on the DMH network, including any departmental savings or other cost reduction offsets; improvements in client flow through the network; improvements in care quality and outcomes; and any other pertinent metrics; and
    d. Opportunities for further bed expansion, and the associated costs, needed to reach the pilot's 500 bed target, of whichever type and mix will help meet DMH's network needs that considers the work of all County efforts to expand the availability of mental health beds and services.

5. Direct the DMH Director to work with the CEO to develop a proposed funding plan for the costs associated with the remaining beds needed to get to the pilot's 500 bed target, in consultation with affected departments as necessary, which if adopted would to be phased in over future budget cycles, as needed, that will allow the recommendations to be considered within the context of DMH remaining available funding, the overall budget and numerous competing funding priorities and requests. If complete, include this proposed funding plan with the January 2021 report to the Board of Supervisors.
    a. Include in the plan options to convert an entity's existing licensed or approved beds to other types of licensed or approved beds which will meet the needs of the DMH network that consider one-time cost-sharing provisions whereby the County may fund a portion of the cost of bed conversions.
    b. Include in the plan consideration of additional funding that may be available through the State and federal government, private insurers and philanthropy.

6. Direct the DMH Director, in coordination with the CEO, to conduct a needs assessment for staffing and/or contract providers to further develop and improve outpatient and administrative programs and services that support the DMH network of facility-based treatment, including but not limited to: (1) mobile crisis response services; (2) utilization management services; (3) Full Service Partnership services; and (4) other alternatives to hospitalization, such as intensive outpatient and partial hospitalization; funded by DMH available ongoing funds and report back to the Board.
    a. Include in the assessment needs for additional management staff, technology, facility space, or other administrative infrastructure to support the work of these staff and programs.

7. Direct the CEO, in coordination with the Departments of Health Services, Mental Health, Public Health, Children and Family Services, the Homeless Initiative, the LA County Development Authority, and other departments serving populations who use the beds/services, to perform an analysis of the array of County programs and funding streams related to supportive housing (including board and cares, permanent supportive housing, and interim/bridge supportive housing and living environments otherwise) for those with physical, mental, or substance use disorder needs.
    a. Direct the CEO to include in this analysis options for managing these programs and funding streams to improve efficiencies and ensure needed supportive housing capacity as delineated above is developed using available funds.

Introduction

The January 22, 2019 motion, "Addressing the Shortage of Mental Health Hospital Beds"[1], highlights a serious deficit in LA County's mental health system of care. Our system is not delivering enough high-quality mental health hospital services to meet the need, and the effects of this deficit are dire:

- The Department of Health Services' psychiatric emergency rooms are severely overcrowded, with patients sometimes having to stay several days while they wait for a hospital bed.
- On any given day, four to five thousand individuals with serious mental illness and often co-occurring substance use disorder are incarcerated in LA County justice systems and need care. Many of their incarcerations could have been prevented entirely had they received needed treatment.
- Roughly 25% of adult homeless individuals in LA County have a serious mental illness and need care. These individuals often cycle in and out of hospitals and justice systems without ever being put on a sustainable path to recovery.
- Readmission rates at our mental health hospitals are far too high. According to a recent analysis by an outside consultant[2], our Medi-Cal fee-for-service hospital network in LA County has an average 30-day readmission rate of 37.8%. The national average is closer to 20%[3].
- Too many clients are getting stuck in our hospitals because there aren't enough post-hospital beds and services. Waitlists to transition to the next level of care are long and getting longer, especially for hospital clients on a mental health (LPS) conservatorship. Special populations, such as those who are currently or formerly justice-involved, those with co-occurring substance use disorder or co-morbid physical health conditions, those older than 65, and the developmentally disabled, are especially difficult to place.
- There has been an increase in episodes of client violence in hospitals, impacting both hospital staff and especially other clients.

To respond to this motion, we drew on the knowledge and experience of many subject matter experts both in and outside LA County. Much of this report references an analysis of our mental health and substance use disorder facility-based services conducted by Mercer Health & Benefits LLC. This report also relies on early work by the Office of Diversion and Re-Entry (ODR) and the RAND Corporation to examine the population of individuals with serious mental illness in LA County justice systems. Finally, for the past several months we have organized a Hospital Network Steering Committee consisting of experts from the Department of Mental Health (DMH), the Department of Health Services (DHS), the Department of Public Health (DPH), the LA Superior Court, and several private healthcare systems. This committee's ideas and recommendations are also incorporated throughout.

These experts come from different backgrounds and parts of the system, and they didn't always agree on the nuances of the problems or ideal solutions to address them. But there was general agreement on three things:

- There is indeed a shortage of mental health hospital services for those who truly need them.

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[1] http://file.lacounty.gov/SDSInter/bos/supdocs/131546.pdf

[2] "Countywide Mental Health and Substance Use Disorder Needs Assessment". Mercer Health & Benefits LLC.

[3] https://www.hcup-us.ahrq.gov/reports/statbriefs/sb189-Hospital-Readmissions-Psychiatric-Disorders-2012.pdf

- Creating new hospital beds is unlikely, on its own, to resolve this shortage.
- The only way we can sustainably address this problem is to look at the whole system of mental health beds and services, including those that play a role prior, during, and after hospital stays, and address all of the factors (e.g. capacity and service quality) across this continuum which in combination act to constrain the availability of mental health hospital beds.

A Complex Problem

The availability of mental health hospital beds depends on both the capacity of hospital beds in the system and the quality of services delivered. Higher quality services are more likely to promote client recovery and reduce the risk of readmission, which can reduce future demand for hospital beds and services and alleviate bed shortages.

However, the availability of hospital beds also depends on what happens before and after the hospital. High-quality pre-hospital beds and services, especially those which respond to and address mental health crises, take care of people in crisis before they escalate to a hospital level of need and help to reduce the flow of clients into hospitals. And high-quality post-hospital beds and services provide safe places for hospitalized clients to go once they no longer require acute care, helping to increase the flow of clients out of hospitals and open up hospital beds for clients who truly need them.

Hospitals themselves have little control over these pre- and post-hospital beds and services. And yet both have an outsized impact on the availability of mental health hospital beds. This kind of problem is a hallmark of a complex system, and it drives home the need for holistic system planning and development to address it.

Developing All Types of Needed Mental Health Beds and Related Services

We must continue to build a public mental health system of care that does as much as possible to mitigate the risk of hospitalization, justice system involvement, and homelessness and ensures hospitals are able to focus primarily on serving those clients who truly need acute care. To accomplish this, we need a comprehensive approach to develop all types of needed mental health beds and related services throughout the continuum.

The mental health beds/facilities in LA County's public mental health system of care can be divided into three broad types:

- **Mental Health Hospital**: 24/7 acute care for short-term episodes

- **Mental Health Subacute**[4]: 24/7 subacute (locked) care for longer-term episodes
- **Mental Health Residential**[5]: 24/7 residential (unlocked) care for both short- and longer-term episodes

In addition, there are many non-facility-based services in our system of care which also help to reduce the flow of clients into hospitals or increase the flow of clients out of hospitals and into community settings. We describe the mental health beds and related services in the care continuum in more detail throughout this report.

The rest of this report offers recommendations for system changes to develop all types of needed mental health beds and related services across LA County's public mental health system of care. These include recommendations for improving the availability and quality of (1) pre-hospital beds and services, (2) post-hospital beds and services, and (3) hospital beds and services themselves. We also offer recommended changes to improve the coordination of these services as well as to better serve the special populations who often have the most difficulty receiving the care they want and need.

All directives from the January 22 motion have been incorporated throughout this report, with a broader look at how to expand the DMH network of mental health beds and related services, not just hospital beds.

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[4] In the medical field, long-term 24/7 care, such as our mental health subacute care, is known as "extended care". Our subacute facilities are commonly referred to as "IMDs" (Institutions for Mental Disease), but this term is potentially misleading. IMD is a federal term, and it refers to any 24/7 treatment facility with more than 16 beds which *primarily* provides mental health or substance use care. All of our subacute facilities are IMDs, but so are many of our hospitals as well as some of our residential treatment facilities. Critically, federal Medicaid does not currently pay for services provided in IMDs to adults ages 21 to 64.

[5] The version of these beds designed for longer-term episodes is commonly referred to as "stepdown" or "IMD stepdown", though again the term IMD is potentially misleading.

Improving Mental Health Pre-Hospital Services (Client Flow In)

A robust network of high-quality pre-hospital services effectively increases the availability of all mental health beds in our system of care because these services help to safely reduce the flow of individuals in crisis into hospital settings. These services also crucially help to reduce the risk of incarceration or homelessness during and following a crisis.

Technically, almost any non-hospital service or care setting could be considered a "pre-hospital" service, in that the entire non-hospital system of care has a responsibility to do what it can to reduce client risk of hospitalization. Our network of general outpatient mental health services, for example, prevents many future crises by keeping clients in the community engaged and moving forward toward recovery.

But this section focuses specifically on those pre-hospital services most likely to serve clients during a crisis and which most directly impact client flow into hospitals. As much as possible these services respond to clients in crisis and attempt to resolve those crises safely and humanely in the community, with the hope of preventing escalation to an acute hospital level of care or justice-system involvement.

Pre-Hospital Services

The DMH system of care includes several types of pre-hospital services for individuals experiencing a mental health crisis, as well as mechanisms to coordinate these services. These include:

- **24/7 call centers** which field crisis calls and help dispatch mobile crisis response teams, including the DMH ACCESS Center, the National Suicide Prevention Lifeline (operated in LA County by Didi Hirsch), and 211LA.
- **Mobile crisis response teams**, including the DMH Psychiatric Mobile Response Team (PMRT) program as well as Psychiatric Emergency Teams (PET) operated by private hospitals. These teams are often dispatched by the call centers above and help to triage and resolve mental health crises in the field. If needed, they can place clients on a psychiatric hold and arrange for their transport to a hospital.
- **Law enforcement co-response teams** such as the LAPD's Systemwide Mental Assessment Response Team (SMART) program and the LA County Sheriff's Mental Evaluation Team (MET) program. These teams include DMH clinicians paired with specially trained law enforcement officers. They are dispatched by law enforcement agencies typically following first contact by regular law enforcement, so they especially play a role in mitigating the risk of incarceration for individuals in crisis.
- **Full Service Partnership programs (our version of assertive community treatment)** which, in addition to providing outpatient care to some of our most vulnerable clients in the community, are also responsible for responding to those clients' crises 24/7.
- **Behavioral health urgent care centers and psychiatric emergency rooms** which are designed to provide up to 23 hours of crisis stabilization and observation services to clients in crisis.
- **Crisis residential treatment, peer respites**, and other residential facilities which provide an overnight, voluntary alternative to hospitalization during crises.

Recommended Changes to Pre-Hospital Services

The County's public mental health system of care must do what it can to mitigate the risk of crises escalating to hospitalization, justice involvement, and homelessness. For every 365 bed-days of acute hospitalizations or incarcerations avoided, the County effectively "creates" one hospital or jail bed and its associated services for an individual who truly needs it. And if that bed isn't needed, we avoid having to build it; but also, most importantly, we avoid the individual, family, and community harm that comes with avoidable hospitalizations, incarcerations, and homelessness. The human cost of a system that fails to adequately prevent these outcomes is the highest cost.

Crisis Now, a coalition led by the National Association of State Mental Health Program Directors (NASMHPD), has put forward a model of pre-hospital crisis care that has proven successful in several jurisdictions including Arizona. If their model were applied to LA County, they estimate that we would need roughly 486 behavioral health urgent care center beds/chairs, 413 short-term crisis beds (e.g. crisis residential treatment), and 75 mobile crisis response teams (assuming 4 clients served per team per day) along with robust services to coordinate and support them (including call centers). If these were in place and fully supported, they estimate we would need only 1,307 mental health hospital beds in total across the county to provide acute psychiatric care[6].

Of course, this model is a formulaic estimate. Many aspects of our county and system of care are uniquely challenging, including differences in client populations, disparities and inequities, geography, and so on. It is likely that our county's true needs differ from the estimates in this model; they could be lower, or they may be even higher. Nevertheless, models like this are important because they are useful, even if they may not be exactly "right". They highlight potential gaps in our system of care, and even more importantly they show us a different paradigm of how the system could work. At a minimum, models like this, especially when our system differs, should prompt us to examine how well we are meeting the needs of our clients for these types of services.

In contrast to what the Crisis Now model suggests we need, our current pre-hospital services network has only 132 urgent care beds, 81 crisis residential beds, and 45 mobile crisis response teams (not including law enforcement co-response teams), although there are many more of these types of beds currently in development. We have closer to 2,400 mental health hospital beds. We also have 69 psychiatric emergency beds across 3 facilities operated by the LA County Department of Health Services (DHS), though they often must operate at a capacity much above this. But these beds are needed to triage the crisis cases that are most likely to merit hospitalization. Due to lack of availability of both pre-hospital crisis services and acute hospital beds, the DHS psychiatric emergency rooms are almost always overcrowded, making it extraordinarily difficult to meet the needs of the most acute clients in crisis.

There are many solutions we need to pursue to improve the availability and quality of pre-hospital services. By improving these services we can reduce the flow of clients into hospital settings, a critical step to address the shortage of mental health beds in our system of care. The following are our recommended changes to improve the DMH network of pre-hospital beds and related services.

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[6] From https://crisisnow.com. Bed estimates come from the Crisis Now bed calculator tool using a population of 10,160,000 and an average acute inpatient length of stay of 9 days.

1 – Develop more behavioral health urgent care centers

We currently have 132 behavioral health urgent care beds/chairs in our system of care spread across 8 different facilities. In addition, there are a few urgent care centers in the pipeline: Star View City of Industry, which will have 12 beds for adults and 6 beds for adolescents; a High Desert UCC in the Antelope Valley, which will have 12 beds for adults and 6 beds for adolescents; and a new facility on the Olive View-UCLA Medical Center Campus, which will have 12 beds for adults and 6 beds for adolescents and will replace the current 8 bed facility on the campus. This will bring the total urgent care beds in our network to 178 across 10 facilities.

Both Mercer and our Hospital Network Steering Committee are recommending further expansion of these beds. The Crisis Now model suggests we may need 486 urgent care beds to meet the need for pre-hospital crisis care, which would be an increase of 354 beds from our current network. This kind of expansion would mean we could resolve many more crises in the community before they reach a hospital level of need and hopefully avoid many unnecessary hospitalizations, incarcerations, and homeless episodes.

Urgent care beds provide community-based crisis care. They need to be accessible to clients, their families, and first responders, including providing convenient service to law enforcement to allow them to drop off clients in crisis and quickly return to their patrol. Furthermore, they are ideally paired with short-term 24/7 crisis beds, such as our crisis residential treatment programs, to enable quick escalation of care for crisis cases as needed while still providing an alternative to hospitalization.

Ideally, these facilities should be in communities everywhere across LA County. They are not considered IMDs, so crisis stabilization services provided to all eligible Medi-Cal beneficiaries will receive federal matching funds. And given that increased use of these centers should result in a reduction in hospitalizations and emergency room episodes, this could allow for a more efficient use of limited hospital and emergency room resources for those that truly need them and possibly result in a net reduction in health care costs.

2 – Continue to develop crisis residential treatment and similar programs

We currently have 81 crisis residential treatment beds across 6 facilities. In addition, we have many crisis residential beds in development:

- 16 beds at the MLK Community Hospital Behavioral Health Center (BHC)
- 64 beds on the LAC+USC Medical Center Campus, as part of Phase I of the planned Restorative Village, spread across 4 units
- 80 beds on the Olive View-UCLA Medical Center Campus spread across 5 units
- 80 beds on the Rancho Los Amigos National Rehabilitation Center Campus spread across 5 units
- 48 beds at 3 private facilities (SSG, LACADA, and The Teen Project)

This is 288 crisis residential beds in the pipeline which, when added to our current network, will give us a total of 369 crisis residential beds overall, close to the Crisis Now model's estimate of the amount needed.

In addition to continuing to develop these new beds, we must also ensure they have robust interfaces with the urgent care centers to facilitate easy transitions of clients in crisis who require more than 24 hours of treatment but do not necessarily need a hospital level of care. However, even for clients who do eventually need hospital care, having urgent care and crisis residential facilities triage these clients first helps move them toward a speedier recovery and a shorter hospital stay. These facilities *are* considered IMDs if they are more than 16 beds in size; therefore, for now, we must build them as distinct 16 bed programs to be able to receive federal Medicaid matching funds for their services.

There are other kinds of crisis beds that are also valuable as alternatives to hospitalization. Peer respite facilities provide overnight crisis care and are majority-run by peers with lived experience of mental illness. There is a growing body of evidence that peer respites can be a highly effective alternative to hospitalization during crises[7]. Currently, we have only 2 peer respite centers in LA County. This is an effective service type we highly recommend for further expansion.

3 – Continue to develop a more robust network of mobile crisis response services

We currently have 90 front line staff in our Psychiatric Mobile Response Team (PMRT) program, enough for about 45 teams. Due to challenges with serving clients quickly, such as wait times to secure ambulance transport for clients, these teams are typically only able to serve 2 to 3 clients per day.

The Crisis Now model estimates we need 75 mobile crisis response teams to meet the need, and that assumes each team would be able to serve 4 clients per day. Thus, this model would suggest we need a more robust network of mobile crisis response services, especially when combined with a larger network of urgent care and crisis residential beds.

We must continue to expand our PMRT program. In addition, currently PMRT teams are only regularly staffed Monday through Friday during business hours. After hours and on weekends the PMRT service relies entirely on voluntary overtime from PMRT and other clinicians around DMH. This makes it difficult to build a robust 24/7 service that is matched to client demand patterns. We must continue to explore changes in order to expand teams overall and significantly reduce response times to crisis calls.

Furthermore, we must continue to look at ways to improve service times. Ambulance transport is a big barrier; teams often must wait hours with clients for an ambulance to arrive before they can move on to another crisis call. We're currently exploring several ways to resolve this issue including alternative client transportation options such as the Innovation 7 Therapeutic Transportation project[8].

4 – Continue to improve the quality and coordination of pre-hospital services for clients in crisis

It is important to have pre-hospital crisis services which are widely available. In addition, these services must be well-coordinated and high-quality to increase the likelihood of resolving crises without the need

[7] https://www.integration.samhsa.gov/images/res/PDF,%20PSWRC.pdf
[8] http://file.lacounty.gov/SDSInter/dmh/1044118_CombinedProposalandBudget9-5-18.pdf

for hospitalization or incarceration. There are several areas where our network of pre-hospital crisis services could be improved in this regard.

Mental health peer support staff – individuals with lived experience of mental health who provide support to others in need – can be incredibly effective at helping to reduce the risk of hospitalization and incarceration for those in crisis. Yet peers are inadequately and inconsistently utilized as part of our network of pre-hospital crisis services. We are working to expand the use of these kinds of staff throughout.

There is also opportunity for improved coordination between the major call centers fielding crisis calls in LA County. To better coordinate mobile response team dispatch, there should be a uniform set of standards for crisis call centers along with training for call center agents to ensure greater consistency in triage and dispatch for these crisis services.

Full Service Partnership (FSP) programs are responsible for responding 24/7 to their clients' crises, but many programs do so inconsistently and/or inadequately. This is a major focus of our current efforts to revamp the FSP program to have a much greater focus on care outcomes.

There is not enough information sharing between crisis responders and regular mental health treatment providers. First responders often have little visibility on clients' treatment history nor information about their current mental health providers (e.g. FSP), and thus they often feel like they are working in the dark to resolve client crises. This is especially a problem for the most acute clients in emergency rooms; these facilities need access to client clinical information in real-time which will help them to better triage and resolve crises.

Better information sharing for individuals in crisis would also allow greater use and visibility of psychiatric advance directives (PAD), or general advance directives for clients who do not feel they have a psychiatric illness. These documents allow a client to specify, at a time when they are well enough to do so, what future treatment they are ok with if they eventually become unable to make decisions for themselves during a mental health crisis[9].

We are in the early stages of exploring how we can improve information sharing during crises. New ways of utilizing health information exchanges (HIEs), such as the LANES network or private HIEs built for this purpose, could help tremendously to resolve problems stemming from a lack of information during crises.

In general, existing technologies to help us coordinate high-quality pre-hospital crisis care across the county must be improved. Per a previous Board of Supervisors' motion, we are developing an application[10] for tracking the availability of mental health beds throughout our system of care, including urgent care and crisis beds. Our mobile crisis response teams will have access to this application on their phones, which will greatly assist these teams in finding nearby available crisis beds.

[9] https://www.nrc-pad.org/

[10] The Mental Health Resource Locator and Navigator (MHRLN) application.

5 – Develop options for intensive outpatient and partial hospitalization programs for clients in crisis

For individuals who need the intensity of crisis care provided by crisis residential facilities but don't require 24/7 supervision, intensive outpatient and partial hospitalization programs (IOP/PHP) are a great option. These programs typically provide a comprehensive program of mental health services and supports at least 3 times per week for 4 or more hours each time, thus approaching a level of intensity of facility-based mental health services. But clients in these programs can still attend school or work and live at home, so these programs often prove less disruptive to clients' lives than admission to a hospital, subacute, or residential facility.

Unfortunately, these programs are a small part of our current system of care and are hardly used at all as part of the crisis care continuum. Medi-Cal has implemented two versions of these kinds of programs, called Day Rehabilitation (DR) and Day Treatment Intensive (DTI). But there are no DTI/DR programs for adults in LA County. They are almost exclusively used for youth clients who are part of the child welfare system.

The problem is not a lack of intensive outpatient and/or partial hospitalization programs; there are plenty of these in LA County and they are frequently offered by hospitals as an alternative to hospitalization. The problem seems to be with Medi-Cal DTI/DR programs specifically, which are the only programs like IOP/PHP available to Medi-Cal specialty mental health beneficiaries. In 2002, the then CA State Department of Mental Health placed new mandates on DTI/DR programs that were widely seen as challenging. In response, most facilities (including all in LA County) closed their adult DTI/DR programs rather than try to comply with these new regulations.

The lack of these programs for adults is a significant deficit in our system of care. Certain clients in crisis do benefit from these kinds of programs, and without them we are forced to use alternatives which all too often end up including hospitalization. We must explore how to develop these programs again for adults in LA County, especially as a way of diverting clients in crisis who don't need 24/7 monitoring away from hospitals and toward less disruptive settings.

6 – Continue to develop supportive and holistic pre-hospital services for clients who are on or may need a mental health (LPS) conservatorship

Our July 10, 2018 report back to the Board, "Expanding LPS and Probate Conservatorship Capacity in LA County"[11], highlighted the need for an outpatient process for conserving gravely disabled clients so that they do not need to be hospitalized first in order to be conserved. This outpatient conservatorship process will be critical to developing better pre-hospital services for those who are on or may need a mental health conservatorship. Many of our gravely disabled clients in need of conservatorship do not need an acute level of care. Placing them in a lower level of care with a conservatorship process that does not require hospitalization has the potential to significantly reduce hospitalizations overall for this population.

[11] http://file.lacounty.gov/SDSInter/bos/supdocs/116143.pdf

In addition, we need to develop more structured ways of ensuring that all appropriate alternatives to conservatorship, such as the Whole Person Care Intensive Service Recipient (WPC-ISR) or Assisted Outpatient Treatment (AOT) programs, are attempted for eligible clients before they are referred for a mental health conservatorship. Standard referral guidelines for these programs, along with better information sharing among crisis providers (including crisis call centers), as identified above, would help significantly with this.

7 – Continue to improve diversion services and programs that serve as alternatives to incarceration for justice-involved clients in crisis

Lastly, we must continue to improve our pre-hospital services which help to divert clients prior to incarceration. Our law enforcement co-response teams are an essential element of this kind of diversion, and we should continue to evaluate, improve, and expand these programs as necessary.

In addition, our Mental Health Court Linkage Program (CLP) also provides critical diversion services post-arrest but pre-incarceration. This program includes two residential facilities to which it can divert justice-involved clients before they are incarcerated, especially individuals determined to be misdemeanor incompetent to stand trial (MIST). In addition, the CLP provides linkage to outpatient services for justice-involved clients as a voluntary alternative to incarceration. However, the program requires further expansion to fully meet the need. There are not enough clinical staff in the program to cover all the LA County courts likely to encounter people with serious mental illness. Expanding this program would provide additional opportunities to divert clients in crisis prior to incarceration.

Finally, forensically trained peer support staff can be an invaluable addition to crisis services for clients at risk of justice involvement. These staff can work with other clinical staff and law enforcement to help reduce the risk of incarceration for those in crisis. We must continue to evaluate ways to expand the use of peer support staff as part of these services.

Improving Mental Health Post-Hospital Services (Client Flow Out)

Just as we need a robust network of high-quality pre-hospital services to safely reduce the flow of clients into hospital settings, we also need enough high-quality post-hospital beds and services to safely increase the flow of clients out. In combination these two groups of services help to ensure that clients are only admitted to and remain in hospitals while they need an acute level of care.

Given that hospital and emergency services are also the costliest in the mental health system of care, having a robust network of pre- and post-hospital services that reduces hospitalizations and emergency room admissions is also financially prudent. But most importantly, by minimizing the need for hospital care and reducing incarceration due to mental illness, we limit the human cost to clients, families, and communities across the county.

Again, technically all non-hospital services could be considered "post-hospital" in that they all provide care for individuals who may have been previously hospitalized. Our network of general outpatient services, for example, serves many formerly hospitalized individuals and plays a critical role in providing treatment, facilitating recovery, and minimizing the risk of re-hospitalization.

But this section focuses specifically on the post-hospital beds and services which most directly affect the flow of clients out of hospital settings and also help to serve clients who are diverted out of justice settings. These are the services which, when unavailable, often cause clients to get "stuck" in hospitals while waiting for an appropriate place to go or which delay or deny diversion out of jail for individuals who would otherwise be good diversion candidates. They are a critical component of the system for getting clients as quickly and safely as possible to an appropriate level of care and for increasing the availability of mental health hospital beds for those who truly need acute care.

Post-Hospital Services

Our mental health system of care includes several types of post-hospital beds and services as well as mechanisms to coordinate them. All of these services improve the flow of clients out of hospitals and also provide safe settings to which appropriate clients can be diverted out of jails. They include:

- **Subacute beds and services**. These are locked settings designed to provide longer-term 24/7 mental health care to individuals with long-term intensive mental health needs. Most are licensed as Skilled Nursing Facilities with Special Treatment Programs (SNF/STP), though a few are licensed as a Mental Health Rehabilitation Centers (MHRC). All of the individuals placed in our subacute facilities are on a mental health (LPS) conservatorship because of grave disability[12]; however, not all conservatees require a subacute level of care. For adults we have both general subacute services as well as specialized subacute services for certain populations, such as those with forensic backgrounds or who have complex medical conditions. For youth we have two licensed Community Treatment Facilities (CTF) which provide this level of care for those ages 12 to 18.

[12] "Gravely disabled" is defined by CA WIC code as a condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter.

- **State Hospitals**. These are hospitals operated by the California Department of State Hospitals that mostly serve those who have been placed there via court order, such as individuals deemed Incompetent to Stand Trial (IST) or Not Guilty by Reason of Insanity (NGRI). They are all licensed as Acute Psychiatric Hospitals (APH), though some also have Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) units on site. We consider these to be part of our "post-hospital" network of subacute beds and services because, unlike our regular network of mental health hospitals in LA County that serve individuals with short-term acute psychiatric needs, State Hospitals serve individuals with the most serious long-term needs. In this way they are much closer to our subacute facilities, in function and level of care provided, than to our acute hospitals.
- **Residential treatment beds and services**. Also known as "stepdown" services, these are unlocked settings which are designed to provide longer-term 24/7 mental health care to individuals with chronic mental health needs, but in a less secure facility that allows for greater client autonomy and integration into the surrounding community. Our Enriched Residential Services (ERS) for adults and our Short-Term Residential Therapeutic Programs (STRTP) for youth are examples of this type of service.
- **Supportive housing units and services** which provide housing and varying levels of support to help keep individuals housed. They do not provide 24/7 mental health care but are often paired with outpatient mental health programs including Full Service Partnerships (FSP). Our board and care facilities, permanent supportive housing, and interim/bridge supportive housing and shelters are examples of this type of service.
- There are some **outpatient services** in our system of care which can significantly improve the flow of clients out of hospitals and jail systems. These especially include the Full Service Partnership programs (our version of assertive community treatment) that provide hospital and jail in-reach services to help transition clients who will be living in supportive housing or with family post-discharge.

Recommended Changes to Post-Hospital Services

Too many clients who no longer need an acute level of care are getting "stuck" in our hospitals because of a lack of safe and available post-hospital options. Beds at subacute and residential facilities are always full. Because of this, waitlists for these levels of care are long with clients typically waiting at least a month to be admitted for residential care and at least 2 months for subacute care, though often longer for individuals with specialized needs. The waits for State Hospitals are the longest, sometimes as long as a year. And while they wait most clients stay in acute hospitals even though they no longer require acute care.

Even though all psychiatric hospitals have a responsibility to continue treating clients waiting for the next level of care, this responsibility disproportionately falls on our public DHS hospitals. At our private fee-for-service Medi-Cal hospitals approximately 12.5% of bed-days are "administrative", meaning clients no longer meet acute clinical criteria and are waiting for a specific lower level of care setting that is eligible under State regulations for administrative day payment. However, this rate is doubled at the DHS hospitals where more than 25% of bed-days are administrative. Hospitals receive a lower daily

reimbursement rate for clients on administrative status compared to clients who still meet acute clinical criteria.

In addition to the 25% of patients in DHS hospitals awaiting admin-eligible placements, an additional ~50% of patients in DHS facilities are awaiting placement in lower level of care mental health settings that are not eligible for administrative days; for these cases DHS receives zero reimbursement. At the private fee-for-service Medi-Cal hospitals these clients on denied days are relatively rare.

These "denials" may have been because either: a) the client was initially acute and then improved clinically but not to the point they could be safely discharged to a non-administrative day-eligible care setting; or b) the client was not initially acute and only required a subacute or residential level of care from the outset (but was admitted to protect the client's safety in the absence of the availability of a suitable placement). In the first case, the initial acute days are paid, but all days waiting for a suitable non-administrative day-eligible care setting are denied in full. In the second case, because the client didn't meet acute clinical criteria at the start, their bed-days are all "denied" and hospitals are not reimbursed for them at all, even if the level of care needed would otherwise be eligible for administrative day payment.

Thus in total, approximately three-quarters of all patients in DHS acute psychiatric facilities are waiting for various lower level of care placements in the mental health continuum of care, and receiving minimal to no reimbursement for the costs associated with those days, a data point that is illustrative of the overall challenges described in this report and the need to build up lower level of care capacity across the full continuum.

These clients waiting in hospitals on either administrative or denied status create a financial burden for the hospitals that may contribute to poor care and discharge planning and premature release. The degree to which a hospital's clinical and operational practices related to patient discharges are affected by this financial incentive varies widely by hospital, with consideration of their mission, medical staff philosophy, and other financial factors. As an example, clients on administrative or denied days take up a bed that could otherwise be filled by clients who actually need acute care and would earn the hospital the regular acute reimbursement rate. This financial burden is a system problem that requires system change to fully address; hospitals themselves are not to blame. Yet the fact remains that the most difficult-to-place safety net clients disproportionately end up in the public DHS hospitals while they wait for a subacute or residential bed.

In addition, at any given time there are 4 to 5 thousand individuals in jail settings with serious mental illness (SMI) and often substance use disorder (SUD) who need care. According to a preliminary study by the DHS Office of Diversion and Re-Entry (ODR), approximately 56% of this jail population with SMI may be divertible out of the jail. But in order to reach this theoretical rate of diversion there must be enough facilities and services to divert to. The lack thereof is a major reason why only 5-10% of this population is currently being diverted.

And finally, the Los Angeles Homeless Services Authority (LAHSA) estimates that approximately 25% of adult homeless individuals in LA County have a serious mental illness that likely perpetuates their homelessness. With an estimated 54,000 adult homeless individuals in the county, this means that

nearly 14,000 of them may have SMI[13]. The County provides services and housing for as many as it can, but many still have unmet needs for mental health care which will require facility-based mental health treatment or supportive housing to address.

All of this underscores the serious need for post-hospital beds and services. The lack of these services causes logjams and unmet needs throughout the system of care and especially at our public hospitals and emergency rooms. And the result is often unnecessary hospitalization or incarceration along with a significant cost to public finances and human welfare. The following are our recommended changes to improve the DMH network of post-hospital beds and related services.

1 – Develop more subacute beds and services

The DMH network of subacute care for adults (not including the State Hospitals) consists of 1,648 beds spread across several facilities both in and outside LA County. Of these, DMH routinely uses approximately 1,000 beds for its clients on any given day. The rest are used by other county mental health plans and private health plans for their clients; the beds are always full. We do have some subacute beds in the pipeline: we're currently working to develop 32 subacute beds at Aurora Las Encinas Hospital utilizing under-used acute inventory, and 80 new subacute beds are in development at the MLK Behavioral Health Center (BHC).

The State Hospitals are a special case. Despite technically having the largest number of subacute beds in our network – 6,398 across 5 facilities with 236 more in development at Metropolitan State Hospital in LA County[14] – these beds are actually the least accessible to our clients. Over 90% of State Hospital clients are committed there forensically by court systems, and as that amount grows, fewer beds are available to the counties for their civil (LPS) clients. DMH only has about 320 clients in State Hospitals, with an estimated 25 more in our acute hospitals and another 150 in jail waiting for placement.

According to the model developed by Mercer, if status quo levels of residential care, supportive housing, and community-based outpatient services remain the same and current client flow and DMH utilization patterns persist, the County will need to develop 1,508 new subacute beds to meet the need from the non-jail population with SMI alone[15]. In addition, as described in a memo from the three health departments attached to the CEO's August 7, 2019 report to the Board[16], the Office of Diversion and Re-Entry (ODR) is coordinating a study to determine the mix of new mental health beds needed to serve those with SMI in the jail who may be appropriate candidates for diversion. Their preliminary estimates indicate that we may need to develop 1,418 additional new subacute beds to meet this population's needs.

Furthermore, neither the Mercer estimate of subacute bed needs for the non-jail population nor the ODR estimate of needs for the potentially divertible jail population explicitly accounts for potential unmet needs for subacute care among those currently homeless. Because the homeless with SMI

[13] https://www.lahsa.org/documents?id=3423-2019-greater-los-angeles-homeless-count-los-angeles-county.pdf
[14] https://www.dsh.ca.gov/docs/DSH_Strategic_Plan_2018-2023_sig.pdf
[15] "Countywide Mental Health and Substance Use Disorder Needs Assessment". Mercer Health & Benefits LLC.
[16] http://file.lacounty.gov/SDSInter/bos/supdocs/133209.pdf

frequently utilize acute hospital care and are at a significant risk of becoming incarcerated (two major events factoring into the Mercer and ODR bed estimates, respectively), the Mercer and ODR bed estimates likely account for some of the unmet subacute care needs among the homeless. But there are probably also unmet needs for subacute care among the homeless that aren't reflected in these estimates. Determining these additional subacute bed needs will require additional exploration and analysis.

Thus, if current resource and utilization patterns among the non-jail population with SMI persist, and if we are able to increase diversion of the jail population with SMI to the theoretical maximum, the Mercer and ODR analyses suggest we may need to develop nearly 3,000 new subacute beds. And if there are unmet needs for subacute care among the homeless population which are not reflected in these estimates, we may need to develop even more subacute beds.

It is, of course, the hope and intention of the Department of Mental Health that status quo client utilization and flow patterns will not persist and that the supply of residential treatment, supportive housing, and community-based outpatient services will eventually far exceed current levels. This would likely reduce the need for subacute beds significantly. DMH is currently working on a follow-up analysis to the Mercer report to model how improving these factors might reduce the need for new subacute beds, as well as to try to estimate any unmet needs for subacute care among the homeless population that may not be accounted for in the Mercer and ODR bed estimates (see recommendation #9 in this section).

Clearly, this is a complex system. Making a significant change in one part of the system, such as improving the availability and quality of supportive housing, could have a ripple effect and impact bed needs in every other part of the system. Thus, any estimates made today of our bed needs will always carry some uncertainty, as these needs are dynamic and always evolving.

But while some uncertainty is acceptable, inaction is not. The problems mentioned throughout this report due to a lack of post-hospital beds and services are real and serious. The Mercer and ODR estimates of subacute bed needs are valuable; they are data-based and they underscore the magnitude of the problem today. In our recommended actions to the Board of Supervisors we have proposed a pilot bed expansion, and we anticipate that the majority of the new beds will need to be subacute. This gets us moving on a path to actually fix this problem while we continue to refine our models of the system and work on developing services in other areas of the system that are also impactful.

There are two options for developing needed subacute beds: contracting for them and building them ourselves. Contracting has many advantages and is the preferred option, since building new facilities can be very costly. One type of contracting would involve conversion. There are facilities in LA County which are licensed under non-mental health or non-subacute bed types, and many of these have under-utilized beds. The 32 Aurora Las Encinas beds mentioned above are one example. Contracting to convert them to subacute beds for our exclusive use is a win-win, adding capacity we need in the subacute level of care and providing new revenue for the facility that it wouldn't otherwise have. We are continuing to investigate to find other un- or under-utilized bed inventory around the county to convert and contract for in this manner.

Another contracting type involves developing more exclusive contracts for beds in the existing DMH subacute facility network. Currently, none of the subacute beds in our network are exclusively available to DMH clients[17]. Having exclusive contracts can be a way of having more control over client placements in these facilities (e.g. to reduce barriers to client admission). A variant of this involves developing contracts where we at least have admission privileges to the facility, such as when we staff the facility with our own DMH psychiatrists.

The final option for increasing our subacute bed capacity is to build new facilities. Given the great need for more subacute beds it is unlikely we can contract for all of it. We may have to build more subacute facilities to address the lack of bed availability, and the 80 new subacute beds in development at the MLK BHC are a start. As part of the proposed pilot project, we will be working with the CEO to explore further capital development of these beds and to explore potential funding options. We will also be working with the CEO to evaluate siting options that may include the county health campuses and other county-owned sites.

To fund ongoing subacute care in these beds, the biggest barrier is the federal Medicaid IMD exclusion (see recommendation #4). Obtaining the IMD exclusion waiver, currently being piloted by the federal government, or finding some other way to obtain relief from the IMD exclusion, will be critical to expanding our subacute services for those clients who need them.

However, it is important to note that, with or without relief from the IMD exclusion (but especially with it), having a greater capacity of subacute beds would be expected to reduce net health care costs to the county. The care of clients stuck in DHS hospitals on administrative or denied status or in jails who need subacute or residential care is a significant net county cost. Placing these clients in the appropriate care settings instead would allow draw down of state and, with relief from the IMD exclusion, federal dollars for their care. Furthermore, the DHS hospitals would have far fewer clients on administrative and denied status and more clients on acute status, allowing them to draw down full federal matching and state funds for a much greater proportion of the hospital services they provide. These increased revenues and savings to the county could offset any ongoing or existing DHS deficits related to these administrative and denied status clients, as well as be used to further invest in the county's mental health system of care.

2 – Develop more residential treatment beds and services which provider longer-term care

For residential treatment for longer-term care episodes, our network includes 602 Enriched Residential Services (ERS) beds for adults as well as 1,206 Short-Term Residential Therapeutic Program (STRTP) beds for youth. In the pipeline we have 32 general residential treatment beds for adults at the MLK BHC along with many more STRTP beds.

[17] DMH is the designated Mental Health Plan (MHP) for LA County, responsible for organizing a network of providers to serve Medi-Cal and indigent clients with specialty mental health service needs. "Exclusive access" to a bed means that either the bed is owned by the county (e.g. the DHS hospital beds) or that DMH has arranged contractually to be the sole health plan with access to the bed.

The youth STRTP facilities are replacing our former group homes as part of the statewide Continuum of Care Reform initiative. The supply of these beds is generally adequate and waitlists for them are non-existent.

The adult ERS beds are a different story. ERS programs work by placing clients in licensed board and care facilities (also known as adult residential facilities). These facilities provide housing, meals, and 24/7 assistance with activities of daily living. The ERS programs then provide daily mental health services on site as an enhancement to the board and care supportive services.

This means that our ERS beds depend on the board and care network, a network which is in trouble across the state[18]. Board and care facilities are closing rapidly because their business model is broken; revenues are not keeping up with their rising costs. Many counties, including LA County, provide patch payments to some facilities to mitigate this problem, but these supplemental payments are frequently not enough. Because of this, even though we theoretically have 602 ERS beds available for our exclusive use, we frequently have difficulties placing clients in them because of a lack of available board and care beds.

This longer-term residential level of care is important to have in our network of mental health beds. Because these facilities are unlocked, they allow clients who need it to have 24/7 services and support but in a way that also facilitates their integration into the surrounding community. Not only does this community integration provide a bridge to successful independent living; it is also itself a critical driver of client recovery. Clients who are provided with all necessary social determinants of health, including housing, kin and peer relationships, and an occupation and/or community involvement that provides them with purpose, recover far faster and have a lower risk of harmful crises than clients with few or none of these things.

We need to develop more *dedicated* residential treatment beds and services for adults with longer-term care needs which don't rely on the board and care network. We currently have no such beds in our system of care, although as noted there are 32 in development at the MLK BHC. If feasible, it may make sense to develop new beds which can be used for either subacute or residential care, as needed. Many more subacute than residential beds are likely needed over the next few years to meet current unmet needs. However, as the quality of clinical programs and client outcomes at these facilities improve, we anticipate that levels of subacute and residential bed needs may eventually switch. When this happens, it will be valuable to be able to quickly convert subacute beds to residential without having to build or contract for all new residential beds.

Again, we can either contract for or build these beds with considerations similar to the subacute beds. We will be exploring both options thoroughly in partnership with the CEO over the course of the proposed pilot. Ongoing funding would be similarly improved with relief from the IMD exclusion, as any residential treatment facility with more than 16 beds would be considered an IMD. But again, no matter what, it is less costly to both public finances and human welfare to have clients who need this level of care reside in a residential bed compared to a hospital bed, for the same reasons given for subacute beds.

[18] https://calmatters.org/projects/board-and-care-homes-closing-in-california-mental-health-crisis/

3 – Continue to improve quality of care and client transitions across subacute and residential treatment beds and services

While we absolutely need more subacute and residential treatment beds, more capacity on its own is not enough. We must also help drive improvements to the quality of recovery-oriented care in these facilities to ensure all clients receive a real opportunity for recovery and transition to the community and independent living.

One example is the under-utilization of peers and families as part of care throughout this bed network. As noted earlier, when utilized properly peers can be incredibly effective at engaging clients in their care and helping to facilitate their recovery. And families too, when appropriate, can play a critical role in client recovery. But peers and family members are inconsistently and generally under-utilized in care across subacute and residential treatment settings.

There is also a need for more recovery-oriented clinical programming overall at these facilities. Clients in subacute and residential care have chronic mental health needs that require serious, frequent, and persistent care for them to have a chance at recovery. DMH must do more to develop this kind of clinical programming and make sure facilities provide it.

This is especially important when it comes to the special populations that often need these levels of care, including the current and formerly justice-involved, those with co-occurring substance use disorder or co-morbid physical ailments, and the developmentally disabled. These clients often require extra care and support, and it’s important to pay facilities appropriately for it. It’s also important that staff at these facilities are well-trained and equipped to care for special populations. But we must establish a clear expectation that these clients should be admitted and treated no matter the complexity of their care needs. Facilities are expected to serve clients with more complex needs (oftentimes termed “difficult” clients), and it is incumbent upon DMH to ensure they do while we also ensure that facilities are appropriately compensated.

When valuable, we should continue to develop facilities which specialize in these special populations. For example, we should consult with the Department of Developmental Services and the Southern California Integrated Health and Living Project (SCIHLP) to develop new residential options for the developmentally disabled. But whenever possible we should develop facilities which are flexibly capable of serving special populations whether or not they specialize in their care. For example, we should expect appropriate facilities to serve most forensic clients, even those with active charges. Too much division of our mental health bed network into specialties, even if bed capacity is adequate overall, will produce many of the same problems with client placements and inefficient flow we face today.

Finally, the Mercer report consistently identifies a need for better management of client placements and care transitions across our whole network of mental health beds including hospital, subacute, and residential beds. We agree that we need to improve our services for reviewing client stays and managing flow, and we have taken several early steps to do so.

Structurally, we are reorganizing the DMH programs currently responsible for reviewing and managing the placement and transitions of clients in hospitals, subacute, and residential treatment facilities to

create a single combined program that will manage clients across all mental health beds. By doing so, DMH will be able to ensure much greater consistency in care experience and transitions, including ensuring that no clients “fall through the cracks” while moving through this bed network. As part of this effort, we are also reevaluating how we navigate clients from mental health bed facilities to community-based outpatient care, to provide better live handoffs and follow up as needed and ensure clients engage in outpatient services.

As previously mentioned, we are also developing an application (MHRLN) which will significantly assist with managing client care across our mental health bed network. The first phase of this application will provide information on the availability of mental health beds across our system of care. And further planned phases will add additional functionality to the application to assist DMH staff who are reviewing and managing client placements and care transitions across this network.

We are also currently in the process of procuring evidence-based care guidelines to help with utilization management and navigating clients to the most appropriate beds and services for their needs. Care guidelines like this are routinely used by other public and private health plans and can foster a better and more consistent client care experience.

Ultimately, the success of these efforts will be determined by their effect on our clients’ clinical outcomes and experience of care. Our clients deserve to receive the right care at the right time and in the right place. The size of our mental health bed network plays a critical role in this, but so does the quality and coordination of its services.

4 – Support efforts to relax or eliminate the federal Medicaid SMI/SED IMD exclusion

The Centers for Medicare and Medicaid Services (CMS) recently announced a new pilot program (“demonstration opportunity”) which would provide states with a waiver from the IMD exclusion for the treatment of serious mental illness or serious emotional disturbance (SMI/SED)[19]. This follows on a similar successful program providing a waiver from the IMD exclusion for the treatment of substance use disorder in which California is a current participant.

The waiver requires states to take many additional steps to ensure they are improving the quality of their mental health systems of care, including:

- Improving community-based care linked to a set of goals for the pilot;
- Actions or milestones to ensure good quality of care in IMDs;
- Improving connections to community-based care following stays in acute care settings;
- Ensuring a continuum of care is available to address more chronic, on-going mental health care needs of beneficiaries with SMI or SED;
- Providing a full array of crisis stabilization services; and
- Engaging beneficiaries with SMI or SED in treatment as soon as possible.

[19] https://www.cms.gov/newsroom/press-releases/cms-announces-new-medicaid-demonstration-opportunity-expand-mental-health-treatment-services

We strongly recommend pursuit of this SMI/SED IMD exclusion waiver. It is up to the State of California to apply for it, so we recommend all means possible to encourage and support the state in doing so. There may also be alternative ways to obtain relief from the IMD Exclusion for LA County, and if they exist these should also be pursued.

The IMD exclusion is a major barrier preventing needed development of our mental health beds and services, especially subacute and residential beds. It makes it more difficult for our sickest clients to receive subacute and residential care when they need it, which ends up perpetuating cycles of hospitalization, incarceration, and homelessness and likely increases costs to the county, state, and federal government as a result.

Obtaining relief from the IMD Exclusion would create significant opportunities for improved care for our clients across our mental health bed network. We need the help of the state and county in pushing for this vital change.

5 – Continue investing in supportive housing units and services, including board and cares

Developing more supportive housing units and services, including board and cares, permanent supportive housing, and interim/bridge supportive housing, is already a major priority of the county. What is important to note is that these facilities also provide sustainable community-based living options for clients who might otherwise get stuck in mental health hospital, subacute, and residential beds. They also critically help serve clients who are diverted out of the jail; the bulk of clients diverted by the Office of Diversion and Re-Entry are placed in supportive housing settings.

We must continue to develop and support these facilities as a crucial part of the continuum of care. They help stop vicious cycles of homelessness, hospitalization, and incarceration, and through a focus on “housing first” they provide a stable foundation for recovery.

6 – Develop options for intensive outpatient and/or partial hospitalization programs for individuals transitioning out of mental health beds

For individuals transitioning out of a mental health bed, intensive outpatient and partial hospitalization programs (IOP/PHP) can be valuable as a means of continuing the more intensive services associated with mental health beds for a period of time but also allowing clients to return to living with family, in supportive housing, or independent living. In this way these serve as a similar alternative to placement in a mental health bed as they do an alternative to hospitalization during crises.

Unfortunately, the same problems noted with IOP/PHP in the pre-hospital services section apply here as well. Day Rehabilitation (DR) and Day Treatment Intensive (DTI), Medi-Cal’s version of IOP/PHP, are currently unavailable to adults in LA County. We recommend exploring ways to develop these programs again for adults, in this case as a valuable stepdown option for clients exiting mental health beds.

7 – Continue to improve Full Service Partnerships as a post-hospital service

Full Service Partnership (FSP) programs (our version of assertive community treatment) provide the most intensive, everything-it-takes outpatient services to clients with high and complex needs in the community. But they often do not begin engaging clients in our mental health beds until they are nearly or already out the door. Our clients in mental health beds are typically not engaged in care and, when discharged, are often at risk of readmission. It's critical that, for those clients who need an FSP level of care when they return to the community, they are not simply "handed off".

To build up FSPs as a properly integrated component of the post-hospital system of care, we must ensure that all of them begin engaging clients earlier and prior to discharge from mental health beds and the jail. Improving hospital, subacute, and jail in-reach of FSP programs would do a lot to improve care continuity and patient engagement after discharge.

In some cases it may even make sense to keep clients already in FSP enrolled when they are admitted to mental health hospitals, subacute, and residential treatment facilities or incarcerated in the jail. Since FSP programs would not be the primary provider, nor would they be required to respond to crises for clients in mental health beds and jails, they could be paid a significantly reduced rate for these clients. But this would still allow them to check in on these clients from time to time, develop rapport, and create care continuity that would significantly help clients upon release back to the community.

We are currently pursuing a major transformation of our FSP programs for adults where many of these changes are being discussed and planned. This transformation also involves a pilot FSP program specifically for clients on mental health (LPS) conservatorship which aims to better coordinate the services of conservators and FSP clinical care teams.

8 – Develop better post-hospital services for clients on a mental health (LPS) conservatorship

Most of our clients in subacute and residential care are on a mental health (LPS) conservatorship. The pre-hospital services section described the need for services that provide a pathway to conservatorship that doesn't require hospitalization, a goal we're actively working to realize. But currently, most of our conservatees start in hospitals before they are conserved. While they wait in hospitals on a temporary conservatorship (t-con) until their case for full conservatorship is reviewed in court, they take up an acute hospital bed even though most do not require acute care.

There are issues with the conservatorship process, most recently detailed in our July 10, 2018 report back to the Board, "Expanding LPS and Probate Conservatorship Capacity in LA County"[20], which make it difficult to transition t-con clients out of hospitals until they receive a full conservatorship. We must continue to try to improve the conservatorship process to alleviate this issue and make it easier to move conservatees (t-con or full) to the least restrictive setting appropriate for their needs.

In addition, we should continue to create subacute, residential, and supportive housing settings which can serve clients on temporary conservatorships. We have one subacute facility currently (Penn Mar) which is LPS designated and can serve these clients, and we should continue to develop more.

[20] http://file.lacounty.gov/SDSInter/bos/supdocs/116143.pdf

Clients who are on a Murphy conservatorship deserve special mention. These are conservatees with a forensic history and who have been deemed by the court to pose a public safety risk. Placement and treatment may be more difficult than non-Murphy conservatees; nevertheless, they still typically do not require an acute hospital level of care though they often remain in DHS hospitals for long periods of time awaiting placement. While they are often eventually placed in State Hospitals for their long-term care needs, we can and must still try to create placement options for these clients in our regular subacute bed network.

This also applies to clients released from jail on a conservatorship (either Murphy or general). These clients often go to DHS psych ERs followed by DHS acute beds, where they get stuck for long periods of time because of a lack of post-hospital facilities that will admit them. We absolutely must develop placement options that will accept these clients. This may require developing additional trainings for facilities so they are better equipped to manage populations perceived as more difficult.

Finally, we need to work to improve the overall coordination and trust between conservators and clinical providers. These two groups often have difficulty reaching consensus on appropriate post-hospital placements, which can exacerbate conservatee problems with getting stuck in hospital settings. Through the FSP Conservatorship pilot program mentioned above, we are working out ways to improve communication between conservators and clinicians and create better consensus on appropriate post-hospital placements for conservatees.

9 – Conduct further analyses of the system of care to refine estimates of additional needed post-hospital beds and services

The need and demand for mental health beds is highly dependent on a complex array of factors across our system of care. These factors include, among others:

- The supply of mental health beds in the county, including hospital, subacute, and residential.
- Average and variation in lengths of stay in these mental health beds.
- The quality of mental health bed services and care transitions and how that affects lengths of stay (client flow out of beds) and the risk of readmission.
- The supply and quality of community-based outpatient services to care for clients after discharge from a mental health bed, and how that affects the risk of readmission.
- The characteristics of client populations and how these influence types of beds needed and lengths of stay in those beds.
- The ease with which DMH can place its clients in beds they need.
- The supply and quality of pre-hospital crisis services and the degree to which they reduce client flows into mental health beds.
- Projected changes in the client population and these factors over time.

The estimate of 3,000 additional subacute beds needed, for example, is under the status quo scenario where most of these factors remain the same. However, if we can improve these factors, we would likely need fewer subacute beds.

We are currently developing a model, building upon Mercer's analysis, to estimate how our post-hospital bed and service needs may change if we improve upon some of these system factors that drive those needs.

In addition, we will also be developing regular analyses, such as dashboards and reports, which can better identify bed capacity and client flow problems in real-time and produce reliable forecasts of future bed needs and demand going forward.

Improving Mental Health Hospital Services

Finally, even with the highest quality network of pre- and post-hospital beds and services working to safely reduce client flow in and increase client flow out of hospitals, we still need a robust network of mental health hospital services to meet acute psychiatric needs. This is the last critical component of the system of care which affects the availability of mental health beds for those who need them.

The general consensus of the Department of Mental Health, outside analysts, and the many stakeholders we engaged during the past several months is that the quantity of mental health hospital beds in LA County is mostly adequate. We do believe that the quality of these hospital services could be improved overall, including the quality of our own utilization management services, and this could influence both clients' experience of care and, crucially, the flow of clients through these hospital settings.

Mental Health Hospital Services

Our mental health system of care includes several types of hospitals or equivalent acute facility-based services. These include:

- **Medi-Cal fee-for-service (FFS) psychiatric hospitals**. By far the largest part of our hospital network, these private facilities provide acute psychiatric care to Medi-Cal-eligible individuals as well as to individuals with Medicare or private insurance. They typically do not provide services to indigent (uninsured, non-Medi-Cal eligible) individuals, though there are exceptions to this. They may be licensed as General Acute Care Hospitals (GACH), which means they have an acute psychiatric facility or wing which is part of a larger hospital that also provides general acute physical health services. Or they may be licensed as Acute Psychiatric Hospitals (APH), which means they are a freestanding facility that only provides acute psychiatric care. All hospitals licensed as APH in LA County are also considered IMDs for the purposes of federal Medicaid reimbursement, meaning no federal matching funds will be provided for services to adults ages 21 to 64.
- **LA County Department of Health Services (DHS) psychiatric hospitals**. These public facilities provide acute psychiatric care to individuals with all types of insurance, including those who are indigent. There are three DHS hospitals that provide acute psychiatric care: LAC+USC Medical Center (which includes the Augustus F. Hawkins Mental Health Center), Olive View-UCLA Medical Center, and Harbor-UCLA Medical Center. All three of these facilities are licensed as General Acute Care Hospitals (GACH). As the only public hospitals in LA County providing acute psychiatric care, it often falls to them to serve clients with the most acute needs and the costliest episodes.
- **Short-Doyle psychiatric hospitals**. These facilities provide acute psychiatric care exclusively to individuals who are uninsured and not eligible for Medi-Cal as part of the LA County Short-Doyle program. There are two of these hospitals in LA County: Gateways Hospital and Kedren Community Health Center. They are both licensed as Acute Psychiatric Hospitals (APH) and are considered IMDs.
- **Psychiatric Health Facilities (PHF)**. These facilities are not technically hospitals (they are licensed under the separate psychiatric health facility category), but because they also provide 24/7

acute psychiatric care they are typically included in this level of care. There are only a few of these facilities in LA County: two serving adults (operated by Telecare and Exodus Recovery Inc, respectively) and one serving adolescents (operated by Stars Behavioral Health Group). All three are only 16 beds each, so they are not considered IMDs. These are often an excellent acute care alternative to hospitals for clients in crisis.

Recommended Changes to Hospital Services

We believe that the quality of services across our network of acute mental health hospitals could be improved overall. Many clients do not receive adequate recovery-oriented clinical programming during their hospital stay, and peer support staff are again under-utilized in this level of care. Discharge / aftercare planning can be poor, with often limited family work done while clients are in the hospital. All of this can lead to unacceptable rates of readmission and concomitant client harms; for example, the Medi-Cal FFS hospitals' 30-day readmission rate to any other acute hospital setting is 37.8%.

Furthermore, we need to ensure that hospitals provide appropriate acute care to all those who need it. Some hospitals refuse clients they deem too "difficult" to treat. This is especially a problem for current or formerly justice-involved clients as well as those with developmental disabilities. Care for many of these clients tends to fall on the already overburdened public DHS hospitals.

Finally, there are significant deficits in our network of psychiatrists, who play a critical role in ensuring high-quality services and management of clients throughout hospital settings. Taking measures to address these deficits will be critical to improve our mental health hospital services.

According to their model, Mercer is recommending only an additional 32 hospital beds for adults and 12 hospital beds for children. We currently have 32 acute beds in development at the MLK BHC; 16 PHF beds for adults and 16 PHF beds for adolescents. Thus, at this time we believe that, for the non-jail population, the need for additional acute hospital beds in LA County is minimal.

The following are our recommended changes to improve our mental health hospital beds and services. Many of these recommendations are echoed in the Mercer report, which also further describes our current hospital network in greater detail. Even though these recommendations won't significantly increase the capacity of mental health hospital beds in the county, they will all still directly increase the availability of mental health beds and services (including hospital beds) for those who truly need them.

1 – Develop more acute hospital beds for children

Mercer is recommending that we develop an additional 12 mental health hospital beds for children, and we agree that this is a significant need. Children (defined as under the age of 13) with Serious Emotional Disturbance (SED) rarely need acute hospital care. But when they do the need is serious, and we need enough beds distributed around the county both to serve this need and to minimize the burden on family traveling to be with their child during their hospital stay.

We are currently investigating expedient solutions to this problem. It is likely that there is either unused bed inventory or beds that could be converted from another age group to serve children instead. We

will be especially focusing our attention on areas which currently have a significant deficit in child acute beds, such as the San Gabriel Valley.

2 – Develop more acute hospital beds which can serve clients diverted out of the jail

The DHS Office of Diversion and Re-Entry (ODR) currently has 18 acute hospital beds at Olive View-UCLA Medical Center which it uses to serve clients with acute care needs who are diverted out of the jail. This is an extremely successful program which needs expansion.

As previously mentioned, ODR is coordinating a study to determine the mix of new mental health beds needed to serve the divertible jail population with SMI. Their preliminary estimates indicate that we need to develop 52 additional new acute beds to meet this population's needs.

3 – Increase the proportion of acute hospital beds available exclusively to DMH clients

Out of the 2,368 acute hospital beds in our network, we have exclusive access to only 245 of them. These county-exclusive beds include the psychiatric beds at the DHS hospitals, most of the beds at the two Short-Doyle hospitals, as well as 15 beds at two of the Medi-Cal fee-for-service hospitals which are used to treat clients who are indigent.

Given that we routinely utilize nearly 1,000 of these acute beds for our clients on any given day, there is a significant rationale for expanding our network of contracted exclusive beds. Doing so would allow us to better guarantee bed availability for our clients as well as provide a more stable revenue stream for the hospitals themselves.

This could also be a strategy for addressing difficulties placing certain special populations. For example, youth clients with developmental disabilities and autism spectrum disorders are often difficult to place, especially given the complexities of funding and interactions with the CA state regional centers. Having contracted exclusive beds specifically for this population with clearer funding streams and admission criteria could do much to alleviate issues with placing these clients.

4 – Continue to improve quality of care and client transitions across hospital settings

Like with our subacute and residential beds and services, we must continue to try to improve the quality of services and client experience of care in our acute hospitals. Peer support staff and families are also under-utilized in these settings, even though they can help facilitate client engagement, quicker recovery, and more sustainable transitions out of hospitals. Peers can also be invaluable for providing calming care to potentially violent clients.

Moreover, the private hospitals in our network sometimes avoid more "difficult" clients, especially clients from the previously mentioned special populations. Hospitals deserve to be compensated for taking care of clients with the most complex needs, but the hospitals most-consistently shouldering this burden are the public DHS hospitals. DMH must do better to ensure hospitals provide high-quality care

and accept all clients regardless of difficulty. Modified contracts, establishing payment parity between facilities and with other health plans, and enhanced payments for special populations are all potential mechanisms to help with this.

Clinical utilization reviews[21] during hospital stays vary significantly between the types of hospitals in the DMH network. For the Medi-Cal fee-for-service hospitals, DMH reviews episodes retrospectively (after the client is discharged), though we are currently in the process of moving to concurrent reviews (while the client is still admitted) per a state mandate. For clients in the DHS hospitals, DHS staff perform these reviews. DMH has several programs which help to manage the flow of clients moving out of hospitals and on to next levels of care, but these services vary significantly depending on the care destination.

Overall, we need to improve how we manage the placements and transitions of clients in hospital settings, and we have started making several changes already toward this. Structurally, as previously mentioned we are reorganizing the DMH programs responsible for reviewing and managing client placements in hospitals to create a combined program which will manage client placements and transitions across all mental health beds. Notably, we are recommending that this eventually include having DMH perform utilization reviews and authorizing services for payment for client stays in the DHS psychiatric hospitals instead of leaving this responsibility to DHS. We believe this change would reduce burdens to DHS associated with utilization review responsibilities as well as provide opportunities for more seamless management of client care and transitions throughout the system of mental health beds. The previously mentioned bed tracking and client navigation application (MHRLN), currently in development, will also assist with managing client transitions throughout our hospital network and beyond.

5 – Address the shortage of psychiatrists in the system

Lastly, the county has a significant shortage of psychiatrists serving the safety net mental health population, and this also affects the service quality and availability of mental health hospital beds and services.

We are currently taking several measures to address this. We're expanding opportunities for psychiatrists to telework, which will provide a quality of life improvement allowing them the option to work from home part of the time. We're also creating a psychiatrist registry to encourage DMH psychiatrists who wish to work additional hours to do so within our system of care instead of outside it.

There are other solutions we also need to pursue. Many mental health care systems have increased their utilization of psychiatric nurse practitioners, medically and specialty treatment trained psychologists, and advanced practice pharmacists to offload some responsibilities that would otherwise fall on psychiatrists. We need to explore and consider whether and how these physician extenders can play a greater role in our system of care. In addition, we need to develop more training and professional support opportunities for our psychiatrists and other specialty care disciplines. More public care fellowships, for example, would help significantly.

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[21] As the Mental Health Plan for LA County, DMH performs utilization reviews for most of its clients' hospital stays. This includes determining the medical necessity of the stay and either authorizing or denying services for payment.

Recommended Actions for the Board of Supervisors

To help us move quickly to begin implementing the recommended system changes detailed throughout this report, the Department of Mental Health (DMH) is recommending that the Board of Supervisors take the following actions:

1. Authorize the Director of the Department of Mental Health (DMH), or his designee, to conduct a pilot to expand mental health bed capacity and improve existing capacity in the DMH network, within the following parameters:
    a. The pilot will last for two years from the date of Board approval; and
    b. DMH will seek to procure up to 500 State-licensed, approved, or exempt mental health beds of whichever type and mix will help meet the needs of the DMH network, derived through contracting for additional beds using DMH available ongoing funding;

2. For purposes of the pilot implementation and subject to all state and federal laws, prior review and approval as to form by County Counsel, and ten-day written notification to the Board and Chief Executive Officer (CEO), delegate authority to the DMH Director to negotiate, execute, and/or amend contracts with State-licensed, approved, or exempt facilities as needed, with up to a five year initial term and up to two one-year optional extensions, to increase the existing mental health bed capacity, including to:
    a. Revise, modify, or replace existing statement(s) of work;
    b. Reflect federal, State, or County regulatory and/or policy changes;
    c. Add or revise any negotiated supplemental rate(s) or any applicable State established rates; and
    d. Terminate any such contracts in accordance with the County's standard contract termination provisions, including termination for convenience.

3. Delegate authority to the DMH Director, or his designee, to retain a consultant on a temporary and/or intermittent basis to help design and execute an integrated plan for the pilot, develop statements of work for contracts, and assist with other activities as part of the pilot build out, as needed, with a maximum contract amount of $500,000 using DMH available one-time funds.

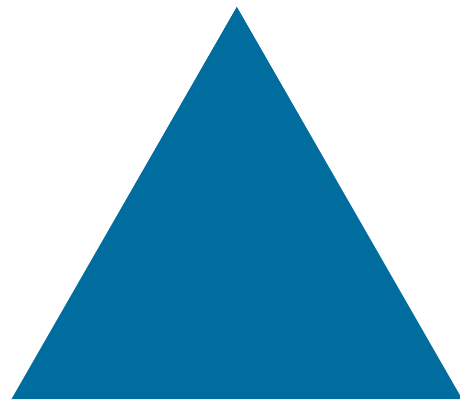
4. Direct the DMH Director to provide an annual status report to the Board of Supervisors with the first report due in January 2021 to include the following information and analysis:
    a. The number, type, and cost of beds contracted through the pilot;
    b. A projection of the amount of remaining DMH funding available to procure additional beds up to the pilot's 500 bed target;
    c. The impact of the additional contracted beds on the DMH network, including any departmental savings or other cost reduction offsets; improvements in client flow through the network; improvements in care quality and outcomes; and any other pertinent metrics; and
    d. Opportunities for further bed expansion, and the associated costs, needed to reach the pilot's 500 bed target, of whichever type and mix will help meet DMH's network needs that considers the work of all County efforts to expand the availability of mental health beds and services.

5. Direct the DMH Director to work with the CEO to develop a proposed funding plan for the costs associated with the remaining beds needed to get to the pilot's 500 bed target, in consultation with affected departments as necessary, which if adopted would to be phased in over future budget cycles, as needed, that will allow the recommendations to be considered within the context of DMH remaining available funding, the overall budget and numerous competing funding priorities and requests. If complete, include this proposed funding plan with the January 2021 report to the Board of Supervisors.
    a. Include in the plan options to convert an entity's existing licensed or approved beds to other types of licensed or approved beds which will meet the needs of the DMH network that consider one-time cost-sharing provisions whereby the County may fund a portion of the cost of bed conversions.
    b. Include in the plan consideration of additional funding that may be available through the State and federal government, private insurers and philanthropy.

6. Direct the DMH Director, in coordination with the CEO, to conduct a needs assessment for staffing and/or contract providers to further develop and improve outpatient and administrative programs and services that support the DMH network of facility-based treatment, including but not limited to: (1) mobile crisis response services; (2) utilization management services; (3) Full Service Partnership services; and (4) other alternatives to hospitalization, such as intensive outpatient and partial hospitalization; funded by DMH available ongoing funds and report back to the Board.
    a. Include in the assessment needs for additional management staff, technology, facility space, or other administrative infrastructure to support the work of these staff and programs.

7. Direct the CEO, in coordination with the Departments of Health Services, Mental Health, Public Health, Children and Family Services, the Homeless Initiative, the LA County Development Authority, and other departments serving populations who use the beds/services, to perform an analysis of the array of County programs and funding streams related to supportive housing (including board and cares, permanent supportive housing, and interim/bridge supportive housing and living environments otherwise) for those with physical, mental, or substance use disorder needs.
    a. Direct the CEO to include in this analysis options for managing these programs and funding streams to improve efficiencies and ensure needed supportive housing capacity as delineated above is developed using available funds.

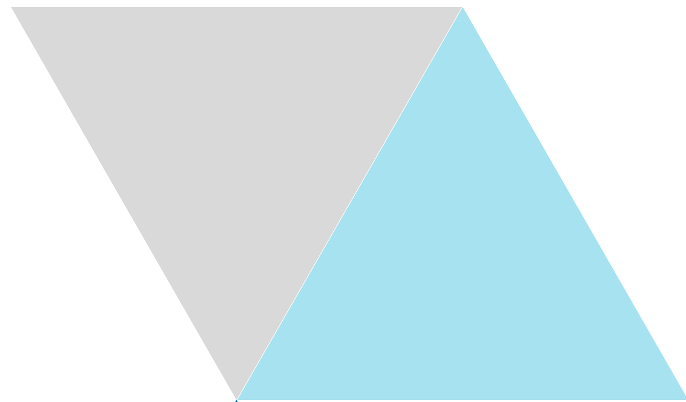
HEALTH WEALTH CAREER

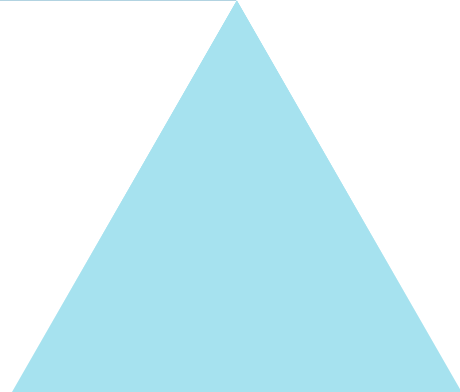


COUNTYWIDE MENTAL HEALTH AND SUBSTANCE USE DISORDER NEEDS ASSESSMENT

AUGUST 15, 2019

Los Angeles County Health Agency





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1
EXECUTIVE SUMMARY

INTRODUCTION

The County of Los Angeles (County) Health Agency (referred herein as “Health Agency” or “County”), which includes the Department of Health Services (DHS), Department of Mental Health Services (DMH), and the Department of Public Health (DPH), retained Mercer Government Human Services Consulting (Mercer), a part of Mercer Health & Benefits, LLC, to perform an assessment of the County’s mental health (MH) and substance use disorder (SUD) treatment needs, capacity, and anticipated gaps across prioritized levels of care; MH acute, subacute and residential, and SUD residential and recovery-based housing. Remaining levels of care, other services or programming available through the County system of care, such as board and cares, permanent supported housing, interim housing, peer respite or intensive community-based services and supports [e.g., full service partnership (FSP) programs], are not included in this needs assessment and analysis.

Key components of the needs assessment include: (1) outlining the existing treatment needs (prevalence), utilization, and capacity for County residents with mental illness and/or SUD[1], (2) projecting utilization trends and/or growth by level of care and population, (3) determining gaps in services according to network adequacy standards, geographic location, and other population-specific priorities, (4) analyzing inefficiencies in client flow across resources, and (5) recommending areas of emphasis to expand services based on findings.[2] The needs assessment applies to County residents eligible for county operated and county contracted MH and SUD services and other available resources across all age groups, including youth with serious emotional disturbance (SED), adults with serious mental illness (SMI) and/or youth (age 12 and older) and adults with SUD conditions.

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[1] The prevalence portion of the analysis was informed by a population needs assessment included as part of the *Los Angeles County Department of Mental Health, Quality Improvement Work Plan Evaluation Report, July 2017* which documented the County’s population at or below 138% of the Federal Poverty Level. However, the County administered MH and SUD program also includes persons not eligible for Medi-Cal, undocumented persons and groups with Medi-Cal eligibility above 138% FPL (perinatal women and adolescents are eligible up to 213% and 266% FPL, respectively).

[2] Description from the Los Angeles County Health Agency Scope of Work for a Countywide Mental Health and Substance Use Disorder Needs Assessment (August 2018).

Due to the Health Agency's current priorities, this needs assessment is focused on evaluating member need and system capacity for facility-based MH and SUD services at the countywide level. Future needs assessments will build upon the results of this assessment and continue to advance the goal of building a MH, SUD and co-occurring continuum of care and provider networks designed to manage crisis and care proactively to mitigate the need for facility-based services, in an environment that supports cultural and linguistic needs.

The current report and analyses are designed as an initial assessment to guide future service expansion and to provide a broader understanding of service needs throughout the County.

ANALYSIS OF PREVALENCE AND UTILIZATION TRENDS

Over the past several years, a number of dynamics within and outside of the County are contributing to an increased demand for intensive MH and residential SUD services. Mercer identified national, state and county factors as well as system specific influencers that are contributing to the need to consider an expansion of MH and SUD inpatient and residential services in the County.

Increased Demand for MH and SUD Services

Legislative and policy changes within the state and county have been implemented over time and have led to an unanticipated increase in demand for intensive MH and SUD services. To respond to these evolving needs, the Health Agency has been forced to rapidly implement program changes and add additional capacity to meet the needs of an increasingly complex and challenging population.

Events over recent years that have had a particularly significant impact on the demand for MH and SUD services include:

- Increased rate of homelessness – The County has been experiencing an increase in persons experiencing homelessness over most of the last decade. Numerous studies have established the relationship between homelessness and prevalence of SMI and SUD conditions.
- Medicaid expansion – Medicaid expansion significantly impacted the number of Medi-Cal eligible persons in California and within the County. Statewide, 3.8 million more individuals gained Medi-Cal coverage due to Medicaid expansion (~1.2 million increase in Los Angeles County).[3]

[3] https://calbudgetcenter.org/wp-content/uploads/Fact-Sheet-Medi-Cal-Millions-Across-California-Faces-Uncertain-Future-11.29.2016.pdf

- Jail mental health population and diversion initiatives –Data provided by MH teams co-located at many of the County jails indicates that there has been a 50% increase in the number of female and male inmates that presented with some form of MH condition between 2013 and 2017. In response to the data, initiatives have been put in place to better meet the MH needs and promote access to MH and SUD treatment services. Recent legislation in California has driven a philosophical shift to transition non-violent offenders and persons with underlying MH and SUD conditions out of jails and into community MH and SUD treatment programs.

- Lanterman-Petris Short (LPS) conservatorship – A LPS conservatorship is the legal term used in California which gives one adult (conservator) the responsibility for being the surrogate decision-maker for an adult (conservatee) who has a SMI. Approximately 4,600 county residents may be on active conservatorship status at any given time. Many of these individuals, whose LPS conservatorship can be initiated during periods of incarceration, present at DHS psychiatric emergency rooms and/or are admitted to DHS inpatient psychiatric units for mandated evaluation periods as part of conservatorship application and assessment proceedings, often with prolonged lengths of stay (private acute hospitals also experience this problem). Because of recent changes with applicants challenging the legal dispositions of these cases and the fact that increasingly more members are pursuing jury trials to decide conservatorship cases, lengths of stay in inpatient psychiatric units have been extended while cases meander through legal proceedings.

- Child and adolescent utilization of psychiatric emergency services – Based on interviews with DHS psychiatric emergency room physicians, social workers and administrators, there is a notable increase in the number of children and adolescents presenting in DHS psychiatric emergency rooms. A recent article published in the *Journal of the American Medical Association – Pediatrics*, highlighted evidence that demonstrated marked increases in suicide attempts and suicidal ideation among children and adolescents presenting to United States tertiary children's hospital emergency departments (published online April 8, 2019). The increased national and local prevalence of children and adolescents who may require ongoing evaluation and psychiatric supervision within a controlled facility-based treatment environment necessitates the Health Agency to examine the current sufficiency of age appropriate resources to meet this emerging need.

- Implementation of the Drug Medi-Cal Organized Delivery System – The Medi-Cal funded pilot program establishes a comprehensive set of SUD services (including SUD residential services) through an organized structure and leverages a continuum of care approach modeled after the ASAM criteria. There has been consensus among the SUD treatment community that the program has improved access to SUD treatment and services.

Prevalence Estimates and Projected Future Utilization of Mental Health and SUD Services

The estimated prevalence of SED/SMI and SUD among children and adults within the County can be used as a starting point to formulate potential demand for services and can be leveraged to support an assessment of system treatment capacity.

Mercer performed an analysis of historic service utilization patterns for children and adults and estimated expected expansions of individuals who will likely access MH and SUD services in future years. These estimates are derived from trended MH and SUD utilization data and considers year-to-year growth based on current population trends and the impacts of jail diversion initiatives, continued proliferation of the homeless population and other factors identified in this report that are leading to an increased demand for MH and SUD services in the County.

Increases in homelessness and criminal justice policy changes will continue to influence future demand and utilization of County administered MH and SUD services. Many of these factors, and likely a myriad of other unidentified and emerging issues, have complex interdependent relationships and reliable data to measure one or more of the factors can be elusive. As such, the needs assessment does not include the application of a formal predictive model to quantify these impacts; but rather seeks opportunities to inform the analysis through an impact review that leverages care facility waitlists, key informant interviews and other available quantitative and qualitative information. Because these factors are embedded characteristics of the current system of care, year-to-year MH and SUD user growth is likely the most accurate method to estimate future demand.

While helpful to gain an understanding of the magnitude of these conditions among the population, estimates of SED/SMI prevalence alone may not be reliable in predicting the extent to which these individuals will actually access and utilize MH services. In addition, the totality of individuals presenting with SED/SMI conditions do not necessarily require the intensive MH facility-based services that are the focus of this needs assessment.

It is also noteworthy to consider that current utilization may be indicative of a pattern of underutilization and may not be representative of the potential demand for services if more treatment options become available or bed capacity is expanded. For example, with approximately 59,000 homeless persons in the County and estimates that 25% of this population are likely to meet diagnostic and functional criteria for an SMI, nearly 15,000[4] of these individuals may need MH and/or SUD services, a number that current service utilization data likely underrepresents due to the inherent challenges with engaging this population in services. In addition, a large percentage of the

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[4] Mercer estimates that nearly 13% of the County's SMI population is expected to utilize acute or subacute services each year. As such, this estimate for the homeless population could include up to 2,000 additional members each year (.13 x 15,000 = 1,950).

jail population will likely be found eligible for diversion, with some percentage of this population needing acute hospital and subacute services.

Summary of Estimated Program Growth[5] (year-over-year) – MH (adults and children) and SUD (persons over the age of 12)

This table provides an aggregate summary of estimated growth for each year across all prioritized levels of care analyzed in this needs assessment. More detail by level of care and population can be found in *Section 4., Prevalence and Utilization Analysis*.

POPULATION	ESTIMATED GROWTH YEAR OVER YEAR (PERCENT)	ESTIMATED GROWTH YEAR OVER YEAR (UNIQUE USERS)
Child – MH	2% – 6%	120 – 350
Adult – MH	4% – 8%	1,800 – 3,600
SUD (age +12)	5% – 10%	600 – 1,200

Current Provider Inventory

Mercer generated an inventory of existing mental health and SUD treatment facilities, with a focus on the number of inpatient and residential beds. Bed capacity and care facility type were compiled, including the volume of available beds and the distribution of facility types across the MH and SUD continuums of care.

Mercer performed an analysis of MH and SUD providers across each inpatient and residential care category and assigned facility type and highlighted facility characteristics and data elements (e.g., numbers of available operating beds, average length of stay, etc.) for each facility type. The intent of the summaries is to provide a snapshot of key statistics associated with each facility type and to promote a more in-depth understanding of available provider capacity, utilization patterns and barriers (real and perceived) impacting access and care.

Full descriptions of all facilities that comprise the inpatient and residential care continuum can be found in *Section 5., Provider Inventory and Capacity Assessment and Appendices A* and *B.*

Assessment of Client Flow

As part of the MH and SUD needs assessment, Mercer performed an assessment of efficiency of client flow. To support the analysis, Mercer examined the following data sources and information:

[5] Percentage and numeric increases refer to estimated growth of persons utilizing MH inpatient, subacute and residential care settings and SUD residential and facility-based withdrawal management services.

- Average length of stay for each facility type (MH) or care facility category (SUD);
- Trended 7-day and 30-day MH readmission rates. For SUD care facility categories, Mercer reviewed 3-month and 6-month readmission rates;
- Aggregated authorization data for fee-for-service hospitals and DHS operated hospitals to discern the proportion of acute, administrative and denied days (MH only);
- Designated facility wait list data collected by DMH (MH only); and
- Results of successive queries of the DPH online Service and Bed Availability Tool (SUD only).

Results of the client flow assessment revealed significant findings and opportunities to improve utilization of existing bed capacity. Key findings include onerous requirements for clinical documentation to demonstrate patient stability, restrictive admission policies, and a structure that discourages referring physician consultation with the potential step-down facility. As a result of the findings derived from the assessment, Mercer is recommending an analysis of DMH's role and processes as gatekeeper for accessing several key MH care facilities.

In addition, SUD bed availability data compiled over successive weeks demonstrated clear trends that should inform possible programming and bed expansion. Specific SUD results can be found in *Section 6., Member Flow Efficiency Assessment.*

An important finding derived from the member flow efficiency assessment was that nearly 2 out of 5 adult individuals discharged from a fee-for-service hospital experienced a readmission within 30 days to another facility type within the acute inpatient hospital care category. In contrast, one out of five adult individuals discharged from a DHS-operated county hospital was readmitted within 30 days during the same time period.

Another significant finding was related to the proportion of administrative and denied days at the fee-for-service hospitals compared to the DHS-operated county hospitals. Under administrative days, the member does not meet medical necessity criteria, but there is evidence that the member is waiting for an appropriate step-down to another care facility for ongoing treatment. Denied days are initiated and accumulate when the member does not meet medical necessity criteria and there is an absence of a definitive discharge plan or the member's discharge from the acute inpatient hospital is imminent or pending the arrangement of appropriate community supports.

The table below illustrates the disproportionate percent of administrative days authorized at the DHS-operated county hospitals when compared to the fee-for-service hospital network. Administrative and denied days together account for almost 75% of the overall bed days in county hospitals compared to approximately 25% for the fee-for-service hospitals. Multiple factors are likely influencing these results, including the volume of members on LPS conservatorship status, and extended wait-times to access step-down facilities. In addition, members who are not formally

placed on a waitlist, or who are waiting for placement at certain lower levels of care, may not meet administrative authorization criteria and may remain in a hospital setting under denied status.

Breakdown of Authorized Days, Acute Inpatient Hospitals – FY 2017

Facility Type	% - Acute Days	% - Administrative Days	% - Denied Days
Fee-for-Service Hospitals	74.9%	11.7%	13.4%
DHS-Operated County Hospitals	27.0%	25.5%	47.6%

An analysis of denial reasons for DHS-Operated County Hospitals reveal that nearly 80% of all denied days are attributed to reason code 70 (Lower level of care = non-billable days) or reason code 50 (Patient does not meet administrative criteria for discharge to home, shelter or street). This finding illustrates a significant unmet need for alternative care settings for members who no longer require acute inpatient hospital treatment.

Stakeholder Themes

As part of the MH and SUD needs assessment, Mercer collected, analyzed and incorporated feedback from multiple stakeholder forums and meetings. Stakeholder input has been organized into themes which then subsequently informed the analysis and recommendations included in this report. See *Section 7., Stakeholder Themes* to review identified system strengths, service gaps and challenges from the perspective of advocates, clients and family members, providers and County staff.

Planned Bed Expansion

The Health Agency has implemented plans to expand bed capacity over the next two years. The expected increases by care facility type are summarized below:

- DMH, DPH and DHS Behavioral Health Center at Martin Luther King Hospital, all new beds:
  - 80 subacute beds for forensic clients
  - 16 acute hospital beds Psychiatric Health Facility for adults
  - 16 acute hospital beds Psychiatric Health Facility for adolescents
  - 16 crisis residential beds
  - 32 general residential beds
  - 16 SUD withdrawal management beds
  - 66 SUD residential treatment beds (33 male/33 female)

- Crisis residential beds in the pipeline at other Los Angeles County campuses (all new beds):
  - 64 beds at LAC+USC
  - 80 beds at Olive View
  - 80 beds at Rancho Los Amigos National Rehabilitation Center
- Other beds:
  - 32 sub-acute beds at Aurora Las Encinas. These will be leased/contracted beds for DMH's exclusive use that utilize existing licensed capacity.
  - 32 adult crisis residential beds at Special Service for Groups and Los Angeles Centers for Alcohol and Drug Abuse. These will be new beds.
  - 16 adolescent crisis residential beds at The Teen Project. These will be new beds.
  - 1 new urgent care center at Star View City of Industry (12 adult beds, 6 adolescent).

Recommendations – MH and SUD Bed Expansion

Mercer's recommendations take into account the current inventory of inpatient and residential care setting capacity for treating Health Agency MH and SUD program participants, including County exclusive/owned beds and available operating capacity that could potentially accommodate a future expansion of dedicated beds.

Coordinating access to, and proper step down from, a network of care facilities that is optimally equipped to meet the population's unique treatment needs would greatly advance the care delivery system beyond its current state.

Mercer offers an assessment of the current provider inventory/network and recommend bed expansions for designated care settings using a data informed formula to estimate additional bed capacity when deemed appropriate.

The tables below depict summary recommendations for expanding current MH and SUD inpatient and residential care setting capacity. Additional information regarding the bed expansion calculations and recommendations can be found in *Section 8., Impressions and Recommendations.*

MH System of Care – Inpatient and Residential Care Facilities

The summary below includes recommendations for increases in bed counts for designated MH care facilities in which the results of the needs assessment demonstrated justification to expand the number of beds. The recommended bed expansion has been adjusted to take into account recently added as well as planned future state beds.

- *Acute inpatient hospital care settings (Fee-for-service hospitals, DHS-County hospitals, Short-Doyle facilities, and psychiatric health facilities):*
  - *Add 12 children beds and 32 adult beds (44 total beds); and*
- *Subacute care settings (State hospitals, specialized subacute, general subacute and community treatment facilities):*
  - *Add 1,508 adult beds*

Select column header descriptions are included below:

County Owned and County Leased Bed Capacity – the number of beds exclusively available to DMH and/or owned/leased by DMH, DPH or DHS;

County Exclusive Bed Utilization[6] – The rate of utilization of all County exclusive and/or owned beds during FY 2017;

Total Bed Capacity – the total number of beds available and operating at the specified care setting facility; and

Total Bed Utilization[7] – The rate of utilization by Health Agency members of all available and operating beds at the specified care setting facility.

Care Setting Category	Facility Type	County Exclusive Bed Capacity	County Exclusive Bed Utilization	Total Bed Capacity	Total Bed Utilization
Crisis Resolution and Triage	Urgent Care Centers	8	83%	132	33%
	Psych ERs	69		69	
	Crisis Residential Treatment Programs			81	39%
TOTAL		**77**		**282**	
Level 1 – Acute Inpatient Hospital	Fee-for-Service Hospitals (including Freestanding)	15	100%	2,045	33%
	County/DHS Operated Hospitals	130[1]	99%	130[1]	99%
	Short-Doyle Facilities	82	100%	127	84%
	Psychiatric Health Facilities			48	81%

[6] The calculation is based on the total FY 2017 unique user bed days divided by the available County exclusive/owned bed days within a year at the designated facility.

[7] The calculation is based on the total FY 2017 unique user bed days divided by all available operating bed days within a year at the designated facility.

Care Setting Category	Facility Type	County Exclusive Bed Capacity	County Exclusive Bed Utilization	Total Bed Capacity	Total Bed Utilization
TOTAL		**227**		**2,350**	
Level 2 – Sub-acute	State Hospitals			490[2]	22%
	Specialized			1,058	52%
	General			590	54%
	Community Treatment Facilities (Youth)			68	57%
TOTAL				**2,206**	
Level 3 – Community Residential	Enriched Residential Services	602	55%	602[3]	55%
	Short-term Residential Therapeutic Program (STRTP)			1,206	N/A[4]
TOTAL		**602**		**1,808**	

1 Excludes 18 beds assigned to the office of Diversion and Re-Entry
2 Only approximately 10% of the total volume of state hospital beds are actually theoretically available to Health Agency members and other county-based MH programs for LPS (civil) client placements. Furthermore, this availability may reduce in the future as more beds are allocated to forensic client placements.
3 Enriched Residential Services are a DMH-specific program utilizing available Board and Care (Adult Residential Facility) beds.
4 Total bed utilization for Short-term Residential Therapeutic Programs could not be reliably calculated as the care settings have experienced a significant expansion in recent years which may not be fully accounted for in these data which are calculated based on FY 2017 users.

SUD System of Care – Residential Withdrawal Management Care Facilities

The recommended SUD bed expansion considers recently added capacity implemented by DPH, including increases in SUD residential and withdrawal management beds and expansion of sober living housing/recovery bridge housing, which has reportedly increased to nearly 1,000 beds that are now available to persons eligible for the DPH administered SUD system of care.

- *ASAM LOC 3.1 – Low Intensity Residential*
  - *Add 397 beds with emphasis on adult male bed expansion*
- *ASAM LOC 3.3 – High Intensity Residential – Population Specific*
  - *Add 149 beds with emphasis on adult and youth female and male bed expansion*
- *ASAM LOC 3.5 – High Intensity Residential – Non Population Specific*
  - *Add 403 beds with emphasis on adult male bed expansion*
- *ASAM LOC 3.2 – Residential Withdrawal Management Clinically Managed*
  - *Add 258 beds with consideration for female and male youth bed expansion*

ASAM Level	Unique Users (FY 2017-2018)	Bed Days (FY 2017-2018)	Average Length of Stay (Days)	2017-2018 Bed Capacity
3.1	8,178	395,750	43.4	2,083
3.3	409	15,571	35.7	490
3.5	2,248	96,120	39.6	1,596
Total	**10,835**	**507,441**	**42.4**	
3.2	2,699	18,825	5.6	1,229
3.7	746	5,302	6.0	10*
4.0	6	14	N/A	10*
Total	**3,451**	**121,569**	**5.8**	**1,239**
RBH	1,334	81,441	56.4	~1,000

*The 10 beds reflect total capacity across ASAM Levels 3.7 and 4.0 since providers can flex these beds based on presenting need. Therefore, the beds should not be regarded as cumulative but rather reflect total capacity if all available beds were assigned to a single ASAM Level (3.7 or 4.0).

Additional Recommendations

The provider inventory analysis also considers the unique needs of the population being served and determines the extent to which the current network can meet those needs. Multiple opportunities exist to strengthen provider agreements and develop incentive structures that reinforce the Health Agency's desired outcomes.

In order to maximize the effectiveness of the MH and SUD provider network, efficient and well-defined processes must be in place for identifying and referring clients, evaluating the client and care setting for clinical appropriateness, and ensuring timely access to care. Admission protocols will ideally be oriented to evidence-based clinical practice guidelines and there should be a robust ongoing clinical review of each client throughout the facility-based system of care to help ensure active treatment and continued need for the care setting. The Health Agency should intentionally and actively monitor key indicators such as average length of stay, readmission rates and clinical outcomes to ensure that efficient and effective care is routinely provided. Care coordination programming and resources should be enhanced considerably and the Health Agency should adopt a care management/utilization review approach that ensures active treatment, the application of evidence-based practices and incorporation of recovery and resiliency principles.

In an effort to present a meaningful set of specific recommendations, Mercer has identified and prioritized recommendations that directly respond to the relevant findings derived from the needs assessment analysis. These recommendations address the adequacy of the current provider inventory and identify opportunities to strengthen and expand the network to be more responsive to the unique needs of members as well as accommodating the anticipated expansion of the population.

Program development initiatives must be targeted and intentional regarding the population that the County is responsible to support. For example, the Health Agency should develop specific capacity within an exclusively contracted network structure to support the long-term residential care needs of individuals with physical health and MH needs. This capacity and capability would be available to the Health Agency to mitigate an established need and resolve a current gap in the care system. In addition, the Health Agency should formalize an approach to an assessment of network adequacy, such as a dashboard, that leverages key data points to support a continuous evaluation of network sufficiency that will proactively identify emerging network gaps and afford opportunities for early interventions that mitigate negative outcomes.

Mercer has also proposed recommendations to enhance client flow, including revisions to the current DMH gatekeeper role and process, implementation of an organized care coordination program, introduction of active care management/utilization review across all restrictive placements and adoption of a data driven system of care oversight role with active involvement and participation of all Health Agency departments and community stakeholders.

1. Address Areas of Need through Program Development

A. Ensure sufficient capacity across all relevant care facilities to address the unique needs of the population. Needs that should be addressed include:

i. Expand acute inpatient hospital beds to accommodate children under the age of 13;

ii. Develop specialized programming across applicable care settings that is readily available to Health Agency participating agencies. Programming expansion should minimally address the following conditions/circumstances:

a. Co-occurring MH and SUD;

b. Individuals with intellectual disabilities and MH conditions, including children with autism spectrum disorders;

c. Adult and youth members with criminal justice involvement;

d. Members on conservatorship status; and

e. Co-morbid physical health and MH.

2. Expand and Strengthen Direct Contracts with Inpatient and Residential Care Providers

A. Only 5% of the current MH operating bed capacity is exclusively available to DMH or owned by DHS (calculation excludes state hospitals and enriched residential services). As the managed care entity responsible for the system of care for county residents with SED, SMI

and/or SUD, it is critical for the Health Agency to establish a robust contracted provider network adequate to meet the needs of the population. In the absence of binding provider agreements, the Health Agency is extremely limited to influence capacity, programming and outcomes for the covered population.

B. The Health Agency should consider developing a comprehensive provider agreement template that incorporates all related program requirements, identifies specific bed capacity that should be available exclusively to the Health Agency, describes admission policies based on national practice guidelines (including explicit language prohibiting exclusions based on the member's health condition), outlines utilization review protocols (including expectations for active treatment) and includes discharge planning expectations.

C. As applicable and permissible under the Medi-Cal program, the Health Agency should explore the use of alternative payment arrangements with providers to reinforce achievement of the Health Agency's goals, objectives and clinical outcomes.

3. Design and Implement a Standardized Approach for the Ongoing Assessment of Network Adequacy

A. As the entity responsible for managing the MH and SUD benefits for a defined population, the Health Agency should establish policies and work processes that support an ongoing assessment of the sufficiency of the provider network. Considerations include the establishment of network management committee that regularly meets to review relevant data and performance measures, examines the adequacy and appropriateness of reimbursement rates and alternative payment arrangements, and reviews decisions with respect to network terminations and expansion.

B. The Health Agency should collect, track and analyze key data elements that inform the sufficiency of the provider network. Key indicators to consider include, but are not limited to, complaint data, results from member satisfaction surveys, volume and type of single case agreements, out-of-area care, referral patterns, waitlists, appointment availability standards, service utilization trends and quality of care concerns.

4. Facility-Specific Recommendations

A. Care setting category: Crisis Resolution and Triage

i. Continue efforts to expand contracts with urgent care centers (private, independent providers as well as DMH operated) and, emphasize through contract terms, crisis resolution outcomes with connections to community supports that alleviate the need for members to engage DHS-operated psychiatric emergency services. When considering

expansion, ensure the appropriate geographic distribution of urgent care centers that can serve children and adolescents.

ii. Consider establishing distinct processing protocols for incoming referrals from jails and law enforcement. This could include designating separate receiving areas and/or observation/stabilization units as well as dedicated staffing resources to address the unique needs of this population. As an alternative, the Health Agency could initiate contracts with independent urgent care centers and/or develop its own capacity to address the needs of forensic and criminal justice referred individuals that require stabilization and evaluation under LPS conservatorship.

iii. Execute contracts with crisis residential treatment programs and leverage the facilities to act as a diversion to entry to both higher and lower levels of care. Ensure that contract terms specify reasonable admission criteria that is based on national guidelines and accepted clinical practice. Consider alternative payment arrangements that reward successful diversions and demonstrate established connections with community supports and services.

B. Care setting category: Acute Psychiatric Inpatient Hospital

i. Expand contracts with fee-for-service hospitals, including units that can accommodate children under the age of 13. Dedicated capacity should include beds for children with co-occurring intellectual developmental disabilities and autism spectrum disorders. Negotiate stronger contract terms that amend current admission policies that tend to allow the hospitals to restrict admissions for clients that may be perceived to be more challenging. As necessary and permissible under current program rules, employ flexibility with reimbursement rates to provide incentives for fee-for-service hospitals to execute contracts and accept Health Agency members for admission. Where possible, consider reducing administrative requirements and present as incentives for potential contractors.

ii. Consider designating a ward at Augustus Hawkins for individuals on conservatorship status that are waiting for admission to a locked subacute facility. This would allow for separate programming and staffing that is tailored to the clinical needs of this less acute population.

iii. Expand facilities and/or contracts with Short-Doyle facilities and develop contract terms that address current admission policies which are perceived as restrictive and inconsistent with general clinical practices (e.g., not accepting individuals who have a history of SUD).

iv. Develop contracts and expand bed capacity for psychiatric health facilities for adults.

C. Care setting category: Subacute

i. Develop and expand exclusive contracts with specialized subacute facilities, including facilities that can accommodate special populations such as individuals with complex medical conditions. Assess the availability of in-county providers to reduce the current inventory of out-of-county facilities (40% of total).

ii. Assess subacute programming to ensure members are frequently engaged in therapeutic milieu and are advancing in recovery. Contract terms should stipulate expectations for programming and should be regularly monitored through periodic utilization review activities. Utilization review should occur more frequently (i.e., every 30 days) to ensure active treatment and ongoing need for the intensity of the service.

iii. Develop and expand exclusive contracts with general subacute facilities, including facilities that accommodate temporary conservatorship holds. Contract terms should clarify admission policies and align criteria with established clinical guidelines.

iv. Consider designating specialized and/or general subacute facilities for access exclusively by DHS-operated county hospitals. The county hospitals are managing a majority of the members in need of locked subacute facilities and should have preferred access to the beds which will free up additional acute inpatient hospital capacity and reduce the number of uncompensated care days.

v. Establish protocols that allow for doctor to doctor consultations between DHS-operated county hospitals and subacute treatment teams to support the clinical review of appropriateness for admission.

vi. Through contract terms, amend current admission policies to subacute settings that serve to restrict access to care. Admission protocols should be clinically appropriate and based on established clinical guidelines. Codify expectations as part of provider agreements between the Health Agency and the provider.

D. Care setting category: Community Residential

i. Continue efforts to expand enriched residential services, which provide aspects of a supervised setting with intensive supports that promote community integration and fosters independence and recovery. Ensure that community partners understand the benefits and availability of these care settings and actively reinforce the identification of appropriate candidates for ERS placements.

E. Care setting category: Acute Withdrawal Management (ASAM Levels 3.7 and 4.0)

i. Consider expanding bed availability for adults and youth under existing provider agreements.

F. Care setting category: Residential Treatment and Withdrawal Management (ASAM Levels 3.1, 3.2, 3.3, and 3.5)

i. Consider expanding or converting existing contracts to ASAM 3.1 bed capacity for adult males.

ii. Expand ASAM 3.2 bed capacity for youth (male and female).

iii. Consider expanding ASAM 3.3 bed capacity for adults and youth.

iv. Examine the need to expand ASAM 3.5 bed capacity for adult males.

5. Review and Revise the Current DMH Gatekeeper Role and Process

A. The practice of a single entity managing limited treatment facility resources and serving as a gatekeeper to accessing designated care facility beds is a reasonable approach. However, there are a number of existing operating protocols that the needs assessment identified that appear to be resulting in inefficiencies and delays in accessing needed care.

i. DMH referral process – assess the need for arbitrary and extended periods of symptom-free documentation as criteria for accepting a referral. While it was noted that the member must demonstrate some period of stability before being considered for an alternative care setting, the manner in which this expectation has been operationalized appears onerous and unrealistic. The fact that many individuals being referred are no longer meeting acute inpatient hospital medical necessity criteria should be sufficient to initiate the referral process.

ii. Examine the need for restrictive and exclusionary admission policies that do not appear to be aligned with clinical practice guidelines and clarify if these expectations are stipulated by the receiving care facilities or criteria that has been developed and applied by DMH. Many of the exclusionary criterion seem unreasonably limiting given the population under review (e.g., history of substance use, recent use of PRN medications, or “as needed” medications).

iii. DMH should establish a formal process to provide feedback to referring entities regarding the appropriateness of referrals and individual case dispositions. This feedback may shape future behavior and could lead to more appropriate referrals that match member needs with the proper type of care facility.

iv. Allow referring entities to interface with identified care facilities to clarify clinical presentations, severity and expected treatment regimens. Physician to physician consultations reflect a standard practice to coordinate effective transitions of care, especially care transitions that involve complex clinical presentations that require placement in supervised care settings.

v. Consider further elevating priority for DHS-operated county hospital referrals. An examination of wait list times based on the referring entity did not demonstrate significant variation in wait times across referral sources, despite acknowledgement that a priority system was in place across referral sources.

vi. Once a member is placed in a DMH managed care facility, a more robust and frequent review of ongoing medical necessity (including the presence of active treatment) should be in place. Allowing members to occupy limited bed space for extended lengths of time, and who may no longer require the level of care, results in additional delays for individuals who need access to the service.

vii. DMH should resolve data collection and tracking issues with respect to maintaining waitlists. Waitlist data is a critical indicator of network sufficiency and a priority should be placed on ensuring that the information is timely, accurate and available for ongoing review by the Health Agency.

6. Explore the Feasibility of Implementing an Organized Care Coordination Program[8]

A. Care coordination encompasses a variety of activities for coordinating services and providers to assist a member achieve his or her recovery goals. These activities, which can occur at a clinical and system level, are performed by designated staff depending on the member's needs, goals and functional status.

B. Individuals with severe and chronic MH and/or SUD conditions can benefit significantly from an active care coordination program to support efficient transitions of care, enhance member engagement in services, and proactively identify and mitigate emerging periods in which an individual may require more supports and intensive interventions to maintain stability. Care coordination is identified as a key strategy that has the potential to improve the effectiveness, safety and efficiency of the health care system. Well-designed, targeted care

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[8] Excerpts of care coordination program expectations were drawn from Arizona's Regional Behavioral Health Authority Scope of Work, Contract/RFP NO. YH17-0001
https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/RBHAs/MMIC_Amd-9_10-1-18_Final.pdf

coordination that is delivered to the right people can improve outcomes for members, providers and payers. A care coordinator should have expertise in member self-management approaches, member advocacy and be capable of navigating complex systems and communicating with a wide spectrum of professional and lay persons, including family members, physicians, specialists and other health care professionals.

C. Care coordination interventions needed for this vulnerable population appear insufficient across the current continuum of care. The Health Agency should engage in a strategic assessment regarding the cost and benefits of establishing a care coordination program for individuals who are determined to be high risk, and/or high utilizers/high cost consumers of Health Agency services, notably those occupying inpatient and residential care settings.

D. Examples of beneficial care coordination activities include:

   i. Establishing a process to ensure care coordination of member needs across the continuum of care based on early identification of health risk factors or special health care needs;

   ii. Monitoring individual health status and service utilization to determine use of evidence-based care;

   iii. Monitoring member services and placements to assess the continued appropriateness, medical necessity and cost effectiveness of services;

   iv. Communicating among behavioral and physical health service providers regarding member progress and health status, test results, lab reports, medications and other health care information when necessary to promote optimal outcomes and reduce risks, duplication of services or medical errors;

   v. Participating in discharge planning from hospitals, jail or other institutions and follow up with members after discharge; and

   vi. Ensure that applicable services continue after discharge.

7. Enhance Utilization Review Activities

A. Restrictive and costly care settings necessitate an established utilization review program that helps ensure the appropriate use of resources and promotes effective treatment interventions. As part of an effort to expand contractual relationships with providers, the Health Agency should regularly review the appropriateness of care across designated care settings.

B. For example, members placed in subacute settings should be reviewed for ongoing medical necessity at least every 30 days. Effective utilization review activities incorporate an assessment of active treatment and promote the use of evidence-based interventions to ensure that members advance in recovery and achieve the highest level of functioning.

C. DMH should implement a process of concurrent utilization review for the fee-for-service hospital network and develop care management strategies that reinforce adherence to contract standards, promotes active treatment and utilizes evidence-based practices when available and appropriate.

8. Implement a Health Agency System of Care Oversight Team

A. All participating Health Agency departments (DMH, DHS and DPH) are accountable for an efficient, cost-effective and efficacious MH and SUD system of care. The Health Agency should establish a data informed system of care oversight role with active involvement and participation of all Health Agency departments and community stakeholders.

B. The Health Agency system of care executive oversight committee would routinely review key indicators of system performance, including, but not limited to, financial and program cost data, aggregated service utilization trends, proposals to expand or develop new programming (e.g., design and implementation of integrated care delivery models), review and approval of value-based purchasing initiatives with providers, design and implementation of strategic initiatives to guide future growth of the program, and oversee periodic assessments of the effectiveness, sustainability and outcomes of the overall health care program.

C. The system of care oversight role could include proposing strategic approaches to engage system partners to assist with achieving a broader set of common goals and system priorities. For example, the committee could seek to establish collaborative care agreements with other system partners that interface with the same targeted population (Regional Centers, corrections, public health).

D. The system of care executive oversight committee should review identified discrepancies in compensation and benefits for health care professionals working across Health Agency Departments.

2
INTRODUCTION

ABOUT THE SYSTEM OF CARE

The County of Los Angeles (County) encompasses over 4,000 square miles and is home to nearly 10.5 million inhabitants, the most populous county in the United States.

Countywide Demographics

County residents are rich in diversity and include individuals who speak a variety of languages and dialects. Primary languages include Arabic, Armenian, Cambodian, Cantonese, English, Farsi, Korean, Mandarin, Russian, Spanish, Tagalog and Vietnamese. County residents comprise a diverse and multiethnic population, representing at least 140 countries and speaking over 200 languages. Over 1.3 million County residents eligible for mental health (MH) and substance use disorder (SUD) services through the County identify Spanish as their primary language.

The County also provides services across all age groups. Table 1. Illustrates, by age grouping, the racial and ethnic distribution within the County's population of individuals at or below 138% of the Federal Poverty Limit (FPL) – 2017.[9]

Table 1 Countywide Demographics – Population at or below 138% of FPL

Region	Age	Total Population	African American	American Indian	Asian/ Pacific Islander	Latino	Multiple Races	White	Other
County of Los Angeles	1 to 12	647,876	52,376	421	30,464	513,633	10,564	38,272	2,146
	13 to 17	222,842	18,229	154	14,270	171,021	3,408	15,286	474
	18 to 64	1,410,914	139,151	2,418	137,221	879,218	19,715	229,541	3,651
	65+	258,967	24,696	473	54,884	91,505	3,325	83,723	359
	All Ages	**2,540,599**	**234,452**	**3,465**	**236,838**	**1,655,378**	**37,013**	**366,822**	**6,631**

County and Health Agency Role in Administering Mental Health and SUD Services

Medi-Cal, California's Medicaid program, is the largest state Medicaid program in the nation.[10] Historically, Medi-Cal has utilized a fee-for-service payment model but has since transitioned away

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[9] Demographic profile is limited to County residents at or below 138% FPL but may not be inclusive of all residents who access County administered MH and SUD services (e.g., undocumented persons).

[10] California Department of Health Care Services website, *Medi-Cal Managed Care*, 2019. Accessed at https://www.dhcs.ca.gov/services/pages/medi-calmanagedcare.aspx

in favor of a managed care delivery system. In this system structure MH and SUD are set up as MCO carve outs. A unique feature of the current Medi-Cal program is the option for counties to operate under different managed care contracting approaches.[11]

The DMH is the State of California's Local Mental Health Plan for the County, and DPH's Substance Abuse Prevention and Control Division oversees the County's Drug Medi-Cal Organized Delivery System.

Department of Health Services[12]

The DHS directly operates four general acute care hospitals, one of which also has licensed acute rehabilitation beds, a network of 25 standalone health centers, the Emergency Medical Services Agency, Housing for Health, Correctional Health Services, and the Office of Diversion and Reentry. Three of DHS' four hospitals provide psychiatric emergency services and acute inpatient hospital services to residents of the County:

Harbor-UCLA Medical Center serves residents in the greater South Bay catchment area. Among other services, it has onsite Psychiatric Emergency Services (PES) and operates 38 adult psychiatric inpatient beds as well as a comprehensive outpatient program operated by DMH.

LAC + USC Medical Center is one of the largest public hospitals in the country. Located just east of downtown Los Angeles, LAC+USC Medical Center provides a full continuum of emergency, inpatient and outpatient services that includes psychiatric services for adults, adolescents and children. LAC+USC operates a PES on its main campus and has a 60-bed inpatient psychiatric ward located at Augustus Hawkins has capacity for 60 psychiatric inpatient bed on the Martin Luther King Jr. Campus in South Los Angeles.

Olive View-UCLA Medical Center serves much of the San Fernando Valley and the Antelope Valley. Olive View-UCLA Medical Center operates a PES and a 32-bed inpatient psychiatric unit. In addition, the DHS Office of Diversion and Re-Entry manages a separate onsite 18-bed inpatient unit at the Olive View location.

Department of Mental Health Services[13]

The DMH, with a budget of approximately $2.4 billion, is the largest county-operated MH department in the United States, directly operating programs in more than 85 sites, and providing

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[11] Tater, M., Paradise, J., & Garfield, R. (2016). *Medi-Cal Managed Care: An Overview and Key Issues* (Issue brief). Henry J. Kaiser Family Foundation. Accessed at https://www.kff.org/report-section/medi-cal-managed-care-an-overview-and-key-issues-issue-brief/

[12] Description summarized from http://dhs.lacounty.gov/wps/portal/dhs

[13] Description summarized from https://dmh.lacounty.gov/

services through contracted programs and DMH staff at approximately 300 sites co-located with other County departments, schools, courts and various organizations. Each year, the County contracts with close to 1,000 organizations and individual practitioners to provide a variety of MH-related services. On average, more than 250,000 County residents of all ages are served every year.

Department of Public Health[14]

The DPH Substance Abuse Prevention and Control Division (SAPC) leads and facilitates the delivery of a full spectrum of prevention, treatment, and recovery support services to reduce the impact of substance use, abuse and addiction in the County. Services are provided through the Antelope Valley Rehabilitation Centers as well as contracts with over 150 community-based organizations to County residents, particularly the un- and/or underinsured. SAPC staff serve as technical experts and consultants to meet the needs of the public and contracted organizations in the field of alcohol and other drug use and abuse.

ABOUT THE NEEDS ASSESSMENT

The County Health Agency retained Mercer to perform an assessment of the County's existing and projected MH and SUD treatment needs, capacity, and anticipated gaps across targeted levels of care (i.e., inpatient, sub-acute and residential) for all age groups, including youth and adults that are eligible for County administered MH and SUD services.

This report consists of a foundational assessment targeting the most intense and restrictive levels of inpatient and residential levels of care designed to treat the County's most acute populations, namely children who are seriously emotionally disturbed (SED), adults with serious mental illness (SMI) and/or persons 12 and older with a SUD. The assessment will help inform key decision-making regarding resource allocation and program development with the end goal of designing and implementing a comprehensive and responsive recovery-based system of care available to the residents of the County.

Like many healthcare delivery systems for individuals and families living at 138% FPL or below, preliminary evidence appears to suggest that the current delivery system lacks sufficient capacity for addressing all of the MH and SUD service needs of the eligible population. Based on a literature review, comparable communities have developed care systems during funding shortages, shifting health care priorities, and decentralized planning efforts led by multiple organizational stakeholders[15]. As a result, community behavioral health systems can have gaps in comprehensive

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[14] Description summarized from http://publichealth.lacounty.gov/

[15] Leff, HS, Hughes DR, Chow CM, Noyes S, Ostrow L. A mental health allocation and planning simulation model: a mental health planner's perspective, 2009.

care and redundancy of resource allocation[16]. These inefficiencies can be addressed to improve the overall responsiveness and effectiveness of the MH and SUD care system. Assessing the local system requires both a framework for defining an adequate care system and a method for estimating demand for each component of the system to address the behavioral health (MH and SUD) needs of the County's population[17].

The needs assessment[18] is intended to inform resource allocation across the continuum of care to more equitably and efficiently distribute interventions and care. Key components of the assessment include:

- The development of an estimate of current treatment needs (prevalence), utilization and provider capacity for County residents with mental illness and/or SUD that utilize County health programs[19]
- An analysis of utilization trends by level of care and population;
- The identification of gaps in services based on capacity, utilization and wait times;
- A collection of preliminary stakeholder feedback through forums, questionnaires, and interviews; and
- Recommendations for the expansion or reallocation of resources of intensive levels of care across the current continuum of services to continue developing a strengths based, recovery oriented and person centered system of care.

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[16] Pfefferbaum R, Pfefferbaum B, Nitiema P, Houston, JB, Van Horn RL. Assessing community resilience: an application of the expanded CART survey instrument with affiliated volunteer responders. Am Behav Sci 2015; 59(2):181-99.

[17] Piper D, Stein-Seroussi A, Flewelling R, Orwin RG, Buchanan R. Assessing state substance abuse prevention infrastructure through the lens of CSAPs Strategic Prevention Framework. Eval Program Plann 2012; 35(1):66-77.

[18] Mercer performed an analysis of historic service utilization patterns for children and adults and estimated expected expansions of individuals who will likely access MH and SUD services in future years. These estimates are generated primarily from past utilization data and additional program growth is expected to occur as a result of jail diversion initiatives, continued proliferation of the homeless population and other factors that are leading to an increased demand for MH and SUD services in the County.

[19] The eligible populations that were included in the needs assessment are aligned with the data and information that was provided to Mercer by the County (e.g., demographic data, prevalence data, utilization data).

3
METHODOLOGY

This needs assessment utilized a multi-component approach to acquire and analyze information from a variety of sources. This section provides a high level description of the methodologies used for each of the information sources.

DATA AND MEASURES USED IN THIS ANALYSIS

A wide range of data sources was utilized to develop measures for demographics, prevalence, utilization, provider capacity and measures associated with member flow through the County's MH and SUD services healthcare system.

Demographic Data

Demographic analysis of individuals living at or below the 138% FPL was conducted for the County. Measures are based upon Public Use Microdata Sample data, organized according to Public Use Microdata Areas (PUMAs) and adjusted for the instances of misalignment between PUMA regions and service areas.

Prevalence Data

Prevalence estimates of individuals with SMI/SED living at or below 138% FPL for the county as well as each service area were based upon a County DMH 2017 Quality Improvement Report and correlated with population estimates from PUMA data. SUD prevalence estimates were projected from National Survey on Drug Use and Health response rates and adjusted for poverty populations.

Utilization Data

Utilization measures were derived from administrative data provided by the County DMH and DPH. To determine the appropriate level of care attributions, episodes of care were linked with facility addresses and general service types (as defined by the County), as national healthcare procedure codes (i.e., CPT, HCPCS, revenue codes) were not available. Because individual recipient addresses were not available, utilization was calculated based on the physical location of each provider, which provides the number of unique users for each provider. Other utilization measures, such as bed days, were also calculated countywide.

Provider Capacity

Provider bed capacity was derived from provider files submitted by the County DMH and DPH, assigned a level of care, and aggregated by both level of care and facility type for MH providers, and by American Society of Addiction Medicine (ASAM) levels for SUD providers. SUD provider data reported licensed and County DPH-contracted beds, whereas MH provider data included County exclusive/owned beds and total operating bed capacity. Total bed counts were aggregated to provide a snapshot of facility-based care capacity.

Member Flow

Member flow information was developed from an analysis of average length of stay, readmission rates, as well as a log of waitlisted individuals for MH inpatient and residential services and the online DPH Service and Bed Availability Tool.

ORGANIZING QUESTIONS AND ANALYTIC APPROACH

The analytic approach was to use “organizing questions” about the system of care that were of interest to the County Health Agency. Multiple measures and data sources were subsequently identified based on supported responses to each of the questions. The core assessment compared prevalence measures with actual utilization; and utilization measures with provider capacity. An analysis of member flow through the system was also conducted. A descriptive analysis of network strengths, gaps and member experiences was generated from these comparisons.

SOLICITING SYSTEM STAKEHOLDER AND COMMUNITY INPUT

Mercer and its sub-contractor, TriWest Group, LLC (TriWest) collaborated with the DMH and the DPH to identify existing stakeholder meetings and other existing forums for gathering preliminary stakeholder feedback. Feedback from these meetings were evaluated for themes and results aggregated and summarized to inform the overall needs assessment and gap analysis. Stakeholders included service recipients and their families, advocates, providers and county representatives.

The purpose of the stakeholder meetings was to gain an understanding of the experience of County residents with accessing and using MH and SUD services for themselves, their child, or another family member or friend as well as an understanding from providers on managing capacity, member flow and available programs to meet individual needs. The goal is to determine what works well, identify barriers, evaluate access to services and evaluate available resources. Feedback and the analysis findings were used to inform recommendations for strengthening the current system of care.

In addition to the stakeholder meetings, Mercer facilitated multiple meetings with Health Agency departments (DMH, DPH, DHS), DMH staff representing MH programs for children and transition age youth, the Office of the Public Guardian, DHS hospital staff and administrators, and representatives from the DHS Mental Health Jail team. Information collected from these meetings informed the overall needs assessment and helped identify system opportunities and final recommendations.

4

PREVALENCE AND UTILIZATION ANALYSIS

A component of the needs assessment involves an analysis of prevalence rates for MH and SUD conditions, as well as an in-depth review of past and recent utilization trends to support estimates of the future need for MH and SUD inpatient and residential services.

Establishing the expected demand for MH and SUD services will support an assessment of the sufficiency of current system capacity and will assist the County with thoughtfully addressing identified gaps in care, including the type and amount of services that are perceived to be needed.

Over the past several years, a number of dynamics within and outside of the County are contributing to an increased demand for intensive MH and residential SUD services. Mercer identified national, state and local factors as well as system specific influencers that are contributing to the need to consider an expansion of MH and SUD inpatient and residential services in the County.

COUNTY POPULATION TRENDS

While the population growth rate in the County has steadied over the past several years, (see Table 2) it has been estimated that the County's population will expand by approximately one million more people — a growth rate of nearly 9% — over the next 15 years[20].

Table 2 – Los Angeles County, California Population Estimate[21]

Year	Population	Growth	Growth Rate
2017	10,163,507	12,949	↑ 0.13%
2016	10,150,558	27,310	↑ 0.27%
2015	10,123,248	50,553	↑ 0.50%
2014	10,072,695	54,091	↑ 0.54%
2013	10,018,604	62,452	↑ 0.63%

[20] https://www.dailynews.com/2017/11/03/an-%E2%80%8Bla-county-forecast-sees-1-million-more-people-but-is-there-enough-housing/

[21] [22] https://www.kcet.org/shows/city-rising/a-2018-snapshot-of-homelessness-in-los-angeles-county

Along with the overall growth of the County, the population of those with SMI and SUD is expected to increase.

Persons Experiencing Homelessness

The County has been experiencing a surge in persons experiencing homelessness over most of the last decade. According to homelessness counts between 2010 and 2017, the number of those experiencing homelessness across the County increased from 38,700 to over 55,000 – a 42% increase and the largest expansion of the homeless population in the nation[22]. Other sources identify that the city of Los Angeles reported one of the largest percentage increases in persons experiencing chronic homelessness of over 46% from 2009–2016[23] (Table 3).

Numerous studies have established the relationship between homelessness and prevalence of SMI — it is estimated that 25% of the homeless population in the United States has a SMI compared to only 4%-6% of the general population[24]. Correlations have also been found that link a decrease in availability of psychiatric hospital beds and increases in rates of persons experiencing homelessness.

Specific to homelessness and SUD, frequent users of EDs are more likely to have co-occurring substance use disorder and be experiencing homelessness. Homeless patients also have higher rates of ED visits when compared to non-homeless patients.[25]

Prevalence estimates of SUD among persons experiencing homelessness vary across studies; however, research has shown that up to two-thirds of this population may have a lifetime history of an alcohol or drug disorder.[26]

A 2013 homelessness assessment report from the U.S. Department of Housing and Urban Development estimates approximately 257,000 persons currently experiencing homelessness have

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[22] https://www.kcet.org/shows/city-rising/a-2018-snapshot-of-homelessness-in-los-angeles-county

[23] https://endhomelessness.atavist.com/mayorsreport2016

[24] https://www.nationalhomeless.org/factsheets/Mental_Illness.pdf

[25] Moulin, A., Evans, E., Xing, G., & Melnikow, J. (2018). Substance Use, Homelessness, Mental Illness and Medicaid Coverage: A Set-up for High Emergency Department Utilization. *Western Journal of Emergency Medicine, 19*(6), 902-906. doi:10.5811/westjem.2018.9.38954

[26] Polcin, D. L. (2015). Co-occurring substance abuse and mental health problems among homeless persons: Suggestions for research and practice. *Journal of Social Distress and the Homeless, 25*(1), 1-10. doi:10.1179/1573658x15y.0000000004

SMI or a chronic substance abuse issue.[27] Strengthening and expanding upon MH and SUD services in the County may help to alleviate some of the increasing rates of homelessness[28].

According to the latest point-in-time count, the number of persons experiencing homelessness in the County has increased by 12% since 2018- currently, there are an estimated 59,000 homeless people countywide.[29] With approximately 59,000 homeless persons in the County and estimates that 25% of this population are likely to meet diagnostic and functional criteria for an SMI, nearly 15,000[30] of these individuals may need MH and/or SUD services, a number that current service utilization data likely underrepresents due to the inherent challenges with engaging this population in services.

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[27] National Coalition for the Homeless (2017). Substance Abuse and Homelessness. Retrieved from: https://nationalhomeless.org/wp-content/uploads/2017/06/Substance-Abuse-and-Homelessness.pdf

[28] Markowitz, F. E. (2006). Psychiatric Hospital Capacity, Homelessness, And Crime and Arrest Rates*. *Criminology, 44*(1), 45-72. doi:10.1111/j.1745-9125.2006.00042.x

[29] Oreskes, B., Pineda, D., Stiles, M., & Díaz, A. (2019, June 05). Rise in homeless numbers prompts outrage and alarm across L.A. County. Retrieved from https://www.latimes.com/local/lanow/la-me-ln-homeless-count-los-angeles-reacts-20190605-story.html

[30] Mercer estimates that nearly 13% of the County's SMI population is expected to utilize acute or subacute services each year. As such, this estimate for the homeless population could include up to 2,000 additional members each year (.13 x 15,000 = 1,950).

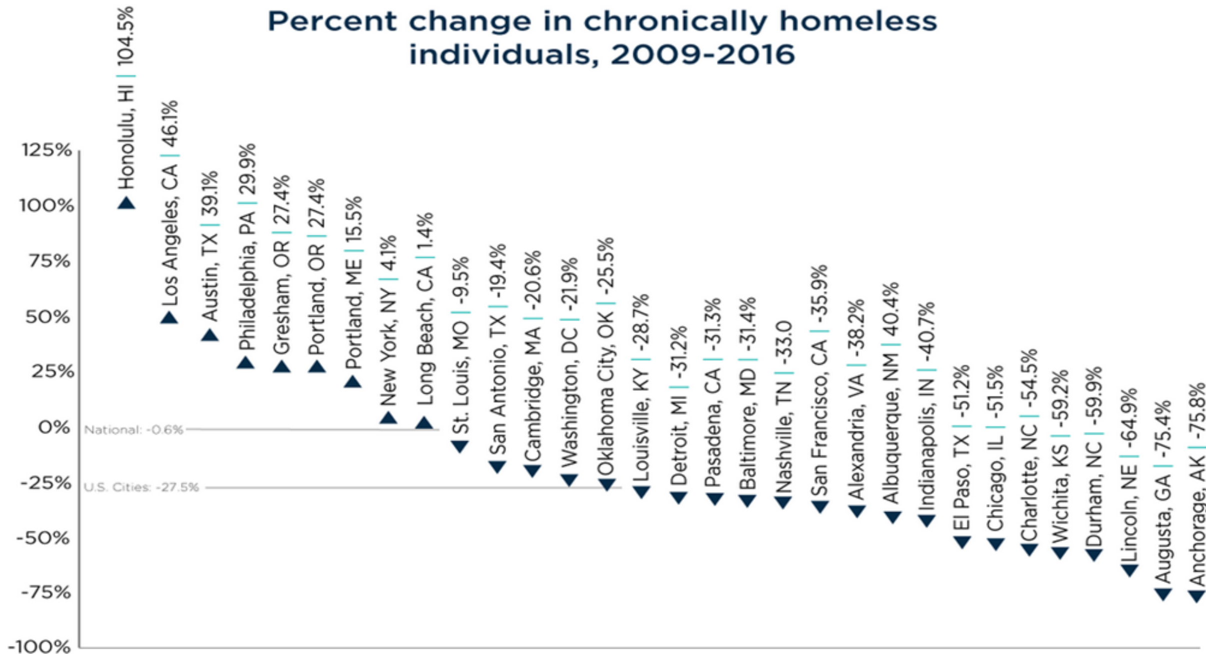

Table 3. – Percent change in chronically homeless individuals by city, 2009 to 2016. Retrieved from https://endhomelessness.atavist.com/mayorsreport2016.

Undocumented Immigrants

Though the immigrant population growth rate in California has been slowing since the 2000s, there is still an estimated 814,000 undocumented immigrants residing in the County[31]. This population, in particular, may experience difficulties accessing needed MH and SUD services due to their immigration status or available resources to support their language and cultural needs within care; studies have shown an increase in isolation, fear and trauma among migrants related to the recent public attention on federal immigration policies[32].

Undocumented persons are not eligible to receive health care coverage under Medi-Cal; rather they must rely on county-based funding programs and services from facilities that have been designated to serve those not eligible under Medi-Cal (i.e. Short-Doyle). This population may impact the County's limited resources in this area and may reinforce the need for expansion of these types of facilities.

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[31] Most recent PPIC estimates–2013, https://www.ppic.org/publication/undocumented-immigrants-in-california/

[32] https://childrenspartnership.org/wp-content/uploads/2018/09/Healthy-Mind-Healthy-Future-Report-Promoting-the-Mental-Health-and-Wellbeing-of-Children-in-Immigrant-Families.pdf.pdf

Older Adults

The County's population of older adults (age 60 and above) is projected to increase by over 170% by 2060[33]. Older adults often present with chronic medical conditions which can be exacerbated by co-occurring MH and/or SUD disorders or vice versa. For example, recent estimates of the prevalence of this population in the County exceed 1.6 million older adults and that up to 1.5% of the population (ages 65+) may have an SMI necessitating access to MH services[34].

Older adults often require specialized care settings to adequately address symptoms of their MH and/or SUD illnesses and to effectively monitor medical conditions and potential complications. The accelerating growth of the older adult population in the county presents challenges for the Health Agency in ensuring that sufficient and appropriate options exist across the care continuum to meet the unique needs of this population.

Health Agency Specific Factors

Legislative and policy changes within the state and county have been implemented over time and have led to an unanticipated increase in demand for intensive MH and SUD services. To respond to these evolving needs, the Health Agency has been forced to rapidly implement program changes and add additional capacity to meet the needs of an increasingly complex and challenging population.

Events over the past 5 years that have had a particularly significant impact on the Health Agency participating departments and the demand for MH and SUD services include:

- Medicaid expansion;
- Jail diversion initiatives;
- LPS conservatorship;
- Increased prevalence of mental illness within the child and adolescent population; and
- Implementation of the Drug Medi-Cal Organized Delivery System Pilot Program.

Expansion of Medicaid Program

California was one of several states that expanded Medicaid eligibility under the Affordable Care Act. As a result, Medicaid expansion significantly impacted the number of Medi-Cal eligible persons in California and within the County.

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[33] California Department of Aging, https://www.aging.ca.gov/data_and_statistics/facts_about_elderly/

[34] https://www.chcf.org/wp-content/uploads/2018/03/MentalHealthCalifornia2018.pdf

California implemented Medicaid expansion on January 1, 2014. Statewide, 3.8 million more individuals gained Medi-Cal coverage due to Medicaid expansion (~1.2 million increase in the County). As of 2016, 4.1 million the County residents were eligible for Medi-Cal (40% of the total population).[35]

Medi-Cal eligible members with SED and SMI are assigned to the County for the provision of covered MH and SUD services. Patients newly enrolled in Medicaid may experience challenges finding providers who accept their coverage because, in general, Medicaid offers lower payment rates than Medicare or private insurance. Even before the implementation of the Affordable Care Act, a sizeable share of providers were unwilling to accept Medicaid reimbursement rates.[36]

In addition to a substantial increase in Medi-Cal members, interviews with Health Agency team members reinforced challenges with treatment facilities that are sometimes unwilling to accept patients eligible for Medi-Cal or other County-based indigent care health programs, a scenario that is reportedly more common with fee-for-service hospitals.

Jail Mental Health Population and Diversion Initiatives

Shifts in Los Angeles County Board Policy have created more diversion opportunities for persons with serious mental disorders in the Los Angeles County Jail System. The Board created the Office of Diversion and Reentry (ODR) in 2015, with 40% of its budget set aside for housing. ODR diverts 98% of its thousands of clients to residential settings, not hospitals or emergency rooms. Additionally, new legislation (e.g., Penal Code 1001.36) in California profoundly increases opportunities for diversion and therefore increased community capacity for this population will be needed.

MH teams co-located in many of the county jails have reported steady increases in persons presenting with significant MH disorders. Data provided by the team indicates that there has been a 50% increase in the number of female and male inmates that presented with some form of MH condition between 2013 and 2017.

For recently released (not diverted) persons in need of acute psychiatric care, the DHS-operated county hospitals have assumed treatment responsibility for this population, who often present in psychiatric emergency rooms and may end up admitted to the County's psychiatric inpatient units.

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[35] https://calbudgetcenter.org/wp-content/uploads/Fact-Sheet-Medi-Cal-Millions-Across-California-Faces-Uncertain-Future-11.29.2016.pdf

[36] https://www.urban.org/sites/default/files/publication/94396/2001576-how-have-providers-responded-to-the-increased-demand-for-health-care-under-the-affordble-care-act_0.pdf

Lanterman-Petris Short Conservatorship

A Lanterman-Petris Short (LPS) Conservatorship is the legal term used in California which gives one adult (conservator) the responsibility for overseeing the comprehensive medical treatment for an adult (conservatee) who has a SMI.

Approximately 4,600 county residents may be on active conservatorship status at any given time. Most of these individuals, whose LPS Conservatorship can be initiated during periods of incarceration, often present at DHS psychiatric emergency rooms and/or get admitted to DHS inpatient psychiatric units for mandated evaluation periods as part of conservatorship application and assessment proceedings (private acute hospitals also experience this problem). Because of recent changes with applicants challenging the legal dispositions of these cases and the fact that increasingly more members are pursuing jury trials to decide conservatorship cases, lengths of stay in inpatient psychiatric units have been extended while cases meander through legal proceedings. Once a person is designated as conserved, finding appropriate long-term placements (often in locked facilities) can be challenging and can extend for months.

Increased Prevalence of Child and Adolescent Suicidality in Emergency Rooms

Based on interviews with DHS psychiatric emergency room physicians, social workers and administrators, there is a notable increase in the number of children and adolescents presenting in DHS psychiatric emergency rooms. Coincidently, a well-circulated article in the *Journal of the American Medical Association – Pediatrics*, highlighted recent evidence that demonstrated marked increases in suicide attempts and suicidal ideation among children and adolescents presenting to United States tertiary children's hospital emergency departments (published online April 8, 2019).

The increased national and local prevalence of children and adolescents who may require ongoing evaluation and psychiatric supervision within a controlled facility-based treatment environment necessitates the Health Agency to examine the current sufficiency of age appropriate resources to meet this emerging need.

Implementation of California's Drug Medi-Cal Organized Delivery System Pilot Program

On July 1, 2017, the County implemented the Drug Medi-Cal Organized Delivery System pilot program. The Medi-Cal funded pilot program establishes a comprehensive set of SUD services (including SUD residential services) through an organized structure and leverages a continuum of care approach modeled after the ASAM criteria.

There has been consensus among the SUD treatment community that the program has improved access to SUD treatment and services. DPH SUD utilization data reviewed later in this report confirms stakeholder observations that access to SUD care has been dramatically enhanced, underlying a previously unmet need for individuals in need of SUD services. The needs assessment will highlight actions needed to sustain and potentially further expand the system's capacity to meet the demand for a full continuum of SUD services and supports.

Application of Factors to Inform Demand for MH and SUD Services

Mercer performed an analysis of historic service utilization patterns for children and adults and estimated expected expansions of individuals who will likely access inpatient, subacute and residential MH and SUD services in future years. These estimates are generated primarily from past utilization data and additional program growth is expected to occur as a result of jail diversion initiatives, continued proliferation of the homeless population and other factors identified in this report that are leading to an increased demand for MH and SUD services in the County. Increases attributed to these factors, including homelessness and criminal justice policy changes, will continue to influence demand and utilization of County MH and SUD services. As such, these events and circumstances affecting the demand for services should be considered by the County when assessing the adequacy of the current system of care.

The scope of Mercer's analysis does not include the application of a formal predictive model to quantify the impact of these contributing elements due to data gaps and inherent challenges with accurately measuring the effects of each discrete policy change or public policy issue, and how other extraneous factors peripheral to the needs assessment may unintentionally skew those estimates. However, estimates of program growth over the next 3 to 5 years and recommendations for bed expansion derived through the analyses of utilization data and the assessment of the current provider network are intrinsically linked to the recent policy changes and societal issues affecting the current health delivery system and are therefore believed to be representative of the demand for MH and SUD services.

SED AND SMI PREVALENCE ESTIMATES

The estimated prevalence of SED/SMI and SUD children and adults within the County can be used as a starting point to formulate potential demand for services and can be leveraged to support an assessment of system treatment capacity.

The percentage of individuals estimated to have SMI/SED in the County (Table 4) was identified using the rates published in the Los Angeles County Department of Mental Health's *Quality Improvement Work Plan Evaluation Report for CY 2017*. The population estimates referenced from this report are limited to those individuals estimated to be living at or below 138%[37] of the FPL.

[37] If an individual's income is at or below 138% FPL and the resident's state has expanded Medicaid coverage (as California has done), then that the person will qualify for Medicaid based only on income.

Table 4 – Estimated Prevalence Rates of Individuals with SMI/SED in Los Angeles County

Age Group	Total Population – at or below 138% FPL	SMI/SED Prevalence	SMI/SED Rate
0 to 17	870,718	151,506	17.4%
18+	1,669,881	196,034	11.7%
Total	**2,540,599**	**347,540**	**13.7%**

With approximately 2.5 million individuals at or below 138% of the FPL in the County, it is estimated that over 150,000 children and adolescents would have an SED condition and that nearly 200,000 adults would be determined to have a SMI.

While helpful to gain an understanding of the magnitude of these conditions among the population, estimates of SED/SMI prevalence may not be reliable in predicting the extent to which these individuals will actually access and utilize MH services. In addition, the totality of individuals presenting with SED/SMI conditions don't necessarily require the intensive MH facility-based services that are the focus of this needs assessment.

Mercer estimates that approximately 10% to 15% of persons with SMI may require and access an acute or subacute bed in a given year[38]. For the County, this results in an estimate of 19,600 (10%) to 29,400 (15%) individuals with a SMI utilizing these care settings each year.

During FY 2017, 19,997 (10.2%) unique MH adult users were noted to utilize acute or subacute services. The County's orientation to the lower end of the estimated continuum may suggest challenges with accessing care and/or the availability and sufficiency of inpatient and subacute services for persons in need.

SUD PREVALENCE ESTIMATES

Table 5 presents estimates for SUD conditions for County residents at or below 138% of the FPL.

[38] Mercer generated this estimate based on a review of historic MH service utilization patterns provided by DMH and conducted an independent review of utilization data for of a comparable system of care serving persons with SMI. The latter analysis revealed that nearly 13% of SMI members utilized a psychiatric hospital or subacute facility during the review period (calendar year 2018).

Table 5 – Estimated Prevalence Rates of Individuals with SUD in Los Angeles County[39]

Age Group	Total Population – at or below 138% FPL	SUD Prevalence	SUD Rate
13 to 17	222,842	30,340	13.6%
18+	1,669,881	242,997	14.6%
Total	**1,892,723**	**273,337**	**14.4%**

For SUD conditions, the estimated prevalence rate for County residents at or below 138% FPL and over the age of 12 is 14.4%, or 273,337 individuals. During FY 2017-2018, 11,873 users, or 4.3% of the estimated number of persons with an SUD accessed one or more withdrawal management and/or residential treatment levels of care (ASAM levels 3.1, 3.2, 3.3, 3.5, 3.7 and 4.0). It's important to note that the totality of individuals presenting with SUD conditions do not necessarily require the intensive facility-based SUD withdrawal management and residential services that are a focus of this needs assessment.
FY 2017-2018 coincides with the County's implementation of the Drug Medi-Cal Organized Delivery System pilot program, which appears to have contributed to a significant increase in the number of individuals who accessed SUD services when compared to SUD service utilization trends over the five prior years.

In comparison, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that 8.4% of the general United States population may be struggling with an SUD at any given time.[40] SAMHSA sponsored another study that found that 7.5% of adults identified with an SUD condition in the prior year actually received SUD treatment services.[41] In California, the National Survey on Drug Use and Health found that 8.5% of residents age 12 and older met the criteria for having had an SUD in the past year. Only about one in ten (10%) received treatment for the condition.[42]

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[39] The DPH SUD program also serves perinatal women (up 213% FPL) and adolescents (up to 266% FPL). These additional program participants were not factored into the prevalence estimates.

[40] *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health*. https://www.samhsa.gov/disorders

[41] https://www.samhsa.gov/data/sites/default/files/report_2790/ShortReport-2790.html

[42] California Health Care Foundation. Medi-Cal Moves Addiction Treatment into the Mainstream: Early Lessons from the Drug Medi-Cal Organized Delivery System Pilots. August 2018.

Co-occurring SMI/SUD Prevalence Rates

Table 6 – Estimated Prevalence Rates of Individuals with Co-Occurring Disorders (MH/SUD) in Los Angeles County

Age Group	Total Population – at or below 138% FPL	MH/SUD Prevalence	MH/SUD Rate
13 to 17	222,842	4,470	2.0%
18+	1,669,881	43,373	2.6%
Total	**1,892,723**	**53,044**	**2.8%**

The number of individuals living at or below 138% FPL with a co-occurring condition is estimated to be 53,044 individuals in the County, or a prevalence rate of 2.8% (see Table 6). By examining individuals who received a MH service and an SUD service during the same time period, Mercer identified a total of 4,560 unique users or 8.6% of the total number of persons estimated to have a co-occurring disorder.

Co-occurring conditions were identified if a person received a DMH inpatient, residential or crisis stabilization service and an SUD residential service during FY 2017. This approach was used as a proxy to identify potential co-occurring conditions in the population, but should be interpreted with caution as the services reviewed are restricted to more intensive MH providers and many additional co-occurring individuals may not have accessed a MH and an SUD service during the period under review.

Mental Health Service Utilization Trends

By examining recent and historic utilization patterns across a wide variety of care settings and age groups, the need for services can be quantified and determinations can be made regarding the sufficiency and adequacy of the current inpatient, subacute and MH residential services network.

The tables below illustrate five-year MH service utilization trends for designated facility types across children (Table 7.), adults (Table 8) and all ages (Table 9).

Table 7. Mental Health Utilization Trends by Fiscal Year* and Facility Type, Children-Age 17 and Younger

<table>
<tr><th></th><th></th><th>FY 2017</th><th>FY 2016</th><th>FY 2015</th><th>FY 2014</th><th>FY 2013</th></tr>
<tr><th>Care Setting Category</th><th>Sub Units</th><th>Unique Users</th><th>Unique Users</th><th>Unique Users</th><th>Unique Users</th><th>Unique Users</th></tr>
<tr><td rowspan="2">Crisis Resolution and Triage</td><td>Psych ERs, Urgent Care Centers, Crisis Stabilization Units</td><td>1,982</td><td>2,070</td><td>2,448</td><td>2,209</td><td>1,808</td></tr>
<tr><td>Crisis Residential Treatment Programs</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>TOTAL</td><td></td><td>1,982</td><td>2,070</td><td>2,448</td><td>2,209</td><td>1,808</td></tr>
</table>

		FY 2017	FY 2016	FY 2015	FY 2014	FY 2013
Care Setting Category	**Sub Units**	**Unique Users**	**Unique Users**	**Unique Users**	**Unique Users**	**Unique Users**
Level 1 – Acute Inpatient Hospital	Fee-for-Service Hospitals (including Freestanding)	3,108	2,810	3,159	3,456	2,961
	County/DHS Operated Hospitals	182	156	193	162	175
	Short-Doyle Facilities	761	767	747	719	686
	Psychiatric Health Facilities	27	27	33	44	39
TOTAL		**3,783**	**3,470**	**3,813**	**4,070**	**3,577**
Level 2 – Subacute	State Hospitals					
	Specialized					
	General					
	Community Treatment Facilities (Youth)	58	55	71	61	24
TOTAL		**58**	**55**	**71**	**61**	**24**
Level 3 – Community Residential	Enriched Residential Services					
	Short-term Residential Therapeutic Program (STRTP)	55	10	2	2	1
TOTAL		**55**	**10**	**2**	**2**	**1**
GRAND TOTAL		**5,880**	**5,605**	**6,337**	**6,354**	**5,430**

*Fiscal Year (FY) refers to the period beginning July 1 to June 30 of each identified year.

Relevant findings for five-year trended children utilization include:

- There has been a 10% increase in utilization at psychiatric emergency rooms and urgent care centers between FY 2013 and FY 2017;
- Over 200 more children are accessing acute inpatient hospital care settings during FY 2017 when compared to FY 2013;
- Children unique users in community treatment facilities has increased more than 140% over the past five fiscal years; and

- Utilization in short-term residential programs has markedly increased between FY 2016 and FY 2017 (increase of 450%).

Table 8. – Mental Health Utilization Trends by Fiscal Year and Facility Type, Adults-Age 18 and Older

		FY 2017	FY 2016	FY 2015	FY 2014	FY 2013
Care Setting Category	**Sub Units**	**Unique Users**	**Unique Users**	**Unique Users**	**Unique Users**	**Unique Users**
Crisis Resolution and Triage	Psych ERs, Urgent Care Centers, Crisis Stabilization Units	24,921	25,117	24,064	23,864	23,040
	Crisis Residential Treatment Programs	530	506	540	499	386
TOTAL		**25,451**	**25,623**	**24,604**	**24,363**	**23,426**
Level 1 – Acute Inpatient Hospital	Fee-for-Service Hospitals (including Freestanding)	15,241	13,966	13,222	11,708	11,278
	County/DHS Operated Hospitals	1,802	1,631	1,862	2,443	2,527
	Short-Doyle Facilities	1,301	1,075	1,090	1,214	1,177
	Psychiatric Health Facilities	1,142	542	505	325	126
TOTAL		**18,450**	**16,478**	**15,977**	**14,953**	**14,588**
Level 2 – Subacute	State Hospitals	232	241	202	140	74
	Specialized	892	843	862	795	452
	General	700	779	1,237	1,360	1,221
	Community Treatment Facilities (Youth)	35	42	42	33	11
TOTAL		**1,617**	**1,729**	**2,214**	**2,193**	**1,721**
Level 3 – Community Residential	Enriched Residential Services	996	1,009	551	253	147
	Short-term Residential Therapeutic Program (STRTP)	2				

Care Setting Category	Sub Units	FY 2017 Unique Users	FY 2016 Unique Users	FY 2015 Unique Users	FY 2014 Unique Users	FY 2013 Unique Users
TOTAL		998	1,009	551	253	147
GRAND TOTAL		45,070	43,390	41,955	40,466	38,909

Relevant findings for five-year trended adult utilization include:

- Unique users occupying facility types within the crisis resolution and triage care setting category have increased over 8% between FY 2013 and FY 2017;
- There has been an increase of over 25% between FY 2013 and FY 2017 in adult acute inpatient hospital unique users, driven by more unique users presenting to fee-for-service hospitals, Short-Doyle facilities and psychiatric health facilities. For County-operated hospitals, there was an increase of 10.5% in unique users between 2016 and 2017, reversing a trend of decreasing unique users between 2013 and 2016;
- A 97% increase in unique users was noted for specialized subacute facilities between FY 2013 and FY 2017. However, general subacute facilities experienced a decrease of almost 75% in unique users during the same time period; and
- As additional capacity has become available, unique users utilizing enriched residential services increased by 578% between FY 2013 and 2017.

Table 9. – Mental Health Unique Users, FY 2017 – All Ages

Care Setting Category	Sub Units	Age Groups				
		1 to 12	13 to 17	18 to 64	65+	All Ages
Crisis Resolution and Triage	Psych ERs, Urgent Care Centers, Crisis Stabilization Units	341	1,641	24,305	616	26,903
	Crisis Residential Treatment Programs			530		530
TOTAL		341	1,641	24,835	616	27,433
Level 1 – Acute Inpatient Hospital	Fee-for-Service Hospitals (including Freestanding)	519	2,589	14,784	457	18,349
	County/DHS Operated Hospitals	33	149	1,699	103	1,984
	Short-Doyle Facilities	339	422	1,292	9	2,062
	Psychiatric Health Facilities		26	1,131	11	1,168
TOTAL		817	2,966	17,888	562	22,233
Level 2 – Subacute	State Hospitals			202	30	232
	Specialized			804	88	892

Care Setting Category	Sub Units	Age Groups				
		1 to 12	13 to 17	18 to 64	65+	All Ages
	General			688	12	700
	Community Treatment Facilities (Youth)		57	35		92
TOTAL			**57**	**1,463**	**119**	**1,639**
Level 3 – Community Residential	Enriched Residential Services			979	17	996
	Short-term Residential Therapeutic Program (STRTP)	7	48	2		57
TOTAL		**7**	**48**	**981**	**17**	**1,053**
GRAND TOTAL		**1,168**	**4,712**	**43,797**	**1,273**	**50,950**

Relevant findings for FY 2017 unique users (all ages) by care setting include:

- Children age 12 and younger were most often treated in an acute inpatient hospital care setting and most commonly within a fee-for-service hospital or a Short-Doyle facility;
- Over 25,000 unique users presented to an emergency psychiatric room or urgent care center during the 12-month period;
- Counts of unique users presenting to fee-for-service hospitals account for 83% of all the unique users within the acute inpatient hospital care setting category; and
- Over 50,000 unique users across all age groups accessed one of the MH care settings during FY 2017.

Table 10 below presents the average daily census for MH care settings across all age groups.

Table 10. – Average Daily Census, Select Mental Health Care Settings, FY 2017, All Ages

Care Setting Category	Sub Units	Age Groups					
		1 to 12	13 to 17	All Children	18 to 64	65+	All Ages
Crisis Resolution and Triage	Psych ERs, Urgent Care Centers, Crisis Stabilization Units						
	Crisis Residential Treatment Programs				31.9		31.9
TOTAL		**0.0**	**0.0**		**31.9**	**0.0**	**31.9**
Level 1 – Acute Inpatient Hospital	Fee-for-Service Hospitals (including Freestanding)	12.9	73.4	86.2	635.3	27.7	749.2
	County/DHS Operated Hospitals	0.7	6.1	6.8	114.1	9.7	130.6

		Age Groups					
Care Setting Category	**Sub Units**	**1 to 12**	**13 to 17**	**All Children**	**18 to 64**	**65+**	**All Ages**
	Short-Doyle Facilities	12.1	10.6	22.6	79.5	1.1	103.2
	Psychiatric Health Facilities	0.6	3.4	3.9	32.1	2.7	38.8
TOTAL		**26.2**	**93.4**	**119.6**	**861.0**	**41.2**	**1,021.8**
Level 2 – Subacute	State Hospitals				92.6	15.8	108.3
	Specialized				394.8	45.0	439.7
	General				274.5	6.3	280.8
	Community Treatment Facilities (Youth)						
TOTAL		**0.0**	**0.0**	**0.0**	**761.8**	**67.0**	**828.8**
Level 3 – Community Residential	Enriched Residential Services				330.9	5.8	336.8
	Short-term Residential Therapeutic Program (STRTP)						
TOTAL		**0.0**	**0.0**	**0.0**	**330.9**	**5.8**	**336.8**

Relevant findings for the average daily census for selected MH care settings across all age groups include:

- Specialized subacute facilities record an average daily census of nearly 440 individuals and account for over half of the average daily beds occupied within the subacute care setting category;
- The County-operated hospitals are meeting and slightly exceeding capacity (130 beds) as measured by the average daily census;
- Enriched residential services average daily census exceeds the average daily census for generalized subacute facilities; and
- With over 2,000 operating beds, fee-for-service hospitals record the highest average daily census (750 individuals) than any other MH care setting.

Projected Future Utilization – Mental Health Services

Between FY 2013 and FY 2017, adult unique users of MH inpatient and residential treatment services increased approximately 4% year-over-year. The most recent year comparison (FY 2016 to FY 2017) demonstrated unique user growth of 3.87%. Children unique users of MH inpatient and residential treatment services experienced less robust growth – approximately 2% year-to-year (FY 2013 – FY 2017).

Conservative estimates of year-to-year growth for child and adolescent unique users of inpatient and residential MH services is 2%; with more aggressive targets projecting 6% growth per year. This equates to 120 to 350 additional unique children users per year. For comparative purposes, the increase of children and adolescent users between FY 2016 and FY 2017 was 275 unique users.

For adults with SMI, estimates of projected MH inpatient and residential services utilization range from 4% to 8% annually. These estimates would translate to 1,800 to 3,600 additional adult users of MH inpatient and residential services per year (slightly higher than observed increases of adult unique users between FY 2016 and FY 2017, which was determined to be 1,680 or growth of 3.87%).

SUD Service Utilization Trends – FY 2013 - 2017[43]

The County is one of several in California that is participating in the Drug Medi-Cal Organized Delivery System pilot program. The pilot program is part of California's effort to expand and reorganize SUD treatment in Medi-Cal under California's Medicaid Section 1115 waiver. The implementation of the pilot program has had a profound effect on the volume of individuals accessing SUD services, particularly residential ASAM levels of care.

The number of unique users of designated ASAM levels of care prior to the implementation of the pilot program can be observed in Table 11, which demonstrates unique users by ASAM levels 3.1, 3.2, 3.3 and 3.5 between FY 2013 and FY 2017.

Table 11 – SUD Utilization Trend – Unique Users, All Ages – ASAM Levels 3.1, 3.2, 3.3 and 3.5 (FY 2013 – 2017)

FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
2,636	5,287	5,617	5,896	6,111

SUD Service Utilization Trends – FY 2017-2018

The County implemented the pilot program on July 1, 2017. The pilot program establishes that counties must use a benefit design modeled after the ASAM Criteria, covering a broad continuum of SUD treatment and support services, including SUD residential services[44]. As such, beginning in FY 2018 (July 1, 2017 – June 30, 2018), DPH is collecting utilization data that delineates treatment episodes by ASAM levels.

[43] Time period reflects July 1, 2012 through June 30, 2017.

[44] California Health Care Foundation. Medi-Cal Moves Addiction Treatment into the Mainstream: Early Lessons from the Drug Medi-Cal Organized Delivery System Pilots. August 2018.

Table 12, presents FY 2017-2018 SUD utilization data and demonstrates the overall increase in users as a result of the implementation of the Drug Medi-Cal Organized Delivery System pilot program in the County.

Table 12. – Number of Users[45], FY 2018, by ASAM Level, by Youth (Age 12-17), Adult and All Ages

		Age Groups		
Care Setting Category	**Sub Units**	**Youth**	**Adults**	**All Ages***
Level 1 – Acute Withdrawal Management	ASAM 4.0 Inpatient Withdrawal Management, Medically Managed	0	2	6
	ASAM 3.7 Inpatient Withdrawal Management, Medically Monitored	3	730	746
	ASAM 3.2 Residential Withdrawal Management	17	2,527	2,699
TOTAL		**20**	**3,259**	**3,451**
Level 2 – Residential Treatment	ASAM 3.5 High Intensity Residential, Non-Population Specific	123	2,106	2,248
	ASAM 3.3 High Intensity Residential, Population Specific	8	397	409
	ASAM 3.1 Low Intensity Residential (+ perinatal)	137	7,919	8,178
TOTAL		**268**	**10,422**	**10,835**
Level 4 – Sober Living Housing	Recovery Bridge Housing		1,334	1,334
TOTAL			**1,334**	**1,334**
GRAND TOTAL		**269**	**11,490**	**11,873**

*All ages" totals represent all individuals identified in the SUD utilization data file, including persons who were not affiliated with an overnight stay.

Relevant findings for FY 2017-2018 users by SUD level of care include:

- Youth users account for 2.5% of the total users within the residential treatment level of care category;
- ASAM Level 3.1 accounted for 75% of all users within the residential treatment level of care category; and

[45] A single user may have accessed one or more levels of care during the review period and totals are summed based on the number of users by level of care.

- There was an 150% increase in the volume of individuals accessing SUD withdrawal management and residential treatment services between FY 2016-2017 and FY 2017-2018. This dramatic increase is attributed to the reorganized SUD delivery system under the recently implemented pilot program.

Projected Future Utilization – SUD Services

Mercer has noted that between FY 2013-2014 and FY 2016-2017, unique users of SUD residential treatment and withdrawal management levels of care increased approximately 5% year-over-year. A significant increase in the numbers of unique users occurred when the SUD service delivery system was reformed beginning July 1, 2017.

Approximately 6% of the estimated population with an SUD condition in the County accessed a SUD withdrawal management and/or residential level of care during FY 2017-2018. Mercer projects that expansion of SUD unique users of more intensive SUD services (i.e., withdrawal management and residential treatment) will revert back to expected year-to-year growth patterns or maintain modest increases due to the pilot program (which may or may not be extended into future years).

Therefore, conservative estimates of projected SUD utilization is 5% to 10% growth annually (in terms of increases of unique users). If these estimates come to fruition, it would translate to 600 to 1,200 additional users of SUD residential services per year.

Summary – Future Demand of Intensive MH and SUD Services

Mercer estimates that approximately 10% to 15% of persons with SMI eligible for services under the County's MH system of care may require and access an acute or subacute bed in a given year. For the County, this results in an estimate of 19,600 (10%) to 29,400 (15%) individuals with a SMI utilizing these care settings each year. For FY 2017 (most recent data available), almost 20,000 adult unique users utilized an acute or subacute care setting, but this number is expected to increase incrementally each year due to the factors cited in this report, including, but not limited to, increases in homelessness rates and jail diversion initiatives for individuals with mental illness. Mercer projects that the County will likely experience utilization growth of these care facilities equal to the 15% range within the next 3 to 5 years or an increase of approximately 10,000 adult unique users by 2022.

Conservative estimates of year-to-year growth for SED child and adolescent unique users of inpatient and residential MH services is 2%; with more aggressive targets projecting 6% growth per year. This equates to 120 to 350 additional unique children users per year. For comparative purposes, the increase of children and adolescent users between FY 2016 and FY 2017 was 275 unique users.

For SUD conditions, the estimated prevalence rate for County residents that are eligible for services through the DPH-SAPC program over the age of 12 is 14.4%, or 273,337 individuals. During FY

2017-2018, 11,873 users, or 4.3% of the estimated number of persons with an SUD and covered through DPH-SAPC accessed a withdrawal management and/or residential treatment level of care.

An aggregate summary of estimated growth for each year across all prioritized levels of care analyzed in this needs assessment is presented below.

POPULATION	ESTIMATED GROWTH (PERCENT)	ESTIMATED GROWTH (UNIQUE USERS)
Child – MH	2% – 6%	120 – 350
Adult – MH	4% – 8%	1,800 – 3,600
SUD (age +12)	5% – 10%	600 – 1,200

Estimated growth over three and five years across all prioritized levels of care analyzed in this needs assessment follows.

POPULATION	ESTIMATED GROWTH (PERCENT) YEAR OVER YEAR	ESTIMATED GROWTH (UNIQUE USERS) OVER NEXT 3 YEARS	ESTIMATED GROWTH (UNIQUE USERS) OVER NEXT 5 YEARS
Child – MH	2% – 6%	360 – 1,050	600 – 1,750
Adult – MH	4% – 8%	5,400 – 10,800	9,000 – 18,000
SUD (age +12)	5% – 10%	1,800 – 3,600	3,000 – 6,000

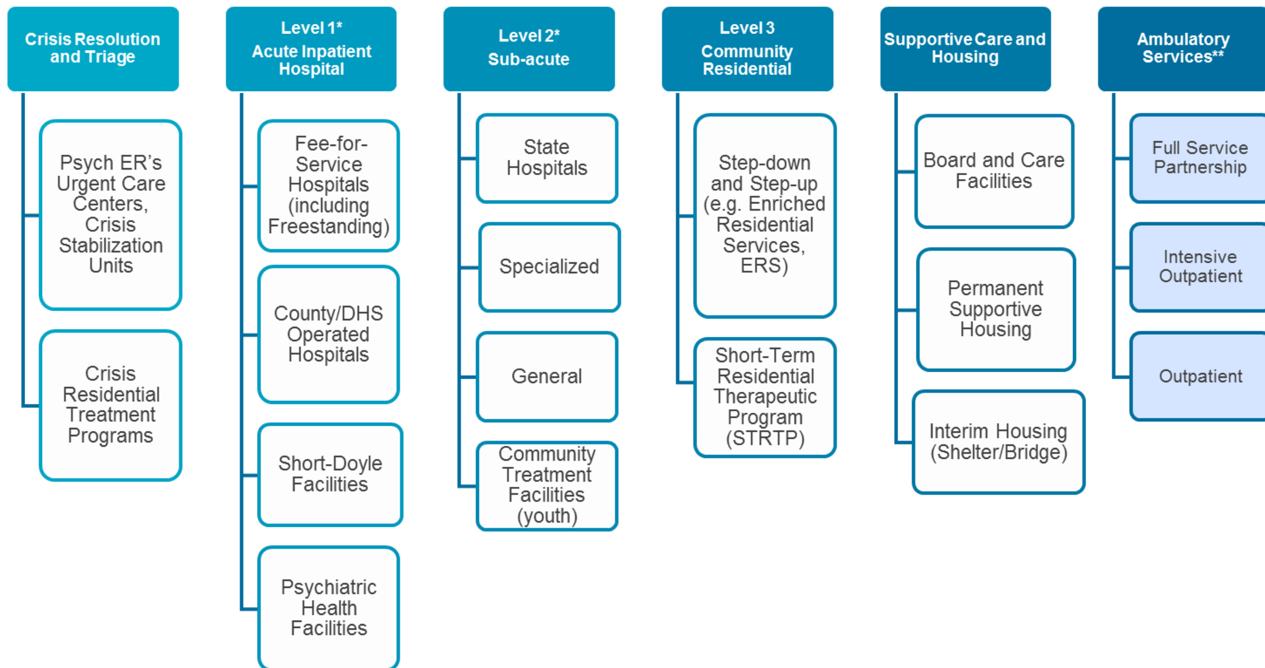
5
PROVIDER INVENTORY AND CAPACITY ASSESSMENT

Mercer reviewed an inventory of capacity in inpatient and residential care settings, public and private, for treating Health Agency MH and SUD clients, and performed an analysis of used versus unused capacity and overall bed availability. For a complete listing of MH and SUD providers, please see *Appendix A and Appendix B, Provider Inventory Tables*.

MENTAL HEALTH CONTINUUM OF CARE

The County DMH operates as a Medi-Cal managed care plan and provides oversight of a full continuum of care for adults with a SMI and children and youth determined to have a SED. Program participants receive services funded through Medi-Cal, the state Medicaid program, as well as state-appropriated MH programs for County residents who require MH services, but do not qualify for Medi-Cal.

County DMH Levels of Care



*Locked Facilities
**Ambulatory services in colored box to be analyzed in a future phase

Mental Health Programs and Services

The care facility continuum is organized by member clinical acuity as well as facility specific characteristics (e.g., length of stay, locked or unlocked). An individual may access MH services anywhere along the continuum of care, and may move through levels of care to meet the individual's needs. Each of the care facilities listed below are defined and described later in this section of the report.

Crisis Resolution and Triage (Unlocked Facilities)

- Psychiatric emergency rooms and urgent care clinics (crisis stabilization)
- Crisis Residential Treatment Programs

Level 1 – Acute Inpatient Hospitals (Locked Facilities)

- Fee-for-service Medi-Cal Acute Psychiatric Hospitals
- County-Operated Hospitals
- Short-Doyle Acute Psychiatric Facilities
- Psychiatric Health Facilities

Level 2 – Subacute (Locked Facilities)

- State Hospitals
- Specialized Subacute Facilities
- General Subacute Facilities
- Community Treatment Facilities (Youth)

Level 3 – Community Residential (Unlocked Facilities)

- Enriched Residential Services
- Short-term Residential Therapeutic Programs (Youth)

Supportive Care and Housing (Unlocked Settings)

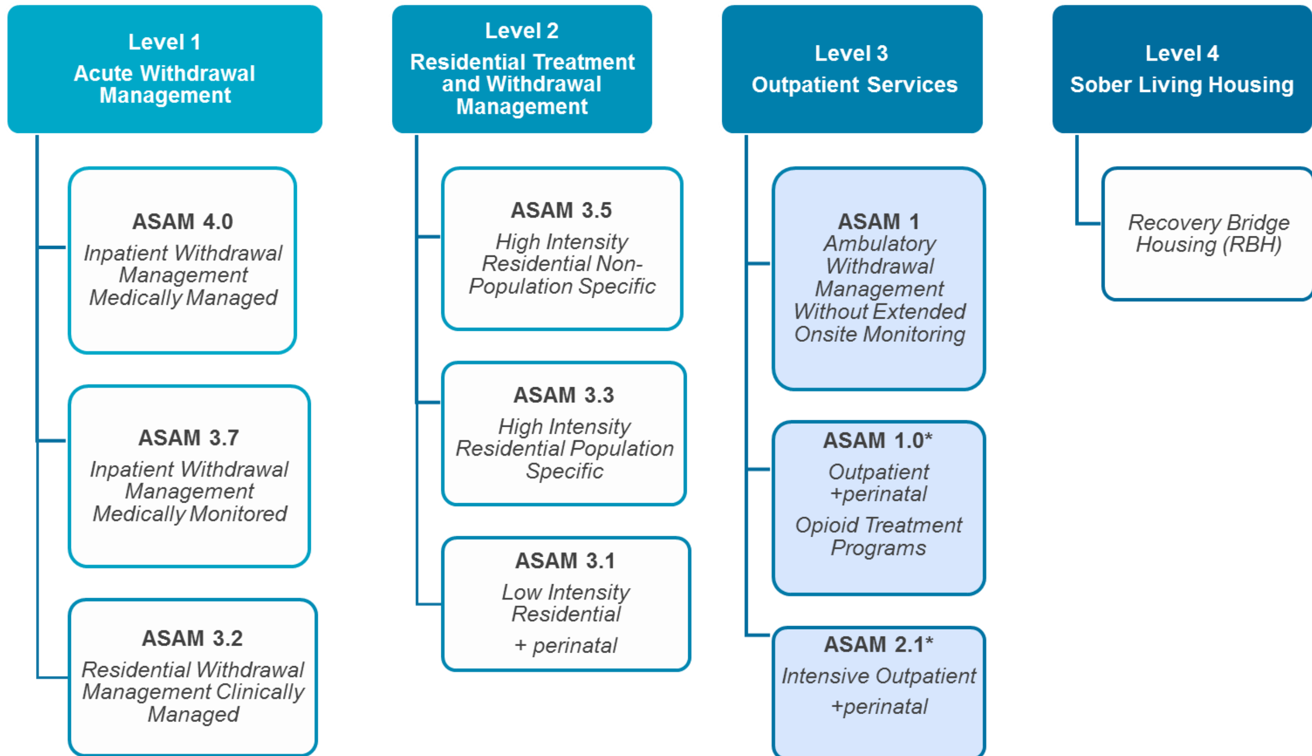
- Board and Care Facilities
- Permanent Supportive Housing
- Permanent Supportive Housing in development
- Interim Housing

SUBSTANCE USE DISORDER CONTINUUM OF CARE

The County DPH operates and provides oversight of a full continuum of care for youth (ages 12 and older) and adults for County residents who receive SUD services through Medi-Cal, or who have an income of up to 138% of the FPL, but do not qualify for Medi-Cal. Consistent with DMS, the DPH SAPC Division also includes groups with Medi-Cal eligibility above 138% FPL, specifically perinatal women and adolescents are eligible up to 213% and 266% FPL, respectively.

The SUD level of care continuum is based on ASAM levels of care. For the final and comprehensive network assessment (future stages of this assessment), the entire SUD continuum of care will be evaluated. The foundational stage of the network assessment and gap analysis focuses on LOCs 1, 2 and 4, as depicted in the graphic below.

County DPH SUD Levels of Care



*ASAM levels identified in colored box to be analyzed in a future phase

SUD Programs and Services

ASAM specifies various services that offer withdrawal management. Withdrawal management includes medical support, supervision and medications for withdrawal from alcohol and other drugs.

ASAM withdrawal management services are provided across all levels of intensity. Each of the ASAM levels of care listed below are defined and described later in this section of the report.

Care Setting 1 – Withdrawal Management

- *ASAM 4.0* – Inpatient Withdrawal Management Medically Managed
- *ASAM 3.7* – Inpatient Withdrawal Management Medically Monitored
- *ASAM 3.2* – Residential Withdrawal Management Clinically Managed

Care Setting 2 – Residential Treatment

- *ASAM 3.5* – High Intensity Residential Non-Population Specific
- *ASAM 3.3* – High Intensity Residential Population Specific
- *ASAM 3.1* – Low Intensity Residential (+ perinatal)

Care Setting 4 – Sober Living Housing

- Recovery Bridge Housing

Provider Capacity – Mental Health and SUD Care Continuum (Inpatient and Residential Care Settings)

Mercer generated an inventory of existing MH and SUD treatment facilities with a focus on the number of inpatient and residential beds. Bed capacity was compiled, including the volume of available beds and the ratio of beds across the MH and SUD continuums of care. Table 13 and table 14 below summarizes existing facilities and their bed allocation/capacity for the MH and SUD care continuum for both inpatient and residential care settings.

Table 13. – Current Bed Allocation/Capacity (County exclusive/owned beds and operating beds) – Mental Health Care Settings

Care Setting Category	Facility Type	County Exclusive/Owned Bed Capacity	Operating Bed Capacity[46]
Crisis Resolution and Triage	Psych ERs, Urgent Care Centers, Crisis Stabilization Units	77	201
	Crisis Residential Treatment Programs	0	81

[46] Operating bed capacity refers to the total number of beds available to any payer source and is inclusive of any County exclusive/owned capacity.

Care Setting Category	Facility Type	County Exclusive/Owned Bed Capacity	Operating Bed Capacity[46]
Total Care Setting		**77**	**282**
Level 1 – Acute Inpatient Hospital	Fee-for-Service Hospitals (including Freestanding)	15	2,045
	County/DHS Operated Hospitals	130	130
	Short-Doyle Facilities	82	127
	Psychiatric Health Facilities	0	48
Total Care Setting		**97**	**2,220**
Level 2 – Subacute	State Hospitals	0	490*
	Specialized	0	1,058
	General	0	590
	Community Treatment Facilities (Youth)	0	68
Total Care Setting		**0**	**6,614**
Level 3 – Community Residential	Enriched Residential Services	602	5459**
	Short-term Residential Therapeutic Program (STRTP)	0	1,206
Total Care Setting		**602**	**6,665**

* Includes beds at all available State Hospitals (large volume of forensic patients). Only 10% of the total volume of state hospital beds are actually available to Health Agency members and other county-based MH programs.
** Operating bed capacity for Enriched Residential Services is based on the available Board and Care Home (Adult Residential Facility) network.

Table 14. – Current Bed Allocation/Capacity (contracted, owned and operating) – SUD Care Settings

Care Setting Category	ASAM Level	Contracted Capacity*	Licensed/Non-contracted Capacity*
Level 1 – Withdrawal Management	*ASAM 4.0* – Inpatient Withdrawal Management, Medically Managed	10	NR
	ASAM 3.7 – Inpatient Withdrawal Management, Medically Monitored	10	NR
	ASAM 3.2 – Residential Withdrawal Management, Clinically Managed	1,229	1,827
Level 2 – Residential Treatment	*ASAM 3.5* – High Intensity Residential, Non-Population Specific	1,596	2,399
	ASAM 3.3 – High Intensity Residential, Population Specific	490	718
	ASAM 3.1 – Low Intensity Residential (+ perinatal)	2,083	3,061
Level 4 – Sober Living Housing	Recovery Bridge Housing	~1,000	N/A

*Since existing DPH provider contracts and facility licenses can include multiple ASAM levels, bed counts are specific to each ASAM level based on the total potential capacity if all beds were designated to that single ASAM level. As such, bed counts are not cumulative across ASAM levels.

FACILITY-SPECIFIC ANALYSES

In the facility-specific analysis section that follows, each inpatient and residential care category and assigned facility type is highlighted through the presentation of select facility characteristics and data elements (e.g., numbers of available operating beds, average length of stay, etc.).

The intent of the summaries is to provide a snapshot of key statistics associated with each facility type and to promote a more in-depth understanding of available provider capacity and utilization patterns (FY 2017). Unless otherwise specified, summary data applies to all populations served by the program, including children, adolescents, adults and older adults.

Mercer selected the following data elements to support the MH and SUD facility-specific summaries:

Number of Distinct Facilities – for each facility type presented, the total number of facilities available to members receiving MH and SUD services through the Health Agency.

Number of Operating Beds – the total number of available operating beds associated with the specified facility type.

Number of County Exclusive/Owned Beds – the total number of DMH exclusive and/or DMH and DHS owned beds for the identified facility type.

Utilization Rate to Operating Bed Capacity (All Available Beds) – A calculation that factors the number of bed days utilized during the review period as a percentage of the overall operating bed capacity. Consider that a 25-bed operating facility has the capacity to generate 9,125 bed days per year (25 beds X 365 days = 9,125). The metric output is calculated by (1) dividing the total number of bed days utilized (2) by the total operating bed day capacity. For example, 8,213 bed days are utilized over a one-year review period (i.e., FY 2017)[47] within a 25-bed facility. 8,213/9,125 = 90% utilization rate to operating bed capacity. (Metric calculated for MH care facilities only)

Utilization Rate to Operating Bed Capacity (Owned/Contracted Beds) – Same calculation as described above but the bed facility capacity is restricted to those beds that are DMH exclusive

[47] Fiscal Year 2017, or FY 2017, refers to the period of time beginning July 1, 2016 through June 30, 2017.

and/or DMH and DHS owned beds, as applicable to the facility type. (Metric calculated for MH care facilities only)

Unique Unduplicated Users – The number of unduplicated individuals who utilized the care facility during the review period (MH – FY 2017; SUD – FY 2017-2018).

Total Bed Days – The total number of bed days utilized within the facility type during the review period (MH – FY 2017; SUD – FY 2018).

Average Length of Stay – The average length of stay based on all discharges at the facility type during the review period (MH – FY 2017; SUD – FY 2018).

In addition to presenting facility characteristics and select data metrics, Mercer obtained additional information about each care facility through face-to-face and telephonic interviews with DMH, the DMH Office of the Public Guardian, DHS hospital and administrative staff and representatives from the DHS Mental Health Jail Team. When available, this information is summarized as "care facility themes" and adds additional context, challenges and opportunities for many of the facility types reviewed.

The contextual themes also emerged from stakeholder focus groups (see *Section 7., Stakeholder Findings*) as well as the aforementioned interviews with DMH and DHS staff. Please note that unless stipulated, this information has not been validated with supporting quantitative data. Therefore, the information should be reviewed as qualitative in nature and is based on the experiences of those from which the input was solicited. However, understanding even qualitative themes is an important component of the analysis in order to help inform not just the quantity of beds needed, but the types of beds, the location of beds, specialty areas to consider and the process to efficiently access the beds when needed.

At-a-glance: Crisis Resolution and Triage Care Settings

Psychiatric emergency rooms and urgent care clinics (crisis stabilization) provide care and monitoring for individuals experiencing acute MH symptoms and provide symptom management and stabilization to ensure individual safety. Urgent care programs have capacity for crisis triage and stabilization in which individuals can be evaluated for up to 23 hours.

PSYCHIATRIC EMERGENCY ROOMS AND URGENT CARE CENTERS	
Number of distinct facilities	11
Number of operating beds*	201
Number of County exclusive/owned beds*	77
Utilization rate to operating bed capacity (FY 2017) – All available beds	33%
Utilization rate to operating bed capacity (FY 2017) – County exclusive/owned beds	83%

PSYCHIATRIC EMERGENCY ROOMS AND URGENT CARE CENTERS	
Unique unduplicated users (FY 2017)	26,903
Total bed days (FY 2017)	11,624
Average length of stay (FY 2017)	15-30 Hours**

*County-operated psychiatric emergency room beds/operating capacity can be exceeded during periods of overflow.

**As reported during DHS facility specific staff interviews, March 27-29, 2019.

Care Facility Characteristics

Psychiatric Emergency Services

- For many individuals, DHS operated psychiatric emergency rooms are the point of entry into the County behavioral health system of care.
- DHS operates psychiatric emergency departments in three distinct locations with a total of 52 beds available for adults and 17 beds available for children age 13 and older.[48]
  - One County-operated psychiatric emergency room (Harbor-UCLA Medical Center) reported utilization trends have decreased over the past year. This same facility reported that a pediatric emergency room is rarely over capacity and has a very low census during summer months.
  - Other DHS facilities report the psychiatric emergency room being over capacity on a daily basis.
- Lengths of stay at the DHS operated psychiatric emergency rooms can range from a median of 15 hours to some stays extending to 30 or 40 hours. In some cases, patients can stay for up to a week or ten days, especially when there are no beds available in the community.
- In some psychiatric emergency departments, SUD providers are available to coordinate SUD service referrals and most DHS facilities have access to a DMH liaison who can assist with facilitating treatment facility placements managed by DMH.
- In addition to adult and adolescent psychiatric emergency rooms, LAC + USC operates a 24-bed inpatient ward that is designated for members who present with co-occurring physical health and MH conditions.
  - The beds on this unit are licensed as medical/surgical.

[48] All County-operated psychiatric emergency rooms reported accommodating additional patients during periods of overflow.

- The unit does not include a therapeutic milieu and members are confined to their bedrooms with the exception of two daily breaks to the patio.

- Members on the unit do not meet medical necessity criteria for inpatient psychiatric services.

- Member lengths of stay can reportedly extend for several months to years.

Urgent Care Centers

- Eight distinct urgent care centers offer 132 operating beds with many physically located adjacent to one of the four DHS operated county hospital campuses. One DMH owned facility is located in Sylmar, California and has capacity for eight beds.

- Urgent care centers can hold patients for up to 23 hours.

- 28 beds, or approximately 20% of the overall capacity, is designated for children age 13 to 17.

Acuity of Presenting Population

- All DHS operated facilities report that a significant percentage (estimated to be as high as 75%) of emergency department patients present on 5150 LPS holds. LPS holds can include evaluation periods of 72 hours, and potential for extended evaluation periods of 14 days and 30 days based on the individual's clinical presentation and need for ongoing assessment.

- DHS staff noted that jails triage and identify persons who may appear to be suffering from a SMI, initiate a temporary conservatorship in conjunction with the person's release from jail and then escort the person to a DHS psychiatric emergency department. In one recent month, one DHS emergency room admitted six individuals that presented under these circumstances.

- As referrals from jails increase, individuals tend to present with forensic backgrounds, higher acuity, and can exhibit assaultive and violent behavior. In response, the DHS operated facilities have implemented advanced non-violent crisis intervention training for staff and have begun to staff units with security personnel.

- DHS operated psychiatric emergency rooms report increases in homeless individuals with no support system or family, which limits the range of available discharge dispositions.

Law Enforcement Referrals and Impact on Emergency Room Capacity

- Recent legislation established a procedure to grant pretrial diversion to a person suffering from a mental disorder. The law authorizes a referral for MH treatment to be made to a county MH agency when the court finds that the defendant's mental disorder played a significant role in the commission of the charged offense.

- All DHS operated psychiatric emergency rooms reported increasing numbers of referrals from law enforcement and shared that jails tend to release and immediately transition individuals to the emergency department.

- Based upon DHS' established catchment area, one DHS operated psychiatric emergency department (Harbor-UCLA Medical Center) accepts referrals and admissions from thirty-six different law enforcement agencies.

Special Populations

- DHS operated psychiatric emergency rooms treating children noted increases in suicidal ideation and behaviors with this population, including seasonal surges in utilization following commencement of the school year. Nationally, a recent study demonstrated marked increases in suicide attempts and suicidal ideation among children and adolescents presenting to emergency departments across the United States.[49]

- Children with intellectual developmental disabilities, autism spectrum disorder and juvenile justice involvement presenting to psychiatric emergency rooms can experience longer lengths of stay due to need to coordinate with other agencies (e.g., Regional Centers, courts) and limited options when placement for ongoing evaluation and treatment is recommended.

Expansion of Private and DMH Urgent Care Centers

- The expansion of private and DMH directly operated urgent care centers has supplemented the Health Agency's continuum of crisis resolution and triage care settings and has reportedly alleviated some of the demand on DHS operated psychiatric emergency rooms. DHS staff noted the following observations and, at times, limitations related to these alternatives to county-operated psychiatric emergency rooms:

  – Most urgent care centers are LPS designated, but do not accept patients with a history of violence or who may require extended stays in supervised settings.

  – Urgent care centers can accept some patients that have historically presented at the DHS operated psychiatric emergency rooms (e.g., members seeking medication refills).

  – While some facilities serve children, many locations only treat adults.

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[49] Plemmons, G, Hall M, Doupnik, S. et al. Hospitalization for suicide ideation or attempt: 2008-2015. *Pediatrics* 2018; 141(6): e20172426. doi: 10:1542/peds. 2017-2426.

  - A majority of the patients referred to urgent care centers secure appropriate dispositions (70%), while the remainder are ultimately referred to DHS operated psychiatric emergency rooms.

Diversion

- During periods of high utilization, DHS operated psychiatric emergency rooms can request to be placed on diversion status. Diversion periods are capped at three hours per episode and only impact members presenting to the emergency department via ambulance transport. Diversion status does not extend to, or otherwise impact other referral sources (e.g., law enforcement, walk-ins).

Challenging Dispositions

- For patients presenting at DHS operated psychiatric emergency rooms and requiring higher levels of care, finding placements can be time consuming and challenging, especially for individuals on conservatorship status that require a locked setting.

- Identified obstacles for locating an appropriate placement include:

  - I/DD members affiliated with a Regional Center. Residential treatment programs for I/DD and MH co-occurring conditions do not readily exist (one facility was identified as a potential option, but not all of the Regional Centers have a contract with the placement and staff report challenges with getting children and youth admitted to the program). At times, children with autism spectrum disorder may present to LAC + USC to gain access to treatment at the Augustus Hawkins inpatient unit;

  - Members presenting with medical co-morbidities;

  - Members on parole;

  - Pregnant members; and

  - Members with pending or positive urine drug screens.

Staff Recruitment and Retention Challenges

- In general, the County system makes it difficult to recruit and retain staff. Retaining social workers has been a challenge for some DHS operated facilities and child psychiatrists are noted as difficult to recruit. In addition, DHS psychiatrists are compensated less than DMH psychiatrists and do not have access to location bonuses offered by DMH.

- Most DHS staff noted a lack of equality in pay for psychiatric social workers compared to medical social workers. In addition, certain County social work staffing designations are not available to all DHS facilities.

- The increase in violence on some of the units is impacting retention for residents and fellows, and DHS is not always able to retain residents and fellows who are not eligible for a loan repayment program that is available to DMH residents.

Safety Issues and Space Limitations

- In some locations, DHS operated psychiatric emergency rooms are not configured optimally and some lack physical space to ensure patient and staff safety.

- Due to patient acuity and the increased frequency of assaultive behavior, significant time and resources are expended on security as opposed to investing in care and treatment.

Crisis residential treatment programs for adults are unlocked and have MH clinical support co-located within the facility. The targeted average length of stay is 15 to 30 days.

CRISIS RESIDENTIAL TREATMENT PROGRAMS	
Number of distinct facilities	6
Number of operating beds	81
Number of County exclusive/owned beds	0
Utilization rate to operating bed capacity (FY 2017) – All available beds	39%
Utilization rate to operating bed capacity (FY 2017) – County exclusive/owned beds	N/A
Unique unduplicated users (FY 2017)	532
Total bed days (FY 2017)	11,624
Average length of stay (FY 2017)	21 Days

Care Facility Characteristics

- Crisis Residential Treatment Programs are a DMH managed care setting. There are six distinct facilities with 81 operating beds, none of which are directly contracted with the Health Agency.

- The 532 unique users during FY 2017 are the lowest number of users for an adult care setting with the exception of unique users of state hospitals (n=232).

- Lengths of stay are intended to be relatively short – 14 to 30 days.

- Though not widely utilized compared to other care settings, there has been a 27% increase in unique users between FY 2013 and FY 2017 as program capacity has expanded.

Admission Criteria

- Some referring entities identified perceived limitations with accessing Crisis Residential Treatment Programs and felt that the admission criteria were exclusionary. In reviewing some of these identified limitations, DMH did not consistently agree with the referring entities perceived

limitations. For example, the following limitations were noted by referring entities and, when available, DMH's response to the noted restriction:

- Members expressing any suicidal ideation within the past 30 days were inappropriate for admission (DMH did not definitely state that a member presenting in this manner would be excluded from admission).
- Members presenting as age 59 and older are excluded from admission (DMH acknowledged that there were age restrictions, but did not confirm the specific age cut-off or the rationale for the age restriction).
- Members who are not accompanied with a clear transition plan and/or discharge disposition will not be accepted (DMH disagreed with this interpretation).
- Other potential limitations identified for accessing a DMH managed level of care was the recent use of restraints (DMH concurred) and the administration of pro re nata (PRN) medications (DMH indicated additional review of prescribing patterns would be undertaken in these circumstances).

- One DHS operated facility reported that they had only successfully placed three members in a Crisis Residential Treatment Program over the past six months.

Summary Impressions: Crisis Resolution and Triage Care Settings

DHS operated psychiatric emergency rooms are receiving more referrals from law enforcement and many individuals presenting to the facilities are needing evaluation for LPS conservatorship. At times, the emergency rooms have requested to be placed on diversion status, which may provide limited and short-term relief.

The advent of private and DMH owned urgent care centers has helped alleviate some of the demand on the DHS operated psychiatric emergency rooms and has reduced patient volume by addressing some of the more benign presenting problems of patients, such as medication refills. However, a proportion of patients presenting at DHS operated psychiatric emergency rooms may require admission to higher levels of care and finding placements can be time consuming and challenging, especially for individuals on conservatorship status that require a locked setting.

Crisis residential treatment programs now include 6 distinct facilities and offer up to 81 operating beds. However, there are perceived limitations with accessing these settings and established admission criteria and care programming diminish the viability of leveraging this care setting to meet the clinical needs of a large segment of the population.

At a glance: Acute Psychiatric Inpatient Hospital Care Settings (Locked Facilities)

Acute inpatient hospital care settings include the following facility types (all facilities are available to children, adolescents and adults):

Fee-for-service Medi-Cal acute psychiatric hospitals provide acute inpatient services to Medi-Cal eligible individuals. These facilities may or may not be contracted with the County DMH, but are required to submit retrospective review authorization requests to the County DMH Treatment Authorization Request Unit.

Care Facility Characteristics

- Fee-for-service hospitals include 34 distinct facilities and over 2,000 operating beds, but only 15 beds (less than 1% of the available capacity) are under exclusive contract with DMH. DMH contracted beds demonstrated an occupancy rate of 100% during FY 2017.

FEE-FOR-SERVICE HOSPITALS	
Number of distinct facilities	34
Number of operating beds	2,045
Number of County exclusive/owned beds	15
Utilization rate to operating bed capacity (FY 2017) – All available beds	33%
Utilization rate to operating bed capacity (FY 2017) – County exclusive/owned beds	100%
Unique unduplicated users (FY 2017)	18,349
Total bed days (FY 2017)	273,461
Average length of stay (FY 2017)	7.5 Days*
Proportion of administrative authorization days (FY 2017)	12%

*Reflects Adult Population only

- At 33%, the utilization to operating bed capacity rate is the lowest of all facility types within the acute inpatient hospital care setting category. However, unique users (18,349) and total bed days (273,461) far exceed any other facility type in this category.

- The County primarily utilizes fee-for-service hospitals for covered beneficiaries that are Medi-Cal eligible, though the facilities are also utilized through other contracting arrangements (e.g., uninsured contracts).

- At 7.5 days (adults), fee-for-service hospitals record the lowest average length of stay of any inpatient or residential care setting.

- Only three fee-for-service hospitals (33 beds) serve children members younger than age 13.

- The proportion of administrative authorized days to total authorized days is 12%, much lower than the DHS-operated hospitals.

Admission Criteria

- Some system stakeholders felt that the fee-for-service hospitals applied restrictive admission policies that effectively limited the type of patient that could access these care settings. Examples of when an admission would not be considered included:
  - Patients exceeding 250 pounds;
  - Patients presenting with fall risks;
  - Patients with forensic backgrounds and/or correctional system involvement;
  - Patients with co-morbid medical and MH conditions;
  - Patients perceived to be too symptomatic or clinically acute;
  - Patients on conservatorship status; and
  - Patients that lack a clear discharge plan or post-hospitalization disposition.
- It was noted during the DHS hospital staff interviews that over time, the number of available inpatient beds across the County has declined, while chronically mentally ill patients are increasing in volume. The lack of available beds may be related to competition with other payer sources (e.g., private insurance carriers) and differentials in reimbursement rates between the County and other insurance carriers.
- In response to the relatively short lengths of stay, stakeholders believed that, in some cases, members were prematurely discharged from a fee-for-service hospital and would subsequently present at one of the DHS operated psychiatric emergency rooms in need of further stabilization.

County operated hospitals provide an important component of the County's healthcare safety net by offering 24/7 medical monitoring and psychiatric inpatient hospital services to residents of the County, including Medi-Cal eligible members and indigent persons (some facilities are available to children and adolescents).

COUNTY OPERATED HOSPITALS	
Number of distinct facilities	3
Number of operating beds	130
Number of County exclusive/owned beds	130
Utilization rate to operating bed capacity (FY 2017) – All available beds	99%
Utilization rate to operating bed capacity (FY 2017) – County exclusive/owned beds	99%

COUNTY OPERATED HOSPITALS	
Unique unduplicated users (FY 2017)	1,984
Total bed days (FY 2017)	47,450
Average length of stay (FY 2017)	22 Days
Proportion of administrative authorization days (FY 2017)	27%

Care Facility Characteristics

- DHS operates three acute psychiatric inpatient units. The facilities and available operating beds are as follows:
  - **Augustus Hawkins (affiliated with LAC+USC Medical Center)** – 5 adult wards with 50 available beds; 1 adolescent ward with 10 available beds.
  - **Harbor – UCLA Medical Center** – two inpatient facilities; one unit has 14 adult beds and the other unit can accommodate 24 individuals (adults only), including those with co-morbid physical health and MH conditions (including pregnant women).
  - **Olive View – UCLA Medical Center** – an adult inpatient unit with capacity for 32 beds. In addition, the DHS Office of Diversion and Recovery manages an onsite 18 bed unit dedicated to adult individuals assigned to a jail diversion program.
- There is a paucity of available children beds available within and outside of the DHS operated hospital system. All of the DHS operated hospitals compete for beds at Augustus Hawkins' adolescent ward. By necessity, the unit must simultaneously accommodate youth who present with a wide range of conditions, including SED, I/DD and conduct disorders.
- The DHS operated psychiatric inpatient hospitals have an occupancy rate near 100% and accumulated over 47,000 bed days during FY 2017; second only to the fee-for-service hospitals within the acute psychiatric inpatient hospital care setting category despite possessing 15x less bed volume.
- The average length of stay at the DHS operated psychiatric inpatient hospitals is 22 days – nearly three times as long as the average length of stay for adults at the fee-for-service hospitals.
- A significant proportion of the DHS operated psychiatric inpatient census is referred from the jail system (15%) and/or presents on temporary conservatorship or conservatorship status (between one-third and two-thirds of the patient census on a given day). Many patients referred from the jail and placed on temporary conservatorship status do not meet medical necessity criteria for psychiatric inpatient services (2 of 21 recent jail referred admissions as reported by one DHS facility).

- The DHS operated psychiatric inpatient hospitals perform utilization review on the entire active patient census each day. DHS utilization review staff apply medical necessity criteria that is based on InterQual® and state standards. Members can be determined to be on acute status (meet medical necessity criteria), administrative status (actively on a waitlist for an alternative level of service) or denied status. The hospital is reimbursed at a reduced per diem rate for members on administrative status and receive no compensation for members on denied status. Some of the DHS hospital facilities report that 20% to 70% of the census can be on denied status on any given day.

Population Characteristics

- Most DHS operated hospital facility staff reported increased assaultive behavior on the inpatient units, citing recent incidents in which staff have been injured. The concern has escalated with the increase of patient referrals from jail settings and some units are planning to add security staff on the patient units to mitigate the threat of violence.

- The DHS operated psychiatric hospitals serve a high volume of individuals who present on temporary conservatorship status. These patients are described as acute, difficult to discharge (e.g., registered sex offenders, persons with a history of arson) and are required to be evaluated on the units for designated periods of time (“on-hold”).

- All the facilities reported increases in requests for jury trial for individuals being petitioned for conservatorship which requires additional preparation and staff time as well as contributing to longer lengths of stay as the legal preparation and court hearing process can be extended over several months.

- Public guardians assigned to persons on conservatorship status can influence discharge planning by rejecting placements and demanding that the patient be transitioned from the inpatient unit to a locked facility.

- Augustus Hawkins’ adolescent unit is experiencing increases of admissions of sex trafficked adolescent females and have been encouraged to initiate conservatorship petitions for these youth when appropriate.

- DHS operated hospitals have noted increases in patients presenting with co-occurring MH and I/DD conditions. Many of these patients are assigned to one of seven regional centers in the County. The regional centers are responsible for administering long-term care services and supports for eligible members. The DHS operated hospitals described challenges in coordinating care and accessing needed services with the regional centers, all of which operate uniquely and have relationships with different treatment and placement facilities.

Discharge Dispositions

- One DHS operated hospital facility estimated that 60% of the patient census could be safely discharged to a lower level of care. Long lengths of stay can extend over several months while patients await placement at step-down or other facilities. While a certain percentage of patients are perceived to be stable enough for discharge with available community supports and supervision (e.g., family members), discharging these individuals to a shelter is deemed unsafe and clinically counter-indicated. Because of the unique clinical presentation and acuity of these patients, DHS has few options for alternative settings to ensure appropriate care transitions. Staff responsible for discharge planning experience persistent challenges to identify sufficient capacity to address the demand for intensive services that are needed for this population.

Short-Doyle acute psychiatric facilities are inpatient hospital beds purchased by the County DMH for individuals enrolled in the Short-Doyle County Mental Health Services Program (all facilities are available to children, adolescents and adults).

SHORT-DOYLE FACILITIES	
Number of distinct facilities	2
Number of operating beds	127
Number of County exclusive/owned beds	82
Utilization rate to operating bed capacity (FY 2017) – All available beds	84%
Utilization rate to operating bed capacity (FY 2017) – County exclusive/owned beds	100%
Unique unduplicated users (FY 2017)	2,062
Total bed days (FY 2017)	37,671
Average length of stay (FY 2017)	16.8 Days

Care Facility Characteristics

- Short-Doyle facilities are limited to two distinct facilities and 127 operating beds. 82 or 65% of the available beds are under contract with DMH.
- Short-Doyle facilities are a DMH managed care setting and are designated facilities for patients that are uninsured or under-insured (e.g., not eligible under Medi-Cal).
- Utilization to total operating bed capacity rate is 84%, but increases to 100% when factoring only DMH contracted capacity.
- FY 2017 unique users (2,062) exceed DMH operated acute psychiatric hospitals FY 2017 unique users (1,984).
- Both Short-Doyle facilities accept children, with one offering 17 beds for children age 0-12 and the other designating 27 beds for youth age 13-17.

Accessing a Short-Doyle Facility Bed

- Outside entities, such as DHS operated psychiatric emergency rooms and hospitals, must initiate a referral to DMH in order to access a Short-Doyle facility bed. Referring entities must screen members for insurance coverage, contact DMH multiple times per day to determine bed availability, and typically wait one to three hours to determine if DMH can accept the patient for admission.

Admission Criteria

- System stakeholders identified restrictive admission policies that limit the type of patient that could access a Short-Doyle facility. Examples included:
  - Patients who have recently been restrained;
  - Patients with a history of SUD;
  - Patients with co-morbid medical and MH conditions; and
  - Children diagnosed with an autism spectrum disorder.

Psychiatric health facilities offer psychiatric inpatient treatment for adults and youths. These facilities provide acute short-term treatment in non-hospital settings that have more flexible facility and staffing requirements than acute inpatient hospitals (some facilities are available to adolescents and adults).

PSYCHIATRIC HEALTH FACILITIES	
Number of distinct facilities	3
Number of operating beds	48
Number of County exclusive/owned beds	0
Utilization rate to operating bed capacity (FY 2017) – All available beds	81%
Utilization rate to operating bed capacity (FY 2017) – County exclusive/owned beds	N/A
Unique unduplicated users (FY 2017)	1,169
Total bed days (FY 2017)	14,131
Average length of stay (FY 2017)	27.4 Days

Care Facility Characteristics

- Psychiatric health facilities include three distinct facilities and 48 operating beds (each facility is capped at 16 beds). None of the available beds are under contract with DMH.
- Adult psychiatric health facilities are DMH managed care settings, while one psychiatric health facility that is designated to treat adolescents is outside the purview of DMH.

- Utilization to total operating bed capacity rate is 81%, but increases to 108% when only considering the two adult psychiatric health facilities. The occupancy rate at the adolescent psychiatric facility was determined to be only 21%.
- FY 2017 unique users (1,169) are the lowest within the acute psychiatric inpatient hospital care setting category, likely due to the limited number of operating beds.
- Average length of stay is 27.4 days, the longest length of stay within the acute psychiatric inpatient hospital care setting category.

Viability of Care Setting as a Step-Down Option

- One DHS staff member indicated that psychiatric health facilities were rarely considered when seeking placement for members due to the limited number of facilities, the low volume of beds and the perception that beds were infrequently open and available.

Summary Impressions: Acute Psychiatric Inpatient Hospital Care Settings

Over 22,000 unique users presented at one or more of the acute psychiatric inpatient hospital care settings during FY 2017. The care setting category includes fee-for-service hospitals with operating capacity for over 2,000 beds. However, DMH has exclusive contracts with less than 1% of the total fee-for-service hospital bed volume. Average length of stay in the fee-for-service hospitals is 7.5 days for adults, 7-day readmission rates were found to be over 19%, and the proportion of administrative and denied days to total bed days is approximately 25%. In contrast, lengths of stay at DHS-operated county hospitals are three times longer, the 7-day readmission rate is less than 8%, and the proportion of administrative and denied days to total bed days is almost 75%.

Short-Doyle facilities play an important role in the continuum of care by providing much needed capacity for members who do not qualify for the Medi-Cal program. In addition, one Short-Doyle facility includes beds available to young children; a demonstrated area of need for the system. Psychiatric health facilities are less viable options for County clients based on the limited number of available beds and the high occupancy rate for adult patients (over 100%).

At a glance: Subacute Care Settings (Locked Facilities)

State hospitals provide long-term inpatient care for individuals with impairments that require 24/7 monitoring. State Hospital individuals can be placed via court-order and are typically challenged with significant mental and functional impairments. The facilities are secure and locked, and lengths of stay tend to be extended (adults only).

STATE HOSPITALS	
Number of distinct facilities	5
Number of operating beds	490*
Number of County exclusive/owned beds	0

STATE HOSPITALS	
Utilization rate to operating bed capacity (FY 2017) – All available beds	22%*
Utilization rate to operating bed capacity (FY 2017) – County exclusive/owned beds	N/A
Unique unduplicated users (FY 2017)	232
Total bed days (FY 2017)	39,537
Average length of stay (FY 2017)	531 Days

* Includes beds at all State Hospitals (large volume of forensic patients). Only 10% of the total volume of state hospital beds are actually available to Health Agency members and other county-based MH programs.

Care Facility Characteristics

There are five state hospitals that are operated by the California Department of State Hospitals (DSH) and available to the County for the placement of members. However, with the exception of Metropolitan State Hospital, many of these beds are designated for individuals being placed through county superior courts or the California Department of Corrections and Rehabilitation (CDCR).

State hospital commitment categories include the following:

Incompetent to Stand Trial: Felony defendants found incompetent to stand trial by a court are placed in a state hospital, where the focus of treatment is to stabilize their condition and return them to trial competency so the court may adjudicate their pending charges.

LPS Act: These patients are treated under a conservatorship agreement. Conservatorships are for severely disabled individuals who represent a danger to themselves or others due to mental illness. They may not have been charged with a crime, but are instead referred by local community MH programs through involuntary civil commitment procedures pursuant to the LPS Act.

Mentally Disordered Offenders: Parolees who committed one of a specified list of crimes and who were treated for a severe mental disorder connected to their original crime can be committed to a state hospital as a condition of parole for a period not to exceed the length of their parole term.

Mentally Ill Prisoners transferred from CDCR: These inmate-patients are transferred from CDCR for inpatient MH care with the expectation that they will return to a CDCR facility when they will no longer require inpatient treatment.

Not Guilty by Reason of Insanity: Patients judged by the court to be not guilty because they were insane at the time of the felony crime are committed to a state hospital for treatment for a period equal to the maximum sentence of their most serious offense.

Sexually Violent Predators: Individuals who are convicted of a legislatively defined set of sex offenses who complete their prison sentences are evaluated by DSH or independent evaluators.

Those that meet Sexually Violent Predator criteria receive a probable cause hearing and are placed in a state hospital pending full commitment.

The table below depicts percentages of patient commitment categories by state hospital as of 2016[50]. The data below includes patients who are not in the facility because of a court appearance or who are at a general acute care hospital to receive other medical treatment. The Health Agency most commonly seeks admission for members under the LPS designation at Metropolitan State Hospital, though a small number of patients are admitted to Napa State Hospital when Metropolitan does not have current openings.

State Hospital	Bed Capacity	Incompetent to Stand Trial	Lanterman-Petris Short	Mentally Disordered Offender	Mentally Ill CDCR Prisoner	Not Guilty by Reason of Insanity	Sexually Violent Predator
Atascadero	1,275	22%	1%	48%	19%	19%	
Patton	1,527	39%	6%	18%		37%	<1%
Metropolitan	826	41%	39%	5%		15%	
Napa	1,270	30%	17%	6%		47%	
Coalinga	1,500		<1%	23%	4%	<1%	73%

State hospitals are DMH managed care settings and require referring entities to complete a referral packet before being considered for placement.

- During FY 2017, there were 232 unique users associated with the state hospital care setting.
- Average length of stay is 531 days, the longest length of stay across all inpatient and residential care settings.
- Utilization to total operating bed capacity rate is 22%, due to extended wait times to access beds, long lengths of stay once admitted, and the relatively low volume of unique users.

Accessing a State Hospital Bed

- Extended length of stays and limited beds dedicated to LPS conserved patients impact the number of members that can be placed at state hospitals.
- The wait for a state hospital bed can commonly persist for one to two years.
- Prior to be accepted for admission, Metropolitan State Hospital conducts a forensic screen on the applicant which can reportedly take an additional two to three months to complete.

[50] Data was retrieved from each state hospital website via https://www.dsh.ca.gov

- Prior to being considered for placement to Napa State Hospital, an applicant must be denied admission at Metropolitan State Hospital.
- DHS personnel reported that an applicant must be referred and denied by all available subacute facilities before being considered for placement at a state hospital. DMH staff partially refuted this interpretation and inferred that, while this may be true in some cases, the determination for placement is contingent on the applicant's clinical presentation.

Specialized subacute facilities provide long term residential care with enriched staffing. Many of the facilities provide specialized treatment programs such as caring for criminal justice system involved individuals with substantial MH needs (adults only).

SPECIALIZED SUBACUTE	
Number of distinct facilities	9
Number of operating beds	1,058
Number of County exclusive/owned beds	0
Utilization rate to operating bed capacity (FY 2017) – All available beds	52%
Utilization rate to operating bed capacity (FY 2017) – County exclusive/owned beds	N/A
Unique unduplicated users (FY 2017)	892
Total bed days (FY 2017)	160,499
Average length of stay (FY 2017)	342.7 Days

Care Facility Characteristics

- Specialized subacute facilities include nine distinct facilities and 1,058 operating beds serving adults only. None of the beds are under exclusive contract with DMH. Population specializations for these subacute facilities include the following:

Specialized Subacute Facility	Population Specialization
Alpine Special Treatment Center	General Population – High Acuity
Crestwood - Bakersfield	Forensic – High Acuity
Harbor View Center	Forensic
La Casa Mental Health Rehabilitation Center	General Population – Transition Age Youth
La Paz	Geriatric – Complex Medical Conditions
Olive Vista	Forensic
Sierra Vista	Forensic
Sunbridge Shandin Hills	Forensic – General Population
Sylmar Health	Forensic

- Specialized subacute facilities are DMH managed care settings, with one facility dedicated to geriatric patients (age 65 and older) and the remaining facilities treating patients age 18 to 64. Four of the facilities are out-of-county, comprising nearly 35% of the available operating bed capacity.
- Utilization to total operating bed capacity rate is 52%, likely due to competition for beds from other payer sources and referral entities.
- There were 892 unique users and 160,499 bed days utilized during FY 2017 – the highest number of users and bed days for any facility within the subacute care setting category.
- Average length of stay is 342.7 days, the third longest length of stay within the subacute care setting category.

General subacute facilities provide residential care that includes at least 27 hours of rehabilitation groups weekly. These skilled nursing facilities are certified as Special Treatment Programs and are designed for community reintegration rather than ongoing long-term care (adults only).

GENERAL SUBACUTE	
Number of distinct facilities	6
Number of operating beds	590
Number of County exclusive/owned beds	0
Utilization rate to operating bed capacity (FY 2017) – All available beds	54%
Utilization rate to operating bed capacity (FY 2017) – County exclusive/owned beds	N/A
Unique unduplicated users (FY 2017)	700
Total bed days (FY 2017)	102,472
Average length of stay (FY 2017)	122 Days*

*Over half of the individual cases reviewed involved lengths of stay of 14 days or less which significantly reduced the ALOS calculation for this care facility.

Care Facility Characteristics

- General subacute facilities include six distinct facilities and 590 operating beds. None of the beds are under exclusive contract with DMH.
- General subacute facilities are DMH managed care settings and currently can only accommodate patients age 18 to 64.
- Utilization to total operating bed capacity rate is 54%, likely due to competition for beds from other payer sources and referral entities.

- There were 700 unique users and 102,472 bed days utilized during FY 2017.
- Only one general subacute facility is LPS designated and can accept individuals who are placed on temporary conservatorship hold, though placement of individuals on LPS status rarely occurs at this facility due to time requirements for physicians to testify at conservatorship hearings.
- General subacute care facilities include:
  - Landmark Medical Center;
  - Laurel Park Center;
  - Meadowbrook Manor;
  - Penn Mar (LPS designated);
  - View Heights Convalescent; and
  - Community Care Center.

Accessing a Subacute Bed (Specialized and General Subacute)

- To access a subacute bed, the patient must be on a conservatorship and DMH requires up to 14 days of clinical documentation to help determine the appropriate level of care.
- DHS staff noted that there are extensive waiting lists for subacute beds which are not readily available.
- DMH serves as the gatekeeper for subacute facilities and makes determinations where individuals will be placed. DHS staff submitting referral packets to DMH noted the following limitations:
  - DHS is unable to interface or communicate with subacute facilities and are not afforded opportunities to conduct doctor to doctor consultations to review the clinical appropriateness of specific patients.
  - DHS cited circumstances in which the subacute facility was provided inaccurate information about the patient being considered for placement.
  - Some DHS staff reported that explanations for why a patient is not accepted to a subacute facility is not routinely provided to the referring party (DMH responded that written rationale is provided to the referral source when not accepting a patient for a designated level of care).

Admission Criteria (Specialized and General Subacute)

- DHS staff expressed that restrictive admission policies were in place that limited the type of patient that could access these care settings. Examples of when an admission would not be considered to a subacute facility included:
  - Recent administration of PRN medications (DMH countered that PRN medication use would only be exclusionary based on the pattern of use);
  - Patients with a history of sleep apnea (DMH denied that this criterion was in place);
  - The presence of co-occurring physical health and MH conditions (DMH reported that there is currently one subacute facility that can accommodate these patients);
  - Patients with SUD addictions (DMH indicated that all subacute facilities accept patients with co-occurring SUD and MH conditions);
  - Patients with I/DD and MH conditions; and
  - Patients on parole with the CDCR.

Subacute Facility Lengths of Stay and Ongoing Medical Necessity (Specialized and General Subacute)

Mercer received varying accounts regarding how robust DMH's review of existing subacute facility placed members is and if patients that are stable are being regularly assessed for ongoing medical necessity and/or discharge readiness. DMH does apply a functional ability scale upon a member's admission to a subacute facility and then applies the tool again every 90 days. DMH reported that members are transitioned to a lower intensity service if the results of the functional assessment indicate that the subacute facility care setting is no longer needed. Discharge planning can commence as far out as 90 days prior to expected release from the facility.

Community treatment facilities are locked environments providing supportive needs-driven services to children and adolescents. The community treatment facilities seek to prepare youth for lasting reintegration into their families and the community.

COMMUNITY TREATMENT FACILITIES (YOUTH)	
Number of distinct facilities	2
Number of operating beds	68
Number of County exclusive/owned beds	0
Utilization rate to operating bed capacity (FY 2017) – All available beds	57%
Utilization rate to operating bed capacity (FY 2017) – County exclusive/owned beds	N/A
Unique unduplicated users (FY 2017)	93

COMMUNITY TREATMENT FACILITIES (YOUTH)	
Total bed days (FY 2017)	14,261
Average length of stay (FY 2017)	352 Days

Care Facility Characteristics

- Community treatment facilities for youth (age 13-17) include two distinct facilities and 68 operating beds. None of the beds are under contract with DMH.
- Access to community treatment facilities are not managed by DMH.
- Utilization to total operating bed capacity rate is 57%.
- There were 93 unique users and 14,261 bed days utilized during FY 2017.
- The average length of stay is 352 days, which is significantly longer than the length of stay in short-term residential therapeutic programs, another residential setting available to DMH eligible children and youth.

Summary Impressions: Subacute Care Settings

The subacute care setting category includes California's state hospitals with approximately 490 beds available for civil (LPS) commitments. There are extended wait times to access beds and protracted lengths of stay that contribute to less robust utilization.

Specialized and general subacute facilities are highly sought after step-down placements, particularly for individuals on conservatorship status. Extensive wait times and perceived restrictive admission policies contribute to challenges in accessing beds for all the clients who may have a documented need for the care settings. Opportunities likely exist to expand bed capacity for the subacute care settings and to enhance components of client flow that would lead to more efficient management of the existing resources.

Community treatment facilities for youth are currently restricted to two facilities with 68 operating beds. The number of unique users was under 100 during FY 2017, though the care setting is relatively new and may gradually experience higher utilization over time. Community treatment facilities are locked and restrictive placements and, when appropriate, alternative community-based care should be thoroughly examined before pursuing a youth's admission to one of these treatment settings.

At a glance: Community Residential Care Settings (Unlocked Facilities)

Enriched residential services are unlocked and provide residential services for six or more months. These facilities are equipped with 24/7 MH clinical support (adults only).

ENRICHED RESIDENTIAL SERVICES	
Number of distinct facilities	18
Number of operating beds	5,459
Number of County exclusive/owned beds	602
Utilization rate to operating bed capacity (FY 2017) – All available beds	N/A
Utilization rate to operating bed capacity (FY 2017) – County exclusive/owned beds	55%
Unique unduplicated users (FY 2017)	996
Total bed days (FY 2017)	122,917
Average length of stay (FY 2017)	234.6 Days

Care Facility Characteristics

- Enriched residential services for adults include potential for a total of 5,459 beds. This potential bed capacity is available within board and care homes, or adult residential facilities. 602 of these beds across 18 distinct facilities are equipped and under contract with DMH to provide enriched services.
- Access to enriched residential services are managed by DMH.
- Utilization to total contracted bed capacity rate is 55%.
- There were 996 unique users and 122,917 bed days utilized during FY 2017.
- The average length of stay for enriched residential services is 235 days.

Short-term residential therapeutic programs are residential facilities operated by a public agency or private organization that provides an integrated program of specialized and intensive care and supervision, services and supports, treatment, and short-term 24-hour care and supervision to children.

SHORT-TERM RESIDENTIAL THERAPEUTIC PROGRAM (STRTP)	
Number of distinct facilities	46
Number of operating beds	1,206
Number of County exclusive/owned beds	0
Utilization rate to operating bed capacity (FY 2017) – All available beds	N/A*
Utilization rate to operating bed capacity (FY 2017) – County exclusive/owned beds	N/A
Unique unduplicated users (FY 2017)	57*
Total bed days (FY 2017)	8,180
Average length of stay (FY 2017)	148.5 Days

* The relatively low number of unique users is attributed to the fact that STRTP programming was recently made available and current utilization is not adequately represented in the data files reviewed by Mercer.

Care Facility Characteristics

- Short-term residential therapeutic programs for children, adolescents and young adults include 46 distinct facilities and a total operating capacity of 1,206 beds. None of the beds are under contract with DMH.
- Of the 46 facilities, five also serve children age 0-12 and fourteen serve transition-age youth (age 18-21).
- Utilization to total contracted bed capacity rate is only 2%.
- There were 57 unique users and 8,180 bed days utilized during FY 2017.
- The average length of stay for short-term residential therapeutic programs is 149 days.

Summary Impressions: Community Residential Care Settings

Enriched residential services have potential to serve as an effective alternative to more restrictive inpatient and residential care settings. This model of care promotes independent living and skills building, and can support an individual's recovery. While providing a much needed alternative care setting, potential users of the service must demonstrate some degree of stability in order to be successful in the program. Almost 1,000 unique users participated in enriched residential services during FY 2017.

Short-term residential therapeutic programs provide structure and supervision for children and adolescents, many of which have involvement in the foster care system. The number of settings are increasing with over 45 distinct locations and 1,200 available beds. Short-term residential therapeutic programs provide a valuable option for children and youth who may benefit from an alternative to more restrictive inpatient and residential care settings.

SUD Programs and Services

The SUD LOC schema is organized based upon the ASAM continuum. Level 1 provides the most acute service, providing 24/7 onsite medical care. On the opposite end of the continuum, Level 4 provides abstinence-based housing for individuals who are receiving outpatient SUD treatment services. Each ASAM criteria is assessed on six dimensions: acute intoxication or withdrawal potential, biomedical conditions or complications, emotional/behavioral/cognitive conditions or complications, readiness to change, relapse/continued use/continued problem potential and recovery environment.

Residential Treatment and Withdrawal Management

ASAM 3.1 services are clinically managed, low intensity residential services with 24-hour structure and available personnel, and at least 5 hours of clinical treatment services per week.

ASAM LOC 3.1 – LOW INTENSITY RESIDENTIAL	
Number of distinct facilities	79
Number of licensed beds	3,061
Number of County exclusive/owned beds	2,083
Unique unduplicated users (FY 2017-2018)	8,178
Total bed days (FY 2017-2018)	395,750
Average length of stay (FY 2017- 2018)	43.4 Days

Care Facility Characteristics

- Low intensity residential settings (ASAM 3.1) include 79 distinct facilities and up to 3,061 licensed beds. 2,083 of the beds are under contract with DPH.
- Low intensity residential facilities (ASAM 3.1) can accommodate youth (137 unique users) and adults (7,919 unique users).
- Average length of stay is 43.4 days.

ASAM 3.2 services are clinically managed residential withdrawal management services for individuals undergoing Moderate withdrawal that requires 24-hour support.

ASAM LOC 3.2 – RESIDENTIAL WITHDRAWAL MANAGEMENT	
Number of distinct facilities	43
Number of licensed beds	1,827
Number of County exclusive/owned beds	1,229
Unique unduplicated users (FY 2017-2018)	2,699
Total bed days (FY 2017-2018)	18,825
Average length of stay (FY 2017-2018)	5.6 Days

Care Facility Characteristics

- Residential withdrawal management/clinically managed settings (ASAM 3.2) include 43 distinct facilities and up to 1,827 licensed beds. 1,229 of the beds are under contract with DPH.
- Residential withdrawal management/clinically managed facilities (ASAM 3.2) included 2,544 unique users during FY 2017-2018.
- Average length of stay is 5.6 days.

ASAM 3.3 services are high intensity, clinically managed residential services with counselors available 24/7, with a less intense environment for those with cognitive and other impairments.

ASAM LOC 3.3 – HIGH INTENSITY RESIDENTIAL – POPULATION SPECIFIC	
Number of distinct facilities	11
Number of licensed beds	718
Number of County exclusive/owned beds	490
Unique unduplicated users (FY 2017-2018)	409
Total bed days (FY 2017-2018)	15,571
Average length of stay (FY 2017-2018)	35.7 Days

Care Facility Characteristics

- High intensity residential-population specific settings (ASAM 3.3) include 11 distinct facilities and 718 licensed beds. 490 of the beds are under contract with DPH.
- High intensity residential-population specific facilities (ASAM 3.3) included 409 unique users during FY 2017-2018.
- Average length of stay is 35.7 days.

ASAM LOC 3.5 – HIGH INTENSITY RESIDENTIAL	
Number of distinct facilities	60
Number of licensed beds	2,399
Number of County exclusive/owned beds	1,596
Unique unduplicated users (FY 2017- 2018)	2,248
Total bed days (FY 2018)	96,120
Average length of stay (FY 2017-2018)	39.6 Days

Care Facility Characteristics

- High intensity residential/non-population specific settings (ASAM 3.5) include 60 distinct facilities and 2,399 licensed beds. 1,596 of the beds are under contract with DPH.
- High intensity residential/non-population specific facilities (ASAM 3.5) included 2,248 unique users during FY 2018 (including 123 youth).
- Average length of stay is 39.6 days.

Acute Withdrawal Management

ASAM 3.7 services include 24-hour nursing care with physician availability.

ASAM LOC 3.7 – INPATIENT WITHDRAWAL MANAGEMENT MEDICALLY MONITORED	
Number of distinct facilities	2
Number of licensed beds	10
Number of County exclusive/owned beds	0
Unique unduplicated users (FY 2017-2018)	746
Total bed days (FY 2017-2018)	5,302
Average length of stay (FY 2017-2018)	6.4 Days

Care Facility Characteristics

- Inpatient withdrawal management medically monitored specific facilities (ASAM 3.7) included 746 unique users during FY 2017-2018.
- Average length of stay is 6.4 days.

ASAM 4.0 services entail 24/7 medical monitoring with 24/7 access to physicians and nursing staff. These services are provided in a hospital-like setting.

ASAM LOC 4.0 – INPATIENT WITHDRAWAL MANAGEMENT MEDICALLY MANAGED	
Number of distinct facilities	2
Number of licensed beds	10
Number of County exclusive/owned beds	0
Unique unduplicated users (FY 2017-2018)	6
Total bed days (FY 2017-2018)	14
Average length of stay (FY 2017-2018)	N/A

Care Facility Characteristics

- Inpatient withdrawal management medically managed specific facilities (ASAM 4.0) included only 6 unique users during FY 2018.

Sober Living/Recovery Bridge Housing

Sober living/recovery bridge housing is a type of abstinence-based, peer supported housing that combines a subsidy for recovery residences with concurrent outpatient treatment. Although SUD treatment support is not provided in the RBH, peer support, group and house meetings, self-help, and life skills development, and other recovery oriented services are available.

SOBER LIVING HOUSING	
Number of distinct facilities	18
Number of County exclusive/owned beds	926

Level of care utilization capacity	523
Unique unduplicated users (FY 2017-2018)	1,334
Total bed days (FY 2017-2018)	81,441
Average length of stay (FY 2017-2018)	56.4 Days

Care Facility Characteristics

- Sober living/recovery bridge housing specific facilities included 1,334 unique users during FY 2017-2018.
- Average length of stay is 56.4 days.

Table 15 depicts unique user by ASAM levels and RBH, as well as aggregated bed days and average length of stay by residential care categories.

Table 15. – Unique Users, Bed Days, Average Length of Stay – Aggregated by SUD Residential Care Setting Categories – FY 2017-2018

ASAM Level	Unique Users	Bed Days	Average Length of Stay (Days)
3.1	8,178	395,750	43.4
3.3	409	15,571	35.7
3.5	2,248	96,120	39.6
Total	**9,928***	**507,441**	**42.4**
3.2	2,699	18,825	5.6
3.7	746	5,302	6.4
4.0	6	14	N/A
Total	**3,304***	**24,141**	**5.8**
RBH	1,334	81,441	56.4

*Total includes individuals who may be represented across multiple ASAM levels within the care facility category and are therefore, not cumulative.

Relevant findings include:

- ASAM Level 3.1 is the highest utilized service across the continuum of SUD residential care;
- ASAM Levels 3.2 and 3.5 have comparable numbers of unique users over the review period;
- Average length of stay is less (5.8 days) in more restrictive acute withdrawal management care settings; and
- Average length of stay in recovery-bridge housing is approximately 2 months.

6
MEMBER FLOW EFFICIENCY ASSESSMENT

Mercer sought to assess the efficiency of patient flow through each level of care to help distinguish if the inability to access care or delays in admission to inpatient and residential levels of care was solely attributed to insufficient capacity or was related to the effectiveness in which existing resources were managed.

To support the analysis, Mercer examined the following data sources and information:

- Average length of stay for each facility type (MH) or care facility category (SUD);
- Trended 7-day and 30-day MH readmission rates. For SUD care facility categories, Mercer reviewed 3-month and 6-month readmission rates;
- Aggregated authorization data for fee-for-service hospitals and DHS operated hospitals to discern the proportion of acute, administrative and denied days (MH only);
- Designated facility wait list data collected by DMH (MH only); and
- Results of successive queries of the DPH online Substance Use and Bed Availability Tool (SUD only);

CLIENT FLOW – MENTAL HEALTH INPATIENT AND RESIDENTIAL LEVELS OF CARE

Average Length of Stay

The average length of stay in each care facility demonstrates how long individuals occupy a finite quantity of beds. The measure can be a valuable indicator of client flow as the average length of stay reveals the extent to which bed capacity is turned over to create openings for other individuals who need the care setting for stabilization, supervision and/or clinical interventions.

Caution should be exercised when interpreting the average length of stay results. The average length of stay measure may not be an optimal metric because the data is not normally distributed. Through a review of the data set of select care facility settings, it was determined that there are clusters of people that stay for an extended period of time, and conversely, there are a grouping of individuals with very brief lengths of stay. As such, the distribution of data lacks uniformity or centralization and there is not a predominance of care episodes that are similar in duration. Rather, the majority of care episodes in some of the care settings reveal sets of brief lengths of stay as well as groupings of longer lengths of stay. As a result, interpreting average lengths of stay for these care settings can be misleading.

Table 16 – displays the average length of stay for each MH inpatient and residential care facility.

Table 16. – Average Length of Stay, MH Inpatient and Residential Care Settings (FY 2017)

Care Setting Category	Sub Units	Age Groups
		All Ages
Crisis Resolution and Triage	Psych ERs, Urgent Care Centers, Crisis Stabilization Units	15-30 hours*
	Crisis Residential Treatment Programs	20.7
Level 1 – Acute Inpatient Hospital	Fee-for-Service Hospitals (including Freestanding)	7.5**
	County/DHS Operated Hospitals	22.3
	Short-Doyle Facilities	16.8
	Psychiatric Health Facilities	27.4
Level 2 – Sub-acute	State Hospitals	531.0
	Specialized	342.7
	General	122.0***
	Community Treatment Facilities (Youth)	352.3
Level 3 – Community Residential	Enriched Residential Services	234.6
	Short-term Residential Therapeutic Program (STRTP)	148.5

*As self-reported by DHS-operated county hospital staff
**Data reflects adult members only
***Over half of the individual cases reviewed involved lengths of stay of 14 days or less which significantly reduced the ALOS calculation for this care facility.

Relevant findings for inpatient and residential care setting average length of stay include:

- Fee-for-service hospitals are characterized by the shortest length of stay (7.5 days/adults) than any other facility type included in the analysis;
- County/DHS Operated Hospitals recorded an average length of stay of 22.3 days; almost three times longer than fee-for-service hospitals;
- The average length of stay at Short-Doyle Facilities is 16.8 days. The facilities are currently reimbursed on a case rate basis for the initial 17 days of care;
- Psychiatric Health Facilities have an average length of stay of 27 days driven, in part, by extended stays for children and older adults;
- State hospitals have the longest lengths of stay, averaging 531 days;

- For children, adolescents and transition age youth, average lengths of stay in community treatment facilities (352 days) are over two times as long as the average length of stay at short-term residential therapeutic programs (149 days); and
- Crisis residential treatment programs are designed for an average length of stay between 14 and 30 days. The analysis found these facilities to have an average length of stay of 21 days.

7-Day and 30-Day MH Readmission Rates

MH readmission rates are an important measure of utilization and often illustrate the effectiveness of discharge planning, care coordination and/or discharge appropriateness. Care facilities that demonstrate persistent and high rates of 7-day and 30-day readmissions disrupt client flow to less intensive service settings and create inefficiencies within the system of care.

7-day and 30-day readmission rate results were calculated for select MH facility types in which the numerator met or exceeded at least 30 cases during the measurement period. For purposes of the analysis, Mercer only calculated readmissions to facility types within a designated care setting category. For example, the acute inpatient hospital care setting category includes the following facility types: fee-for service hospitals, DHS-operated county hospitals, Short-Doyle facilities and psychiatric health care facilities. A re-admission was recorded when an individual was discharged from one of the qualifying facility types and then was subsequently readmitted to that same facility type or another facility type within the inpatient hospital care setting category within 7 or 30 days.

Data is presented in a longitudinal format to support an analysis of readmissions over the most two recent fiscal years in which data was available (FY 2017 and FY 2016). Separate outputs are presented for children and adults.

Table 17. – 7-Day Readmission Rates to the Same Care Setting Category, Mental Health Inpatient and Residential Care Settings Children and Adults (FY 2017 – 2016)

Population: Children		
Facility Type	**7-Day Readmission Rate (2017)**	**7-Day Readmission Rate (2016)**
Fee-for-Service	5.5%	6.8%
Short-Doyle	5.2%	5.1%
Population: Adults		
Facility Type	**7-Day Readmission Rate (2017)**	**7-Day Readmission Rate (2016)**
Fee-for-Service	19.1%	19.4%
County/DHS Operated	7.9%	9.5%
Short-Doyle	2.6%	5.8%
Psychiatric Health Facility	11.4%	11.4%

Relevant findings for 7-day readmission rates across select acute inpatient hospital care settings include:

- 7-day readmission rates for children ranged from 5% to 7% for fee-for-service hospitals and Short-Doyle facilities over both measurement periods;

- 7-day readmission rates for adults revealed that fee-for-service hospitals recorded the highest rates across all MH inpatient hospital facility types during both fiscal years. Short-Doyle facilities were determined to have the lowest 7-day readmission rates of the facility types reviewed; and

- Adult 7-day readmission rates for fee-for-service hospitals are nearly 2.5 times higher than 7-day readmission rates noted for the DHS-operated county hospitals during FY 2017.

Table 18 depicts 30-day readmission rates for select MH inpatient and residential care settings.

Table 18. – 30-Day Readmission Rates to the Same Care Setting Category, Mental Health Inpatient and Residential Care Settings, Children and Adults (FY 2017 – 2016)

Population: Children		
Facility Type	**30-Day Readmission Rate (2017)**	**30-Day Readmission Rate (2016)**
Fee-for-Service	16.1%	17.8%
Short-Doyle	12.5%	13.0%
Population: Adults		
Facility Type	**30-Day Readmission Rate (2017)**	**30-Day Readmission Rate (2016)**
Fee-for-Service	37.8%	38.7%
County/DHS Operated	20.5%	20.9%
Short-Doyle	8.1%	9.2%
Psychiatric Health Facility	24.8%	26.8%

Relevant findings for 30-day readmission rates across select acute inpatient hospital care settings include:

- Nearly 4 out of 10 adult individuals discharged from a fee-for-service hospital experienced a readmission within 30 days to another facility type within the acute inpatient hospital care category over each review period. In contrast, one out of five adult individuals discharged from a DHS-operated county hospital was readmitted within 30 days.

- Short-Doyle facilities recorded the lowest 30-day readmission rates for children and adults over both fiscal years.

- Psychiatric health facilities recorded 30-day readmission rates of approximately 25% during both review periods.

Authorization Data (Fee-for-Service Hospitals and DHS-Operated County Hospitals)

The extent that an acute inpatient hospital is incurring administrative and/or denied authorizations can be indicative that the member population placed in the facility could more appropriately receive

care at an alternative setting if an array of treatment options were readily available and are willing to accept the individual for admission.

Mercer performed an analysis of available authorization data for fee-for-service hospitals and DHS-operated county hospitals. A member occupying a bed at one of these acute inpatient hospital facilities is determined to meet one of three authorization types:

Acute Authorization – the member is deemed to meet medical necessity criteria, continued stay in an acute inpatient hospital is warranted and the treating facility is reimbursed at the full per diem contracted rate;

Administrative Authorization – the member does not meet medical necessity criteria, but there is evidence that the member is waiting for an appropriate step-down to another care facility for ongoing treatment. In these circumstances, the acute inpatient hospital receives a per diem payment for administrative days, but the amount is reduced from the full per diem contracted rate offered to members who meet all applicable medical necessity criteria; or

Denied Authorization – the member does not meet medical necessity criteria and there is an absence of a definitive discharge plan or the member's discharge from the acute inpatient hospital is imminent or pending the arrangement of appropriate community supports. Under denied authorization status, the acute inpatient hospital does not receive any reimbursement or payment for the member's stay.

All fee-for-service hospitals must submit retrospective review authorization requests to the County DMH Treatment Authorization Request Unit. This team then performs a clinical review to determine if the member's stay meets medical necessity. For the DHS-operated county hospitals, each facility has a designated onsite utilization review team that completes a clinical review of each patient each day and generates an authorization decision (e.g., acute, administrative or denied).

All authorization decisions rendered by DMH and DHS are subject to an annual audit performed by the state's Medicaid agency in which a sample of cases are examined to assess the appropriateness of the initial authorization review decision. If the audit results demonstrate an unacceptable degree of congruence, DMH and/or DHS could be subject to recoupment of program funding.

Table 19 illustrates the disproportionate percent of administrative days authorized at the DHS-operated county hospitals when compared to the fee-for-service hospital network. Administrative days account for almost 3x more of the overall bed days in county hospitals than the fee-for-service hospitals. Multiple factors are likely influencing these results, including the acuity of the population served, the volume of members on LPS conservatorship status, and extended wait-times to access step-down facilities.

Table 19 – Percent of Administrative Days Authorized as a Percent of All Bed Days – FY 2017

Facility Type	% – Acute Days	% – Administrative Days	% – Denied Days
Fee-for-Service Hospitals	74.9%	11.7%	13.4%
DHS-Operated County Hospitals	27.0%	25.5%	47.6%

A subsequent analysis of denial reasons for DHS-Operated County Hospitals reveal that nearly 80% of all denied days are attributed to reason code 70 (Lower level of care = non-billable days) or reason code 50 (Patient does not meet administrative criteria for discharge to home, shelter or street). This finding illustrates a significant unmet need for alternative care settings for members who no longer require acute inpatient hospital treatment.

Care Facility Wait List Data (DMH)

As one of its functions, DMH operates as a gatekeeper for members needing access to state hospitals, subacute facilities (general and specialized), Short-Doyle facilities, psychiatric health facilities (adults only), enriched residential services and crisis residential treatment programs. DMH clinical staff receive and triage referral packets for designated levels of care, evaluate member clinical needs and/or determine readiness for discharge.

DMH performs clinical triage and tracks referrals from one facility based level of care to another level of care that is deemed appropriate to meet the member's needs. DMH developed and provided a data file, that was drawn from several other logs and data sources to support an initial assessment of facility-based care and to help identify trends in waitlist facility types and waitlist times.

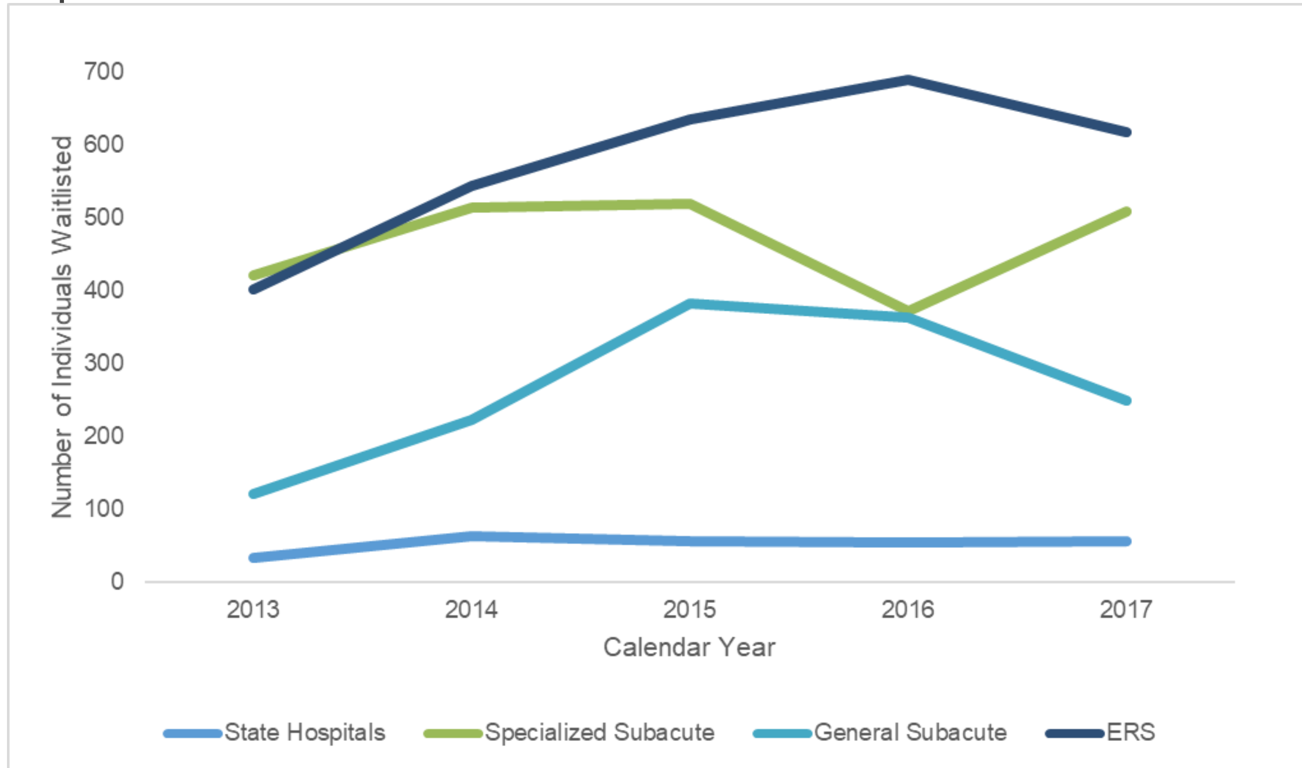
Waitlist Methodology

The DMH data included referrals for placement in one of five settings (State Hospitals, Specialized Subacute, General Subacute, Enriched Residential Services and Crisis Residential Treatment Programs). Crisis residential treatment program settings were excluded from the analysis due to a low volume of referrals (i.e., seven rows of data).

Individuals were categorized according to the year the waitlist event occurred. Individual waitlist data was excluded if the date the individual was placed on the waitlist did not occur within the 2013-2017 timeframe. Data was categorized into waitlist events that resulted in admissions and waitlist events that did not result in admissions. Referring facility field names utilized for the analysis include county contracted, county hospital, fee-for-service, jail and state hospital.

Graph and Table 20 displays trends in the number of individuals placed on a waitlist for each type of MH facility.

Graph and Table 20. – Number of Individuals Placed on Waitlist

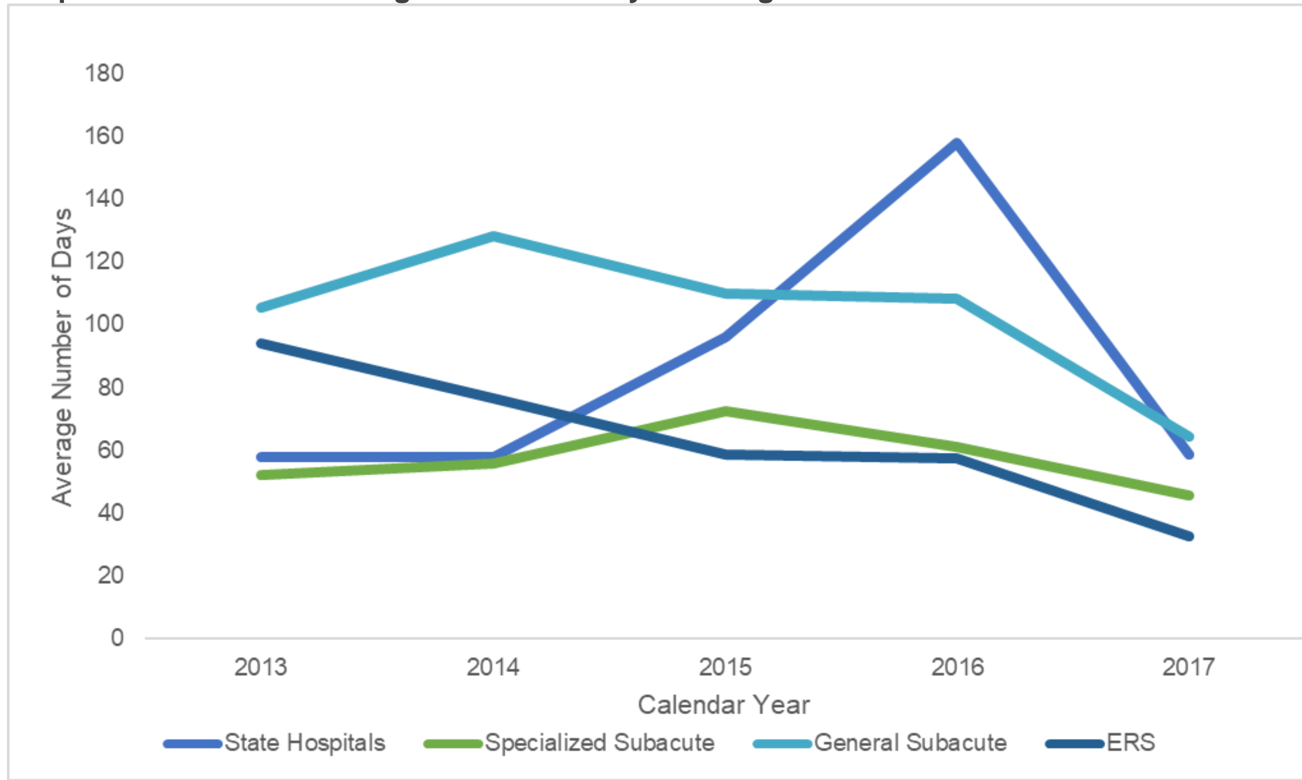


Referred Facility	2013	2014	2015	2016	2017	Percent Change (2013–2017)
State Hospitals	33	62	56	54	56	↑ 69.7%
Specialized Subacute	420	514	520	371	508	↑ 21.0%
General Subacute	121	223	382	363	249	↑ 105.8%
ERS	402	543	635	689	617	↑ 53.5%
TOTAL	**976**	**1,342**	**1,593**	**1,477**	**1,430**	**↑ 46.5%**

All care facilities are associated with increases in the total number of individuals waitlisted between FY 2013 and FY 2017. General subacute care facilities have experienced over a 100% increase during this time period. During FY 2017, there were over 500 individuals on a waitlist for a specialized subacute bed.

The following graph and table illustrates the average number of days that individuals were on a waitlist before being placed, by MH facility type.

Graph and Table 21 – Average Number of Days Waiting for Placement



Average Number of days Waitlisted by Year

Referred Facility	2013	2014	2015	2016	2017	Percent Change (2013–2017)
State Hospitals	57.8	57.9	96	158	58.6	↑1.4%
Specialized Subacute	52.1	55.8	72.6	61.2	45.6	↓ 12.5%
General Subacute	105.5	128.1	110	108.4	64.5	↓ 38.9%
ERS	94.1	76.6	58.5	57.5	32.5	↓ 65.4%
TOTAL	**75.2**	**76.3**	**76.1**	**72.4**	**43.7**	**↓ 41.8%**

The average number of days that individuals were maintained on a waitlist have generally decreased over time, with the exception of persons waiting for a state hospital bed. Enriched residential services experienced the steepest decline since FY 2013 – averaging 32 days in FY 2017. Average wait times for specialized and general subacute care facilities persist for 6 weeks to 2 months respectively.

Not all individuals placed on a waitlist were placed within the time spans included in the data set, as presented in Table 22. The DMH waitlist data file did not specify the reasons that an individual was not placed after being referred to one of the designated care settings.

Table 22. – Percentage of Individuals Remaining on Waitlist

Facility Type	2013	2014	2015	2016	2017	Total
State	9%	6%	25%	25%	13%	14%
Specialized Subacute	14%	18%	25%	35%	28%	25%
General Subacute	33%	23%	54%	56%	27%	37%
ERS	27%	27%	45%	42%	33%	32%
Grand Total	**21%**	**22%**	**40%**	**43%**	**29%**	**30%**

The DMH waitlist data (in terms of the volume of individuals placed on a waitlist and the average number of days incurred before a placement is executed) demonstrates how client flow is interrupted for persons needing access to these care facilities. In most cases, individuals waiting for CMR managed care settings are occupying acute inpatient hospital days on administrative authorization status, a level of service that is not medically necessary or appropriate for the person’s clinical presentation. In turn, this scenario is creating challenges to appropriately admit other individuals who do require the intensity of services from an acute inpatient hospital setting. The inability to timely access care within these subacute and MH residential settings is one indicator that expanded bed capacity may be needed.

CLIENT FLOW – SUD RESIDENTIAL LEVELS OF CARE

Average Length of Stay

Similar to the MH analysis, the average length of stay in each SUD care facility demonstrates how long, on average, that individuals persist in treatment. The measure is a valuable indicator of client flow as the average length of stay reveals the extent to which individuals complete what is typically a prescribed duration of treatment within a supervised SUD care setting.

Table 23 displays the average length of stay for SUD care category.

Table 23. – Average Length of Stay (Days), SUD Care Categories, All Ages (FY 2017-2018)

Care Setting Category	Sub Units	Age Groups		
		Youth	Adults	All Ages
Level 1 – Acute Withdrawal Management	*ASAM 4.0* Inpatient Withdrawal Management Medically Managed	N/A	N/A	N/A
	ASAM 3.7 Inpatient Withdrawal Management Medically Monitored	4.7	6.4	6.4
	ASAM 3.2 Residential Withdrawal Management Clinically Managed	5.2	5.6	5.6
TOTAL		**5.1**	**5.8**	**5.8**
Level 2 – Residential Treatment	*ASAM 3.5* High Intensity Residential Non-Population Specific	29.7	40.1	39.6
	ASAM 3.3 High Intensity Residential Population Specific	41.8	35.6	35.7
	ASAM 3.1 Low Intensity Residential + perinatal	38	43.5	43.4

Care Setting Category	Sub Units	Age Groups		
		Youth	Adults	All Ages
TOTAL		**34.2**	**42.6**	**42.4**
Level 4 – Sober Living Housing	Recovery Bridge Housing	N/A	56.4	56.4
TOTAL			**56.4**	**56.4**

Relevant findings for SUD care setting average lengths of stay include:

- Acute withdrawal management services are characterized by the shortest length of stay (5.8 days);
- Residential treatment ASAM levels demonstrate lengths of stay typically exceed 30 days per treatment episode; and
- Recovery Bridge Housing recorded an average length of stay of 56.4 days.

SUD Care Facility Readmission Rates

SUD readmission rates are an important measure of utilization and SUD treatment effectiveness for conditions with relatively high remission rates. Care facilities that demonstrate persistent and high rates of three-month and six-month readmissions can illustrate challenges with client engagement and adequate post-discharge supports to help maintain periods of sobriety and stability.

Three month and six-month readmission rate results were calculated for select SUD facility care setting categories and associated ASAM level groupings. Some care episodes in the utilization data file included transitions to another ASAM level of care. In these cases, Mercer recognized the initial ASAM LOC for each stay as part of the calculation of total admissions (i.e., denominator for each readmission calculation).

Data is presented for FY 2017-2018. Separate outputs are presented for children and adults.

Table 24. – Three-Month Readmission Rates to the Same Care Setting Category, SUD Residential Care Settings, Children and Adults (FY 2017-2018)

Care Setting Category	Sub Units	Age Groups		
		Children	Adults	All Ages
Level 1 – Acute Withdrawal Management	*ASAM 4.0* Inpatient Withdrawal Management Medically Managed			
	ASAM 3.7 Inpatient Withdrawal Management, Medically Monitored			
	ASAM 3.2 Residential Withdrawal Management Clinically Managed			
TOTAL		**N/A**	**14.5%**	**14.5%**

Care Setting Category	Sub Units	Age Groups		
		Children	Adults	All Ages
Level 2 – Residential Treatment	*ASAM 3.5* High Intensity Residential Non-Population Specific			
	ASAM 3.3 High Intensity Residential Population Specific			
	ASAM 3.1 Low Intensity Residential + perinatal			
TOTAL		**9.4%**	**14.9%**	**14.8%**

Relevant findings for three-month readmission rates across SUD residential care settings include:

- Three-month readmission rates to acute withdrawal management and residential treatment and withdrawal management care setting categories is comparable.

Table 25. Six-Month Readmission Rates to the Same Care Setting Category, SUD and Residential Care Settings, Children and Adults (FY 2017- 2018)

Care Setting Category	Sub Units	Age Groups		
		Children	Adults	All Ages
Level 1 – Acute Withdrawal Management	*ASAM 4.0* Inpatient Withdrawal Management Medically Managed			
	ASAM 3.7 Inpatient Withdrawal Management, Medically Monitored			
	ASAM 3.2 Residential Withdrawal Management Clinically Managed			
TOTAL		**N/A**	**33.2%**	**33.2%**
Level 2 – Residential Treatment	*ASAM 3.5* High Intensity Residential Non-Population Specific			
	ASAM 3.3 High Intensity Residential Population Specific			
	ASAM 3.1 Low Intensity Residential + perinatal			
TOTAL		**16.2%**	**30.0%**	**29.6%**

Relevant findings for six-month readmission rates across SUD residential care settings include:

- Nearly one out of three admissions within six-months constitutes a readmission under the acute withdrawal management care facility category; and

- For the Level 2 – residential treatment care facility category, over 1,200 readmissions were recorded within six months of an initial admission.

SUD Bed Availability Tracker

The DPH Online Service and Bed Availability Tool (SBAT) is a web-based tool that provides a dashboard of available substance use services throughout Los Angeles County, including: outpatient and intensive outpatient treatment, different levels of residential treatment and withdrawal management, opioid treatment programs (methadone clinics), recovery bridge housing, and driving under the influence programs. Service availabilities identified through the SBAT are intended to be updated on a daily basis[51].

Mercer queried and recorded bed availability for the targeted ASAM levels using the SBAT on five different occasions between February 25, 2019 and April 18, 2019. Bed availability by adults and youth, gender and ASAM level and recovery bridge housing is presented in Table 26.

[51] https://sapccis.ph.lacounty.gov/sbat/

Table 26. – Bed Availability for ASAM Levels and Recovery Bridge Housing, Adults and Youth, by Gender

Client Served	Bed Availability				
	2/25/2019	3/8/2019	3/22/2019	4/4/2019	4/18/2019
RBH*					
Total Adult Female	9	2	4	3	6
Total Adult Male	3	4	1	2	3
Total Youth Female	0	0	0	0	0
Total Youth Male	0	0	0	0	0
ASAM Level 3.1					
Total Adult Female	25	41	32	36	26
Total Adult Male	9	4	2	0	6
Total Youth Female	16	16	16	17	17
Total Youth Male	16	16	16	17	17
ASAM Level 3.2					
Total Adult Female	4	4	5	4	6
Total Adult Male	4	4	8	4	6
Total Youth Female	0	0	0	0	0
Total Youth Male	0	0	0	0	0
ASAM Level 3.3					
Total Adult Female	0	5	0	N/A	0
Total Adult Male	0	0	0	N/A	0
Total Youth Female	0	0	0	N/A	0
Total Youth Male	0	0	0	N/A	0
ASAM Level 3.5					
Total Adult Female	12	26	10	22	13
Total Adult Male	0	0	2	4	4
Total Youth Female	15	10	15	15	15
Total Youth Male	16	10	15	16	15
ASAM Levels 3.7 & 4.0					
Total Adult Female	2	2	2	2	2
Total Adult Male	2	2	2	2	2
Total Youth Female	0	0	0	0	0
Total Youth Male	0	0	0	0	0

Relevant findings derived from an analysis of the SBAT demonstrate the following:

- ***Recovery-Bridge Housing*** – No bed availability for female or male youth;

- ***ASAM Level 3.1, Low Intensity Residential + Perinatal*** – Limited bed availability for adult males;
- ***ASAM Level 3.2, Residential Withdrawal Management, Clinically Managed*** – No bed availability for female or male youth;
- ***ASAM Level 3.3, High Intensity Residential, Population Specific*** – Restricted to no capacity for adult and youth females and males;
- ***ASAM Level 3.5, High Intensity Residential, Non-Population Specific*** – Limited bed availability for adult males; and
- ***ASAM Levels 3.7 & 4.0, Inpatient Withdrawal Management (medically managed and monitored)*** – Limited bed availability for adult females and males; and no bed availability for female or male youth.

7
STAKEHOLDER FINDINGS

As part of the comprehensive MH and SUD needs assessment, Mercer collected, analyzed and incorporated feedback from multiple stakeholder forums and meetings. Stakeholder input has been organized into themes which then subsequently informed the analysis and recommendations included in this report.

Background and Methods

Between November 8, 2018, and January 4, 2019, Mercer and TriWest Group, LLC (TriWest) facilitated nine in-person stakeholder groups and two telephonic interviews with, and received written feedback from, advocates, consumers and family members, providers and County staff. The purpose of these stakeholder groups was to gain an understanding of how County residents access and use MH and SUD services, with special emphasis on acute care, subacute care, and residential levels of care. The stakeholder groups also focused on services for people with co-occurring MH and SUD. The goal of these groups was to learn more about how providers manage capacity, patient flow, and programs, and how people experience access to delivery of care.

Because of the limited time period for collecting information, the in-person stakeholder sessions were held during part of the planned Service Area Advisory Committee (SAAC) meetings and the SAPC all-provider meeting. Approximately 50 participants attended each SAAC meeting, which allowed between 20 to 60 minutes on the agenda for stakeholder feedback. Because of limited time on the meeting agendas, there was variability in the details provided at the meetings. Stakeholders at each session may not have fully discussed all system challenges. Time constraints also limited discussion of the strengths. However, there are major themes that emerged from the stakeholder sessions.

In addition to the onsite stakeholder sessions with the SAACs and the SAPC providers, Mercer and TriWest conducted a follow-up telephone interview with a representative from District 2, met with the Mental Health Commission and received limited written feedback from individual members of the SAAC.

Over this one-month period, the stakeholder conversations addressed:

- The availability of MH and/or SUD services against needs in the County, emphasizing acute care, subacute care, residential levels of care, inclusive of co-occurring treatment for MH and substance use conditions;
- How County residents and their families gain access to services;

- Strategies to help with transition and discharge from treatment;
- Strategies to address service capacity gaps; and
- Recommendations for improvements.

MEETING THEMES

While most areas of the county discussed similar needs, stakeholders in each SAAC meeting identified unique strengths, service gaps and challenges. Themes from the SAAC meetings are summarized below.

Service Gaps and Challenges

Access to Inpatient and Residential Services

There are no local children's inpatient psychiatric beds, which has resulted in children and youth being admitted to a local acute care hospital for three-day observation with limited treatment and then discharged without referral; if they are placed in an inpatient or residential program, it is outside of the service area (Bakersfield, Torrance or Ventura). In these cases, parents are unable to see their child or participate in treatment because of the distance and lack of transportation.

- There is no SUD residential treatment for all ages.
- There are challenges related to obtaining medical clearance for people who require inpatient psychiatric care.
- There are significant gaps in inpatient treatment beds, residential beds, shelter beds and respite homes across all ages.
- There are significant gaps in assisting people when they are leaving inpatient care, especially for those with co-occurring disorders.
- In some areas of the County, there is only one psychiatric inpatient provider, which requires individuals and families to use services outside the service area and hinders family involvement and effective discharge planning back to their home community.
- Residential facilities do not have to be locked, but they need effective treatment protocols and an emphasis on developing coping skills.

Capacity

- There are not enough inpatient beds for patients eligible for conservatorship. There are long lengths of stay in these beds along with waiting periods of up to a year to access secure inpatient care, resulting in people being discharged to the street and perpetuating homelessness.

- There is a need for more SUD inpatient beds.

Lack of Availability/Access

- Access to care is one of the biggest issues. A plan for improving access to care should address basic needs (food, shelter, transportation), service needs, welcoming environments (centers that do not stigmatize), staff that are experienced and healthy, and outcomes geared toward wellness and integration of physical health, MH and substance use.

- There is limited access to urgent care for MH, SUD and services to people with co-occurring disorders at all levels of care.

- There is a lack of equality between MH and SUD treatment. While there are gaps in MH services, there is even more limited treatment available for people with SUD. In addition, MH and SUD treatment is not integrated. There are programs that claim to address MH and SUD needs but they do not provide the same level of treatment to address SUD needs (e.g., they may provide clients a "booklet" to help them with their SUD needs).

- There is minimal access to locked facilities.

- Before and post hospitalization, alternative modes of treatment and support such as respite are missing.

- Specific to subacute levels of care, one of the biggest problems is with SUD services. There are SUD providers that reportedly provide co-occurring disorder services, but stakeholders have not heard good reports on access to these services and whether they met criteria for co-occurring disorder treatment. Providers are located outside the service area and access seems limited.

- The availability of services does not seem to match the level of need in the service area. There are services, but to access care you have to "win the lottery," have a chronic level of need that requires hospitalization, or become incarcerated. Mild cases become severe while people are trying to connect to care.

- There is a lack of knowledge in the community about where to go and who to see to access services; it is difficult to navigate a complicated system. Non-profit organizations help to educate the community, but more needs to be done. DMH also tries, but its outreach is limited. A person's level of motivation, in large part, will determine if they engage in treatment after discharge. Also, there are often delays (weeks) in accessing care, and stigma and denial are still a major problem in the community.

Demand/Need

- There is only one urgent care MH crisis unit serving the entire valley.

- There is no urgent care provider within the service area.

- The service delivery system covers a large geographic area.

- There are no county-based hospitals in the service area. People must leave the service area to obtain inpatient psychiatric care. Five hospitals have stopped providing inpatient psychiatric care. A lack of funding is part of the reason there are no inpatient services in the service area.

- There are gaps in supervision and support in board and care facilities and there is a need for more structured programs.

- SUD and MH services are currently provided separately—co-location is needed.

- Hospitals discharge too quickly in a triage mode (targeting people with the most severe illness or past hospitalizations or incarcerations). This problem is one of the chief contributors to repeat hospitalizations and insufficient recovery, and the community needs housing with supportive services or residential treatment (there are long waits for admission) to address this problem. There is a great need for step-down residential treatment that leads to board and care and independent living with supportive services.

- There is a lack of trauma-informed care and no emphasis on resiliency and recovery.

- There is a significant gap in transportation services to treatment facilities.

Timeliness

- There are long delays in accessing inpatient care and residential treatment for all populations. The limited beds create long delays in receiving care during a crisis. Because there are not enough beds and not enough transportation services, people go untreated. Typically, people sit in crisis for hours while they wait for either a placement or transportation to a facility.

- The hospital length of stay can be up to eight months because of a lack of community treatment alternatives, especially Adult Full Service Partnership programs and housing.

- Access to adult psychiatric beds is time consuming, taking an average of three hours to find a bed and up to five hours to admit a person, with many out-of-area referrals.

- There are long (more than a month) wait times to see a psychiatrist across all ages.

- Van rides to facilities outside of Antelope Valley are long (two hours).

Linkage and Care Coordination

- There is poor discharge planning, family communications and follow up when people receive inpatient or residential care outside of Antelope Valley. People are discharged with no plan or transportation back to the local area.

- There is a need for improved facility assessments and discharge planning to connect people to follow-up care to minimize “revolving door” syndrome for many patients (MH and SUD). Facilities that provide follow-up care should connect with patients before they are discharged so they can assess them for services, determine if they are appropriate for their services and ensure they are connected to follow-up services upon discharge. Agencies that provide recuperative care should provide in-reach before patients are discharged.

- There is limited follow-up post emergency department use; people are discharged without linkage to other services; sometimes they are discharged to the street with no place to go.

- People are discharged from hospitals with serious to severe medical/physical health needs without a discharge plan and referrals to recuperative care.

- There are gaps in discharge planning and coordination among community MH organizations for transitioning people back into the community and there are different protocols for each agency.

- Psychiatric hospitals have limited involvement in discharge planning.

- Follow up post hospitalization seems extremely problematic after residential treatment.

- Treatment is episodic and care coordination is limited for all populations. There is a need for care coordination and transition of care from adult detoxification services to outpatient, medical and inpatient facilities.

- Treatment and lengths of stay are limited while people are hospitalized. Patients are hospitalized for short periods of time and do not receive adequate or sufficient treatment during these stays. As a result, these people return to the hospital for another brief admission, which creates a revolving door of repeated, and avoidable, admissions.

- There is a reliance on general or acute care hospitals for treating people with substance-related psychosis, who are then discharged to supportive housing before they are stabilized. People have limited access to physicians and nurses while they are in supportive housing. There is also a need for more around the clock staff support in residential settings. When the staff work day is over, people do not have access to supports and end up seeking services and supports from the hospital again.

- There are gaps in coordination and communication between agencies (e.g., housing, board and care, transitional living, MH, or SUD services); therefore, consumers must navigate the service delivery system on their own.

Special Populations

- There is a lack of specialized SUD services for transition age youth as well as concerns about mixing them with formerly incarcerated adults in SUD and 12-step programs.

- There are limited placement options for foster children and other children in custody, which results in children having to move out of their home communities, limits family involvement and recovery efforts and leads to relapse, additional trauma and multiple placements.
- There is limited specialty care for people with autism spectrum disorder who have symptoms of physical aggression.
- Services for people of color are disproportionately limited compared to services for the white population.
- There is not enough Spanish-speaking MH and SUD staff to serve the population. There is also a misperception that Spanish-speaking people do not want to access services because of cultural barriers, rather than language barriers.
- There is a lack of SUD services for people who do not speak English. Many programs do not have the capacity to provide services in non-English languages, and translation services are expensive. Assistance is needed for people who speak Cantonese, Mandarin and Vietnamese as well as those who speak Spanish.
- There is a limited pool of available bi-lingual, bi-cultural staff; interpreters are inadequately matched to the needs of the community.
- There is a gap in services for older adults across the full spectrum of services (across county as a whole). There is a large and expanding need for specialized services, and resources are limited. Based on research and experience, when these services are provided, long-term care costs decrease.
- The entire state plays “hot potato” in treating co-occurring, cognitive decline/impairment, and MH disorders in older adults. Caring for these people is extremely costly and leads to inadequate care and tremendous expense.
- There are gaps in funding resources for people in poverty or who are uninsured.
- Homelessness is a huge issue for the County as a whole; there is significant homelessness and limited supportive housing and other housing.

SAAC RECOMMENDATIONS

- Increase access to inpatient psychiatric beds for all populations, including children and those under conservatorship.
- Increase access to inpatient services and develop protocols for family involvement and discharge planning.

- Develop more urgent care and crisis resources that have more behavioral health staff.
- Develop more SUD inpatient treatment beds.
- Increase access to integrated physical and behavioral health care in acute care hospitals that can provide both physical and behavioral health care for adults and children.
- Increase access to urgent care facilities operated by the County.
- Transportation is needed across the board for accessing services and attending meetings.
- Provide additional LPS Act designated hospitals for involuntary commitment for adult populations.
- Provide consumers with linkages and connections to existing services, programs and providers.
- Improve the continuity of care for all populations, especially those who use the emergency department, inpatient services and detoxification services, by providing care coordination and community referrals.
- Review the current care coordination system and focus on transition and discharge.
- Vastly improve connections between services with warm handoffs, including transportation and proactive support by MH staff.
- Address challenges in hiring and maintaining an adequate workforce by improving salaries, offering more training and providing paid internships for MH clinicians, psychiatrists and peer specialists.
- Increase peer training and certification as well as the number of paid positions for peers throughout the MH and SUD workforce.
- Provide training to providers on person-centered care and the important role families can play in a person’s treatment, when family input is allowed by the person seeking services.
- Increase reliance on peer support services and provide more local peer support training; advocate for statewide peer certification.
- Improve access to and increase the number of Spanish-speaking clinical and support staff.
- Improve SUD co-occurring disorder services and identify providers who are willing to offer integrated treatment for co-occurring disorder.

- Address the disproportionality of services for people of color. One participant who attended The Color of Trauma training discussed how this could be a possible resource to address the disproportionality of services for people of color.
- Expand youth drug treatment programs and school-based crisis intervention programs to reduce reliance on the juvenile justice system.
- Engage people who are monolingual, youth and people of color in services and planning initiatives.
- Improve connections with community-based organizations to educate and disseminate information to community members who may need behavioral health services.

PROVIDER THEMES

SAPC Providers

Mercer met with SUD providers that offer SAPC services and contract with the County Department of Public Health, the county agency responsible for oversight of the SUD delivery system. These providers offer prevention, outpatient, residential and withdrawal management services, as well as opioid treatment programs, recovery bridge housing, and recovery support services. Approximately 50 providers participated in person and via webinar.

SAPC Provider Gaps and Challenges

- There is an over-reliance on the use of 5150 holds to access care when residential treatment is inadequate.
- Subacute care is not available.
- There is a need for services for clients who are dually diagnosed. These clients often have high levels of need and it is often a challenge to find community services for them. Providers and facilities that have connections to DMH might be able to offer their clients more service options.
- There is a need for “in between services” such as services between a LOC of 3.5 (high-intensity residential treatment) and hospitalization.
- There are gaps in the availability of LOC 3.5 (high-intensity residential treatment) and LOC 3.7 (medically monitored inpatient withdrawal management) beds.
- Flexibility is needed within LOC 3.5 (high-intensity residential treatment), which requires clients to complete 20 hours of service after they see a psychiatrist and receive medication. This amount of service is challenging while people are trying to adjust to medication.
- There is an insufficient number of beds in the detoxification level of care and residential withdrawal management, particularly for people withdrawing from benzodiazepines.

- There is a disconnection between the MH and SUD systems of care. Some providers work in unique situations where their agency provides both types of services but, outside of that, the gaps in care are enormous.
- MH recovery is not part of SAPC programming. There is a need for more collaboration with MH providers.
- There is a need to fit services to people rather than fitting people into services. The effectiveness of treatment is diminished for all participants when those who need a higher level of care are placed in group settings for people requiring lower levels of care.
- There is a shortage of all SUD providers, especially those with dual diagnosis (co-occurring disorders) experience.
- There are challenges in coordinating with MH service providers to manage people with co-occurring disorder and high acuity MH needs.
- There is a lack of rehabilitation skill building and other step-down services for people leaving residential treatment. Outpatient programs do not focus on rehabilitation and recovery skills.
- There are challenges in providing care coordination because of poor reimbursement and coordination across multiple systems (e.g., MH and SUD systems). There are challenges in determining which provider should provide care coordination and which should bill for the service, as well as determining how to coordinate care. There are also challenges in accessing medical records and understanding differences between systems. Both MH and SUD providers are resistant to collaborate.
- Providers have limited knowledge about where to make referrals for specialized services.
- Staffing shortages (due to workforce shortages and challenges in hiring staff) impact ongoing service delivery, care coordination and referrals.
- There are different philosophies among MH and SUD providers that affect access, such as requiring the client to call for the service directly, rather than a care coordinator arranging for an appointment.
- A lack of housing options contributes to homelessness.
- There are gaps in services for monolingual Spanish-speaking patients and for patients that identify as LGBTQ.

SAPC Recommendations

- Address service gaps, particularly in subacute and residential care, and add flexibility to level of care in order to tailor services to people rather than fit people into existing services.
- DMH to develop guidance for providers to on how services can be provided and billed under Medi-Cal or accessed under other funds when a patient is linked to a SAPC SUD provider.
- Mitigate treatment gaps through more provider subcontracts.
- Provide services for monolingual Spanish-speaking patients by hiring more bilingual, bi-cultural staff and interpreters.

RECOMMENDATIONS FOR NEXT STEPS

The use of existing service area and provider meetings was helpful in gathering initial stakeholder feedback, but the limited time on busy meeting agendas made it challenging to identify specific practical priority recommendations from most of the service areas. Stakeholders expressed concerns about the timing of the stakeholder sessions and how these fit into an overarching plan to improve local services.

8
IMPRESSIONS AND RECOMMENDATIONS

Mercer performed a gap analysis to determine the discrepancy between existing facility treatment capacity and projected prevalence and utilization, taking into account any inefficiencies in member flow. This gap analysis includes estimated values for the number of additional beds (new or repurposed) required in each level of care, broken down by age groups, in order to address current and projected gaps. Recommendations to assist the Health Agency in improving the care delivery system and expanding and/or reconfiguring the network are presented in this section.

GENERAL IMPRESSIONS AND RECOMMENDATIONS

The Health Agency's MH and SUD service delivery system is currently experiencing unprecedented growth and pressure to address the covered population's needs for intensive MH and SUD services. Multiple events have recently converged that are directly influencing the volume of County residents in need of intensive MH and SUD services. Increasing numbers of individuals are now eligible for MH and SUD services under the Medi-Cal program, and a steady rise in the County's overall population, including unmatched growth of the homeless population have contributed to an increased demand for services.

This demand is coupled with the ever-increasing complex clinical and societal issues affecting segments of the County's population. As a result of this substantial rise in demand for MH and SUD services and the challenges inherent in effectively engaging and treating the impacted population, the Health Agency is struggling to keep pace to adequately meet these needs.

Addressing these systemic issues requires a comprehensive and thoughtful approach that considers the unique needs of the population. The Health Agency is being tasked to care for the County's most vulnerable residents, including those affected by housing insecurity, poverty, SUDs, mental illness and limited access to family and community supports and resources. When considering the development of new or expanded MH or SUD inpatient or residential beds, the County must make informed decisions based on valid and meaningful data that defines the need, specifies the capabilities of the care settings and identifies the targeted population (groups with specialty conditions, chronicity and severity of disabilities, sensitivity for programming for children, youth and adults).

Prevalence and Utilization

The Countywide MH and SUD needs assessment incorporates an analysis of estimated prevalence and historic utilization trends and seeks to estimate future needs and utilization for MH and SUD inpatient and residential services. Based on the anticipated changes in the volume of potential

users and the types of services that are expected to be needed, future projections for network expansion are recommended (see Recommendations for Bed Expansion below).

Provider Inventory

These recommendations also take into account the current inventory of inpatient and residential care setting capacity for treating Health Agency MH and SUD program participants, including County exclusive/owned beds and available operating capacity that could potentially accommodate a future expansion of dedicated beds. The provider inventory analysis must also consider the unique needs of the population being served and determine the extent that the current network can meet those needs. Building access to a network of care facilities that are not optimally equipped to meet the population's unique treatment needs does little to advance the care delivery system beyond its current state.

Multiple opportunities exist to strengthen provider agreements and develop incentive structures that reinforce the Health Agency's desired outcomes.

Client Flow

In order to maximize the effectiveness of the MH and SUD provider network, efficient and well-defined processes must be in place for identifying and referring clients, evaluating the client and care setting for clinical appropriateness, and ensuring timely access to care. Admission protocols will ideally be oriented to evidence-based clinical practice guidelines and there should be a robust ongoing clinical review of each client throughout the facility-based system of care to help ensure active treatment and continued need for the care setting. The Health Agency should intentionally and actively monitor key indicators such as ALOS, readmission rates and clinical outcomes to ensure that efficient and effective care is routinely provided. Care coordination programming and resources should be enhanced considerably and the Health Agency should adopt a care management/utilization review approach that ensures active treatment, the application of evidence-based practices and incorporation of recovery and resiliency principles.

Specific Recommendations

Mercer has identified and prioritized recommendations that directly respond to the relevant findings derived from the needs assessment analysis. These recommendations address the adequacy of the current provider inventory and identify opportunities to strengthen and expand the network to be more responsive to the unique needs of Health Agency clients as well as accommodating the anticipated expansion of the population. Program development initiatives must be targeted and purposeful regarding the unique population that the County is responsible to support. For example, the Health Agency should develop specific capacity within an exclusively contracted network structure to support the long-term residential care needs of individuals with physical health and MH needs. This capacity and capability would be available to the Health Agency to mitigate an established need and resolve a current gap in the care system.

In addition, the Health Agency should formalize an approach to an assessment of network adequacy that leverages key data points to support a continuous evaluation of network sufficiency that will proactively identify emerging network gaps and afford opportunities for early interventions that mitigate negative outcomes.

Mercer has also proposed recommendations to enhance client flow, including revisions to the current DMH gatekeeper role and process, implementation of an organized care coordination program, introduction of active care management/utilization review across all restrictive placements and adoption of a data driven system of care oversight role with active involvement and participation of all Health Agency departments and community stakeholders.

Finally, Mercer will offer an assessment of the current provider inventory/network and recommend bed expansions for designated care settings using a data informed formula to estimate additional bed capacity when deemed appropriate.

Recommendations for Bed Expansion

In an effort to develop an objective, data driven approach to quantifying additional bed capacity, Mercer developed a formula-based calculation using key data elements collected and analyzed as part of the countywide MH and SUD needs assessment. The initial step in the process was to evaluate all available quantitative and qualitative data to render an initial determination if bed expansion was indicated for each MH and SUD care setting reviewed.

Mental Health Care Facility Bed Expansion

The following care settings/facility types were identified for potential bed expansion based on an analysis of quantitative data and qualitative feedback gathered as part of the needs assessment.

- Psychiatric Emergency Rooms and Urgent Care Centers
  - *Note: Mercer is not recommending a specific quantity of expanded beds for these care facilities, but is suggesting that the Health Agency continue to expand urgent care center capacity to help alleviate over-crowding of DHS psychiatric emergency rooms (see facility-specific recommendations later in this section).*
- DHS-Operated County Hospitals
- Short-Doyle Facilities
- Psychiatric Health Facilities
- Specialized Subacute
- General Subacute

Substance Use Disorder Bed Expansion

The following withdrawal management and residential SUD care facilities were identified for potential bed expansion based on an analysis of quantitative data and qualitative feedback gathered as part of the needs assessment.

- ASAM LOC 3.1 – Low Intensity Residential
- ASAM LOC 3.3 – High Intensity Residential – Population Specific
- ASAM LOC 3.5 – High Intensity Residential – Non Population Specific
- ASAM LOC 3.2 – Residential Withdrawal Management – Clinically Managed
- ASAM LOC 3.7 – Inpatient Withdrawal Management Medically Monitored
- ASAM LOC 4.0 – Inpatient Withdrawal Management Medically Managed

Mental Health and Substance Use Disorder Bed Expansion Formulas

Mercer developed a formula-based calculation to quantify additional bed capacity in select care facilities that met an initial determination that bed expansion was likely needed to meet and/or keep pace with client demand. The approach is presented below in step-by-step procedures and accompanied by explanations of the quantitative data sources that were used to calculate the estimate.

The approach starts by computing recent unique users and applies an estimated growth factor that was derived through the prevalence and utilization analysis (See *Section 4. Prevalence and Utilization Analysis).* The next step assesses the number of users waiting for the care facility (when available, as not all facilities reviewed have an established waitlist for services).

The expected user total (based on unique users and expected growth) is added to the adjusted number waiting for the care setting (as applicable) and converted to expected bed days over a period of one year. Current operating bed capacity and the rate of utilization of that capacity is factored into the final recommendation of additional beds needed.

Measures of ALOS can be a valuable indicator of client flow as the average length of stay reveals the extent to which bed capacity is turned over to create openings for other individuals who need the care setting for stabilization, supervision and/or clinical interventions. However, Mercer found the metric to be highly variable across care settings based on data distribution tendencies (a large group of individuals have relatively short stays and another subset has extremely long lengths of stay). Due to this variation, we don't believe average length of stay is a reliable indicator to inform the need for additional beds.

Multiple assumptions were applied as part of the calculation, including:

- The estimates derived from the calculations are based on data received from the Health Agency and is valid to the extent that the source information is considered complete and accurate;
- The analysis is applied at the care facility level and recommend bed expansion is aggregated to the care facility category level and ASAM LOC for SUD; not individual treatment locations or facility sites. Unique facilities may be experiencing different levels of demand and utilization that may or may not be representative of the totality of facilities included in the care facility grouping (e.g., different DHS-operated county emergency rooms reported varying periods that the facilities were at full capacity);
- Projections of expanded beds is based on expected unique users during FY 2020; and
- The allocation of expanded children and adult beds was based on proportion of historic utilization patterns across children and adult users and estimates may not be indicative of the volume of beds required to address an unmet need.

See *Appendix C, Bed Expansion Calculations to* review illustrations of the model to calculate estimated MH and SUD bed expansion.

Summary of Recommended Bed Expansion – Selected MH and SUD Care Facilities

MH Inpatient, Subacute and Residential Care Settings – Recommendations for Expansion

The summary below includes recommendations for increases in bed counts for designated MH care facilities in which the results of the needs assessment demonstrated justification to expand the number of beds. The recommended bed expansion has been adjusted to take into account recently added as well as planned future state beds.

- *Acute inpatient hospital care settings (Fee-for-service hospitals, DHS-County hospitals, Short-Doyle facilities, and psychiatric health facilities):*
  - *Add 12 children beds and 32 adult beds (44 total beds); and*
- *Subacute care settings (State hospitals, specialized subacute, general subacute and community treatment facilities):*
  - *Add 1,508 adult beds*

SUD Residential Care Facilities – Recommendations for Expansion

The recommended bed expansion considers recently added capacity implemented by DPH, including increases in SUD residential and withdrawal management beds and expansion of sober living housing/recovery bridge housing, which has reportedly increased to nearly 1,000 beds that are now available to persons eligible for the DPH administered SUD system of care.

- *ASAM LOC 3.1 – Low Intensity Residential*
  - *Add 397 beds with emphasis on adult male bed expansion*
- *ASAM LOC 3.3 – High Intensity Residential – Population Specific*
  - *Add 149 beds with emphasis on adult and youth female and male bed expansion*
- *ASAM LOC 3.5 – High Intensity Residential – Non Population Specific*
  - *Add 403 beds with emphasis on adult male bed expansion*
- *ASAM LOC 3.2 – Residential Withdrawal Management Clinically Managed*
  - *Add 258 beds with consideration for female and male youth bed expansion*

Additional Recommendations

1. **Address Areas of Need through Program Development**
   A. Ensure sufficient capacity across all relevant care facilities to address the unique needs of the population. Needs that should be addressed include:
      i. Expand acute inpatient hospital beds to accommodate children under the age of 13;
      ii. Develop specialized programming across applicable care settings that is readily available to Health Agency participating agencies. Programming expansion should minimally address the following conditions/circumstances:
         a. Co-occurring MH and substance use disorders;
         b. Individuals with intellectual disabilities and MH conditions, including children with autism spectrum disorders;
         c. Adult and youth members with criminal justice involvement;
         d. Members on conservatorship status; and
         e. Co-morbid physical health and MH.
2. **Expand and Strengthen Direct Contracts with Inpatient and Residential Care Providers**
   A. Only 5% of the current MH operating bed capacity is exclusively available to DMH or owned by DHS (calculation excludes state hospitals and enriched residential services). As the managed care entity responsible for the system of care for county residents with SED, SMI and/or SUD, it is critical for the Health Agency to establish a robust contracted provider network adequate to meet the needs of the population. In the absence of binding provider

agreements, the Health Agency is extremely limited to influence capacity, programming and outcomes for the covered population.

B. The Health Agency should consider developing a comprehensive provider agreement template that incorporates all related program requirements, identifies specific bed capacity that should be available exclusively to the Health Agency, describes admission policies based on national practice guidelines (including explicit language prohibiting exclusions based on the member's health condition), outlines utilization review protocols (including expectations for active treatment) and includes discharge planning expectations.

C. As applicable and permissible under the Medi-Cal program, the Health Agency should explore the use of alternative payment arrangements with providers to reinforce achievement of the Health Agency's goals, objectives and clinical outcomes.

3. Design and Implement a Standardized Approach for the Ongoing Assessment of Network Adequacy

A. As the entity responsible for managing the MH and SUD benefits for a defined population, the Health Agency should establish policies and work processes that support an ongoing assessment of the sufficiency of the provider network. Considerations include the establishment of network management committee that regularly meets to review relevant data and performance measures, examines the adequacy and appropriateness of reimbursement rates and alternative payment arrangements, and reviews decisions with respect to network terminations and expansion.

B. The Health Agency should collect, track and analyze key data elements that inform the sufficiency of the provider network. Key indicators to consider include, but are not limited to, complaint data, results from member satisfaction surveys, volume and type of single case agreements, out-of-area care, referral patterns, waitlists, appointment availability standards, service utilization trends and quality of care concerns.

4. Facility-Specific Recommendations

A. Care setting category: Crisis Resolution and Triage

i. Continue efforts to expand contracts with urgent care centers (private, independent providers as well as DMH operated) and, emphasize through contract terms, crisis resolution outcomes with connections to community supports that alleviate the need for members to engage DHS-operated psychiatric emergency services. When considering expansion, ensure the appropriate geographic distribution of urgent care centers that can serve children and adolescents.

ii. Consider establishing distinct processing protocols for incoming referrals from jails and law enforcement. This could include designating separate receiving areas and/or

observation/stabilization units as well as dedicated staffing resources to address the unique needs of this population. As an alternative, the Health Agency could initiate contracts with independent urgent care centers and/or develop its own capacity to address the needs of forensic and criminal justice referred individuals that require stabilization and evaluation under LPS conservatorship.

iii. Execute contracts with crisis residential treatment programs and leverage the facilities to act as a diversion to entry to both higher and lower levels of care. Ensure that contract terms specify reasonable admission criteria that is based on national guidelines and accepted clinical practice. Consider alternative payment arrangements that reward successful diversions and demonstrate established connections with community supports and services.

B. Care setting category: Acute Psychiatric Inpatient Hospital

i. Expand contracts with fee-for-service hospitals, including units that can accommodate children under the age of 13. Dedicated capacity should include beds for children with co-occurring intellectual developmental disabilities and autism spectrum disorders. Negotiate stronger contract terms that amend current admission policies that tend to allow the hospitals to restrict admissions for clients that may be perceived to be more challenging. As necessary and permissible under current program rules, employ flexibility with reimbursement rates to provide incentives for fee-for-service hospitals to execute contracts and accept Health Agency members for admission. Where possible, consider reducing administrative requirements and present as incentives for potential contractors.

ii. Consider designating a ward at Augustus Hawkins for individuals on conservatorship status that are waiting for admission to a locked subacute facility. This would allow for separate programming and staffing that is tailored to the clinical needs of this less acute population.

iii. Expand facilities and/or contracts with Short-Doyle facilities and develop contract terms that address current admission policies which are perceived as restrictive and inconsistent with general clinical practices (e.g., not accepting individuals who have a history of SUD).

iv. Develop contracts and expand bed capacity for psychiatric health facilities for adults.

C. Care setting category: Subacute

i. Develop and expand exclusive contracts with specialized subacute facilities, including facilities that can accommodate special populations such as individuals with complex

medical conditions. Assess the availability of in-county providers to reduce the current inventory of out-of-county facilities (40% of total).

ii. Assess subacute programming to ensure members are frequently engaged in therapeutic milieu and are advancing in recovery. Contract terms should stipulate expectations for programming and should be regularly monitored through periodic utilization review activities. Utilization review should occur more frequently (i.e., every 30 days) to ensure active treatment and ongoing need for the intensity of the service.

iii. Develop and expand exclusive contracts with general subacute facilities, including facilities that accommodate temporary conservatorship holds. Contract terms should clarify admission policies and align criteria with established clinical guidelines.

iv. Consider designating specialized and/or general subacute facilities for access exclusively by DHS-operated county hospitals. The county hospitals are managing a majority of the members in need of locked subacute facilities and should have preferred access to the beds which will free up additional acute inpatient hospital capacity and reduce the number of uncompensated care days.

v. Establish protocols that allow for doctor to doctor consultations between DHS-operated county hospitals and subacute treatment teams to support the clinical review of appropriateness for admission.

vi. Through contract terms, amend current admission policies to subacute settings that serve to restrict access to care. Admission protocols should be clinically appropriate and based on established clinical guidelines. Codify expectations as part of provider agreements between the Health Agency and the provider.

D. Care setting category: Community Residential

i. Continue efforts to expand enriched residential services, which provide aspects of a supervised setting with intensive supports that promote community integration and fosters independence and recovery. Ensure that community partners understand the benefits and availability of these care settings and actively reinforce the identification of appropriate candidates for ERS placements.

E. Care setting category: Acute Withdrawal Management (ASAM Levels 3.7 and 4.0)

i. Consider expanding bed availability for adults and youth under existing provider agreements.

F. Care setting category: Residential Treatment and Withdrawal Management (ASAM Levels 3.1, 3.2, 3.3, and 3.5)

i. Consider expanding or converting existing contracts to ASAM 3.1 bed capacity for adult males.

ii. Expand ASAM 3.2 bed capacity for youth (male and female).

iii. Consider expanding ASAM 3.3 bed capacity for adults and youth.

iv. Examine the need to expand ASAM 3.5 bed capacity for adult males.

5. Review and Revise the Current DMH Gatekeeper Role and Process

A. The practice of a single entity managing limited treatment facility resources and serving as a gatekeeper to accessing designated care facility beds is a reasonable approach. However, there are a number of existing operating protocols that the needs assessment identified that appear to be resulting in inefficiencies and delays in accessing needed care.

i. DMH referral process – assess the need for arbitrary and extended periods of symptom-free documentation as criteria for accepting a referral. While it was noted that the member must demonstrate some period of stability before being considered for an alternative care setting, the manner in which this expectation has been operationalized appears onerous and unrealistic. The fact that many individuals being referred are no longer meeting acute inpatient hospital medical necessity criteria should be sufficient to initiate the referral process.

ii. Examine the need for restrictive and exclusionary admission policies that do not appear to be aligned with clinical practice guidelines and clarify if these expectations are stipulated by the receiving care facilities or criteria that has been developed and applied by DMH. Many of the exclusionary criterion seem unreasonably limiting given the population under review (e.g., history of substance use, recent use of PRN medications, or "as needed" medications).

iii. DMH should establish a formal process to provide feedback to referring entities regarding the appropriateness of referrals and individual case dispositions. This feedback may shape future behavior and could lead to more appropriate referrals that match member needs with the proper type of care facility.

iv. Allow referring entities to interface with identified care facilities to clarify clinical presentations, severity and expected treatment regimens. Physician to physician consultations reflect a standard practice to coordinate effective transitions of care, especially care transitions that involve complex clinical presentations that require placement in supervised care settings.

v. Consider further elevating priority for DHS-operated county hospital referrals. An examination of wait list times based on the referring entity did not demonstrate

significant variation in wait times across referral sources, despite acknowledgement that a priority system was in place across referral sources.

vi. Once a member is placed in a DMH managed care facility, a more robust and frequent review of ongoing medical necessity (including the presence of active treatment) should be in place. Allowing members to occupy limited bed space for extended lengths of time, and who may no longer require the level of care, results in additional delays for individuals who need access to the service.

vii. DMH should resolve data collection and tracking issues with respect to maintaining waitlists. Waitlist data is a critical indicator of network sufficiency and a priority should be placed on ensuring that the information is timely, accurate and available for ongoing review by the Health Agency.

6. **Explore the Feasibility of Implementing an Organized Care Coordination Program**[52]

A. Care coordination encompasses a variety of activities for coordinating services and providers to assist a member achieve his or her recovery goals. These activities, which can occur at a clinical and system level, are performed by designated staff depending on the member’s needs, goals and functional status.

B. Individuals with severe and chronic MH and/or SUD conditions can benefit significantly from an active care coordination program to support efficient transitions of care, enhance member engagement in services, and proactively identify and mitigate emerging periods in which an individual may require more supports and intensive interventions to maintain stability. Care coordination is identified as a key strategy that has the potential to improve the effectiveness, safety, and efficiency of the health care system. Well-designed, targeted care coordination that is delivered to the right people can improve outcomes for members, providers and payers. A care coordinator should have expertise in member self-management approaches, member advocacy and be capable of navigating complex systems and communicating with a wide spectrum of professional and lay persons, including family members, physicians, specialists and other health care professionals.

C. Care coordination interventions needed for this vulnerable population appear insufficient across the current continuum of care. The Health Agency should engage in a strategic assessment regarding the cost and benefits of establishing a care coordination program for

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[52] Excerpts of care coordination program expectations were drawn from Arizona’s Regional Behavioral Health Authority Scope of Work, Contract/RFP NO. YH17-0001
https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/RBHAs/MMIC_Amd-9_10-1-18_Final.pdf

individuals who are determined to be high risk, and/or high utilizers/high cost consumers of Health Agency services, notably those occupying inpatient and residential care settings.

D. Examples of beneficial care coordination activities include:

   i. Establishing a process to ensure care coordination of member needs across the continuum of care based on early identification of health risk factors or special health care needs;

   ii. Monitoring individual health status and service utilization to determine use of evidence-based care;

   iii. Monitoring member services and placements to assess the continued appropriateness, medical necessity and cost effectiveness of services;

   iv. Communicating among behavioral and physical health service providers regarding member progress and health status, test results, lab reports, medications and other health care information when necessary to promote optimal outcomes and reduce risks, duplication of services or medical errors;

   v. Participating in discharge planning from hospitals, jail or other institutions and follow up with members after discharge; and

   vi. Ensure that applicable services continue after discharge.

7. Enhance Utilization Review Activities

A. Restrictive and costly care settings necessitate an established utilization review program that helps ensure the appropriate use of resources and promotes effective treatment interventions. As part of an effort to expand contractual relationships with providers, the Health Agency should regularly review the appropriateness of care across designated care settings.

B. For example, members placed in subacute settings should be reviewed for ongoing medical necessity at least every 30 days. Effective utilization review activities incorporate an assessment of active treatment and promote the use of evidence-based interventions to ensure that members advance in recovery and achieve the highest level of functioning.

C. DMH should implement a process of concurrent utilization review for the fee-for-service hospital network and develop care management strategies that reinforce adherence to contract standards, promotes active treatment and utilizes evidence-based practices when available and appropriate.

8. Implement a Health Agency System of Care Oversight Team

A. All participating Health Agency departments (DMH, DHS and DPH) are accountable for an efficient, cost-effective and efficacious MH and SUD system of care. The Health Agency should establish a data informed system of care oversight role with active involvement and participation of all Health Agency departments and community stakeholders.

B. The Health Agency system of care executive oversight committee would routinely review key indicators of system performance, including, but not limited to, financial and program cost data, aggregated service utilization trends, proposals to expand or develop new programming (e.g., design and implementation of integrated care delivery models), review and approval of value-based purchasing initiatives with providers, design and implementation of strategic initiatives to guide future growth of the program, and oversee periodic assessments of the effectiveness, sustainability and outcomes of the overall health care program.

C. The system of care oversight role could include proposing strategic approaches to engage system partners to assist with achieving a broader set of common goals and system priorities. For example, the committee could seek to establish collaborative care agreements with other system partners that interface with the same targeted population (Regional Centers, corrections, public health).

D. The system of care executive oversight committee should review identified discrepancies in compensation and benefits for health care professionals working across Health Agency Departments.

APPENDIX A

MH PROVIDER INVENTORY

Facility Name	Facility Type	Service Area	Contracted/ Owned Beds	Operating Beds — Total	Operating Beds Ages 1–12	Operating Beds Ages 13–17	Operating Beds Ages 18–64	Operating Beds Ages 65+
Antelope Valley Hospital	FFS Hospital	N/A	0	12	0	0	30	0
Aurora Charter Oak	FFS Hospital	N/A	0	134	0	30	104	0
Aurora Las Encinas Hospital	FFS Hospital	N/A	0	96	0	0	118	0
Behavioral Health Center Alhambra Hospital	FFS Hospital	N/A	0	97	11	21	65	0
College Hospital Cerritos	FFS Hospital	N/A	0	187	0	26	161	0
College Hospital Costa Mesa	FFS Hospital	N/A	0	121	0	12	109	0
College Medical Center	FFS Hospital	N/A	0	137	0	0	120	17
Del Amo Hospital	FFS Hospital	N/A	0	166	14	32	120	0
Encino Hospital Medical Center	FFS Hospital	N/A	0	13	0	0	0	13
Glendale Adventist Medical Center	FFS Hospital	N/A	0	60	0	0	60	0
Glendale Memorial Hospital	FFS Hospital	N/A	0	30	0	0	30	0
Glendora Community Hospital	FFS Hospital	N/A	0	21	0	0	0	21
Henry Mayo Newhall Hospital	FFS Hospital	N/A	0	23	0	0	23	0
Huntington Memorial Hospital	FFS Hospital	N/A	0	38	0	0	36	14

Facility Name	Facility Type	Service Area	Contracted/ Owned Beds	Operating Beds — Total	Operating Beds Ages 1–12	Operating Beds Ages 13–17	Operating Beds Ages 18–64	Operating Beds Ages 65+
Inter-Community Medical Center	FFS Hospital	N/A	0	30	0	0	30	0
Joyce Eisenberg Keefer Medical Center	FFS Hospital	N/A	0	10	0	0	0	10
Kaiser Permanente Mental Health Center	FFS Hospital	N/A	0	68	0	0	68	0
LA Community Hospital at Bellflower	FFS Hospital	N/A	0	32	0	0	32	0
Mission Community Hospital	FFS Hospital	N/A	0	60	0	0	60	0
Motion Picture and Television Fund Hospital	FFS Hospital	N/A	0	12	0	0	0	12
Northridge Hospital Medical Center	FFS Hospital	N/A	0	40	0	9	31	0
Pacifica Hospital Of The Valley	FFS Hospital	N/A	0	36	0	0	36	0
Providence Little Company of Mary	FFS Hospital	N/A	0	25	0	0	25	0
Resnick Neuro-psychiatric Hospital At UCLA	FFS Hospital	N/A	0	74	8	17	24	25
San Gabriel Valley Medical Center	FFS Hospital	N/A	0	42	0	0	0	42
Sherman Oaks Hospital	FFS Hospital	N/A	0	19	0	0	0	19
Silver Lake Medical Center	FFS Hospital	N/A	0	143	0	0	147	0
Southern CA Hospital at Culver City	FFS Hospital	N/A	0	105	0	0	87	18

Facility Name	Facility Type	Service Area	Contracted/ Owned Beds	Operating Beds — Total	Operating Beds Ages 1–12	Operating Beds Ages 13–17	Operating Beds Ages 18–64	Operating Beds Ages 65+
Southern CA Hospital at Van Nuys	FFS Hospital	N/A	0	57	0	0	59	0
St Francis Medical Center	FFS Hospital	N/A	0	40	0	0	40	0
Tarzana Treatment Center	FFS Hospital	N/A	0	60	0	0	60	0
USC Verdugo Hills Hospital	FFS Hospital	N/A	0	24	0	0	0	24
White Memorial Medical Center	FFS Hospital	N/A	0	33	0	0	33	0
Total FFS Hospital			***0***	***2,045***	***33***	***147***	***1,708***	***215***
Harbor/UCLA	County Hospital (DHS)	N/A	38	38	0	0	38	0
Olive View	County Hospital (DHS)	N/A	50	50	0	0	50	0
USC Augustus Hawkins	County Hospital (DHS)	N/A	60	60	0	10	50	0
Total County Hospital (DHS)			***148***	***148***	***0***	***10***	***138***	***0***
Gateways Hospital	Short Doyle Hospital	N/A	0	55	0	27	28	0
Kedren Acute Psychiatric Hospital	Short Doyle Hospital	N/A	0	72	17	0	55	0
Total Short-Doyle Hospital			***0***	***127***	***17***	***27***	***83***	***0***
Exodus Recovery Inc.	Psychiatric Health Facility	N/A	0	16	0	0	16	0
La Casa Psychiatric Health Facility	Psychiatric Health Facility	N/A	0	16	0	0	16	0
Star View Adolescent Center	Psychiatric Health Facility	N/A	0	16	0	16	0	0
Total Psychiatric Health Facility			***0***	***48***	***0***	***16***	***32***	***0***

SUBACUTE AND COMMUNITY RESIDENTIAL[53]

Facility Name	Facility Type	Service Area	Exclusive/Owned Beds	Operating Beds — Total	Operating Beds Ages 1–12	Operating Beds Ages 13–17	Operating Beds Ages 18–64	Operating Beds Ages 65+
Anne Sippi Clinic — Anne Sippi Clinic	Enriched Residential Services	4	0	37	0	0	37	0
Anne Sippi Clinic — Pasa Alta Manor	Enriched Residential Services	3	0	90	0	0	90	0
Anne Sippi Clinic — Valley Manor Guest Home	Enriched Residential Services	2	0	58	0	0	58	0
Bridges — Casitas Esperanza	Enriched Residential Services	3	0	12	0	0	12	0
Cedar Street Homes — Homes For Life Foundation-HFL Cedar Street Homes	Enriched Residential Services	7	0	38	0	0	38	0
Gateways Normandie Village — Gateways Normandie Village East	Enriched Residential Services	4	0	60	0	0	60	0
Gateways Satellite — Gateways Satellite	Enriched Residential Services	4	0	38	0	0	38	0
Percy Village — Gateways Hospital And MHC	Enriched Residential Services	4	0	136	0	0	136	0

[53] Includes facilities with pending licenses.

Facility Name	Facility Type	Service Area	Exclusive/Owned Beds	Operating Beds — Total	Operating Beds Ages 1–12	Operating Beds Ages 13–17	Operating Beds Ages 18–64	Operating Beds Ages 65+
Special Services For Groups And Special Needs Program — Adams Residential Care Facility	Enriched Residential Services	6	0	63	0	0	63	0
Special Services For Groups And Special Needs Program — Founders House Of Hope	Enriched Residential Services	7	0	98	0	0	98	0
Special Services For Groups And Special Needs Program — Parkview Manor	Enriched Residential Services	4	0	86	0	0	86	0
Special Services For Groups And Special Needs Program — Westside Manor	Enriched Residential Services	6	0	136	0	0	136	0
Special Services For Groups And Special Needs Program — Windsor Hall Care Home Inc.	Enriched Residential Services	4	0	82	0	0	82	0
Telecare 7 — Bay Breeze Care	Enriched Residential Services	8	0	76	0	0	76	0
Telecare 7 — Founders House Of Hope	Enriched Residential Services	7	0	98	0	0	98	0

Facility Name	Facility Type	Service Area	Exclusive/Owned Beds	Operating Beds — Total	Operating Beds Ages 1–12	Operating Beds Ages 13–17	Operating Beds Ages 18–64	Operating Beds Ages 65+
Telecare 7 — Pico Rivera Gardens	Enriched Residential Services	7	0	185	0	0	185	0
Total Enriched Residential Services			*0*	*1,293*	*0*	*0*	*1,303*	*0*
Boys Republic	Short-Term Residential Therapeutic Program	3	0	8		X		
Boys Republic — ILS	Short-Term Residential Therapeutic Program	OOC	0	118		X		
Boys Republic — Pomona	Short-Term Residential Therapeutic Program	3	0	8		X		
Boys Republic — Silver Lake	Short-Term Residential Therapeutic Program	4	0	6		X		
Child Help — Beaumont	Short-Term Residential Therapeutic Program	OOC	0	21		X		
Crittenton Services for Child & Family — HQ	Short-Term Residential Therapeutic Program	OOC	0	54		X		
David & Margaret	Short-Term Residential Therapeutic Program	3	0	40		X	X	
Eggleston — LaVerne II	Short-Term Residential Therapeutic Program	3	0	6		X		
Eggleston Transitional GH	Short-Term Residential Therapeutic Program	3	0	6		X		
Eggleston West Covina GH	Short-Term Residential Therapeutic Program	3	0	6		X		
Eggleston Youth Center I	Short-Term Residential Therapeutic Program	3	0	6		X		

Facility Name	Facility Type	Service Area	Exclusive/Owned Beds	Operating Beds — Total	Operating Beds Ages 1–12	Operating Beds Ages 13–17	Operating Beds Ages 18–64	Operating Beds Ages 65+
Eggleston Youth Center II	Short-Term Residential Therapeutic Program	3	0	6		X		
Eggleston Youth Center IV	Short-Term Residential Therapeutic Program	3	0	6		X		
Five Acres	Short-Term Residential Therapeutic Program	3	0	70	X	X		
Five Acres — Solita	Short-Term Residential Therapeutic Program	3	0	6	X	X		
Hathaway — Sycamores	Short-Term Residential Therapeutic Program	3	0	43		X		
Haynes Family of Programs	Short-Term Residential Therapeutic Program	3	0	72	X	X	X	
Heritage Group Home I	Short-Term Residential Therapeutic Program	3	0	6		X		
Heritage Group Home II	Short-Term Residential Therapeutic Program	3	0	6		X		
Heritage Group Home III	Short-Term Residential Therapeutic Program	3	0	6		X		
Heritage Group Home IV	Short-Term Residential Therapeutic Program	3	0	6		X		
Heritage Group Home V	Short-Term Residential Therapeutic Program	7	0	6		X		
Hillsides	Short-Term Residential Therapeutic Program	3	0	50	X	X	X	
LA Youth Network	Short-Term Residential Therapeutic Program	4	0	16		X		

Facility Name	Facility Type	Service Area	Exclusive/Owned Beds	Operating Beds — Total	Operating Beds Ages 1–12	Operating Beds Ages 13–17	Operating Beds Ages 18–64	Operating Beds Ages 65+
Maryvale (72 operating at 60)	Short-Term Residential Therapeutic Program	3	0	60		X		
McKinley	Short-Term Residential Therapeutic Program	3	0	28	X	X	X	
Optimist — Boys Ranch & Home	Short-Term Residential Therapeutic Program	4	0	85		X		
Optimist — Carson	Short-Term Residential Therapeutic Program	8	0	6		X		
Optimist — Eagle Rock	Short-Term Residential Therapeutic Program	4	0	6		X		
Optimist — Mission Hills	Short-Term Residential Therapeutic Program	2	0	6		X		
Optimist — Pacific Lodge	Short-Term Residential Therapeutic Program	2	0	51		X		
Optimist — Van Nuys	Short-Term Residential Therapeutic Program	2	0	6		X		
Rancho San Antonio	Short-Term Residential Therapeutic Program	2	0	106		X	X	
San Gabriel Children's Center	Short-Term Residential Therapeutic Program	3	0	6		X	X	
San Gabriel Children's Center	Short-Term Residential Therapeutic Program	3	0	6		X	X	
St. Anne's	Short-Term Residential Therapeutic Program	4	0	32		X		
Trinity — Apple Valley	Short-Term Residential Therapeutic Program	OOC	0	48		X		

Facility Name	Facility Type	Service Area	Exclusive/Owned Beds	Operating Beds — Total	Operating Beds Ages 1–12	Operating Beds Ages 13–17	Operating Beds Ages 18–64	Operating Beds Ages 65+
Trinity — El Monte	Short-Term Residential Therapeutic Program	3	0	43		X		
Trinity — Yucaipa	Short-Term Residential Therapeutic Program	OOC	0	44		X		
Victor — Bonnie House	Short-Term Residential Therapeutic Program	3	0	6		X	X	
Victor — 500 House	Short-Term Residential Therapeutic Program	3	0	6		X	X	
Victor — Green House	Short-Term Residential Therapeutic Program	3	0	6		X	X	
Victor — Romberger House	Short-Term Residential Therapeutic Program	3	0	6		X	X	
Victor — The Cottage	Short-Term Residential Therapeutic Program	3	0	15		X	X	
Vista Del Mar	Short-Term Residential Therapeutic Program	5	0	24		X	X	
Wayfinder	Short-Term Residential Therapeutic Program	6	0	32		X	X	
Total Short-Term Residential Therapeutic Program			***0***	***1,206***				

APPENDIX B

SUD PROVIDER INVENTORY

Agency Name	Address	Phone Number	LOC	Age Group	Licensed Beds	Contracted Beds	SUP	SPA
Alcoholism Center for Women, Inc.	1135 South Alvarado Street, Los Angeles, CA 90006	(213) 381-8500	ASAM 3.1	18 years and older	32	32	1	6
American Indian Changing Spirits	2120 West Williams Street, Buildings 1 and 2, Long Beach, CA 90810	(562) 388-8118	ASAM 3.1	18 years and older	30	30	2	8
Asian American Drug Abuse Program, Inc.	5318 Crenshaw Boulevard, Los Angeles, CA 90043	(323) 293-6284	ASAM 3.1; ASAM 3.1/Perinatal	12 years and older	35	32	2	6
Asian American Drug Abuse Program, Inc.	5825 West Olympic Boulevard, Los Angeles, CA 90036	(323) 933-9022	ASAM 3.1	12 years and older	16	16	2	4
Beacon House Association of San Pedro (THE)	1003 South Beacon Street, San Pedro, CA 90731	(310) 514-4940	ASAM 3.1	18 years and older	18	17	4	8
Beacon House Association Of San Pedro (THE)	132 West 10th Street, San Pedro, CA 90731	(310) 514-4940	ASAM 3.1	18 years and older	20	11	4	8
Behavioral Health Services, Inc.	12917 Cerise Avenue, Hawthorne, CA 90250	(310) 675-4431	ASAM 3.1, 3.2, 3.5	All Ages	23	23	2	8
Behavioral Health Services, Inc.	1775 Chestnut Avenue, Long Beach, CA 90813	(310) 533-4498	ASAM 3.1, 3.2, 3.3	All Ages	63	62	4	8

Agency Name	Address	Phone Number	LOC	Age Group	Licensed Beds	Contracted Beds	SUP	SPA
Behavioral Health Services, Inc.	2180 West Valley Boulevard, Floor 200, Pomona, CA 91768	(909) 865-2336	ASAM 3.1, 3.2, 3.3	All Ages	50	50	1	3
Behavioral Health Services, Inc.	2180 West Valley Boulevard, Floors 100, 300 and 400, Pomona, CA 91768	(909) 865-2336	ASAM 3.1, 3.2, 3.3, 3.5	All Ages	123	121	1	3
Behavioral Health Services, Inc.	2180 West Valley Boulevard, Pomona, 91768	(909) 865-2336	ASAM 3.2	18 years and older	50	2	1	3
Behavioral Health Services, Inc.	2501 West El Segundo Boulevard, Hawthorne, CA 90250	(310) 679-9031	ASAM 3.1, 3.2, 3.5	All Ages	58	58	2	8
Behavioral Health Services, Inc.	341 and 351 East 6th Street, Long Beach, CA 90802	(562) 435-7350	ASAM 3.1, 3.2, 3.5	All Ages	19	18	4	8
Behavioral Health Services, Inc.	615 Elm Avenue, Long Beach, CA 90802	(562) 435-7350	ASAM 3.1, 3.2, 3.5	All Ages	8	7	4	8
California Hispanic Commission on Alcohol and Drug Abuse, Inc.	2436 Wabash Avenue, Los Angeles, CA 90033	(323) 780-8756	ASAM 3.1	12 years and older	6	6	1	4
California Hispanic Commission on Alcohol and Drug Abuse, Inc.	327 North St. Louis Street, Los Angeles, CA 90033	(323) 261-7810	ASAM 3.1	12 years and older	6	6	1	7

Agency Name	Address	Phone Number	LOC	Age Group	Licensed Beds	Contracted Beds	SUP	SPA
Canon Human Services, Inc.	9705 South Holmes Avenue, Los Angeles, CA 90002	(323) 249-9097	ASAM 3.1	18 years and older	43	35	2	6
Chabad of California, Inc.	5675 West Olympic Boulevard, Los Angeles, CA 90036	(323) 965-1365	ASAM 3.1, 3.5	18 years and older	44	44	2	4
Clare Foundation, Inc.	844 Pico Boulevard, Santa Monica, CA 90405	(310) 314-6200 x4014	ASAM 3.1, 3.2, 3.5	18 years and older	40	36	3	6
Clare Foundation, Inc.	905 and 907 Pico Boulevard, Santa Monica, CA 90405	(310) 314-6200 x4012	ASAM 3.1, 3.2, 3.5	18 years and older	49	30	4	6
CRI-Help, Inc.	11027 Burbank Boulevard, North Hollywood, CA 91601	(818) 985-8323	ASAM 3.1, 3.2, 3.5	12 years and older	135	75	3	2
CRI-Help, Inc.	2010 North Lincoln Park Avenue, Lincoln Heights, CA 90031	(818) 985-8323	ASAM 3.1, 3.5	12 years and older	41	40	1	4
Didi Hirsch Psychiatric Service	11643 Glenoaks Boulevard, Pacoima, CA 91331	(818) 897-2609	ASAM 3.1, 3.2, 3.5	All Ages	40	38	3	2
Fred Brown's Recovery Services, Inc.	270 West 14th Street, San Pedro, CA 90731	(310) 519-8723	ASAM 3.1, 3.3, 3.5	18 years and older	14	14	4	8
Fred Brown's Recovery Services, Inc.	276 West 14th Street, San Pedro, CA 90731	(310) 519-8723	ASAM 3.1, 3.3, 3.5	18 years and older	4	4	4	8
Fred Brown's Recovery Services, Inc.	278 West 14th Street, San Pedro, CA 90731	(310) 519-8723	ASAM 3.1, 3.3, 3.5	18 years and older	6	6	4	8

Agency Name	Address	Phone Number	LOC	Age Group	Licensed Beds	Contracted Beds	SUP	SPA
Grandview Foundation, Inc.	1230 North Marengo Avenue, Pasadena, CA 91103	(626) 797-1124	ASAM 3.1, 3.2, 3.5	18 years and older	13	13	5	3
Grandview Foundation, Inc.	225 Grandview Street, Pasadena, CA 91104	(626) 797-1124	ASAM 3.1, 3.2, 3.5	18 years and older	20	20	5	3
HealthRIGHT 360	6109 Afton Place, Los Angeles, 90028	(888) 705-9930	ASAM 3.1, 3.2, 3.5	18 years and older	34	12	3	4
HealthRIGHT 360	845 East Arrow Highway, Pomona, 91767	(909) 624-1233	ASAM 3.1, 3.2, 3.3, 3.5; ASAM 3.1/Perinatal, 3.2/Perinatal, 3.3/Perinatal, 3.5/Perinatal	All Ages	164	100	1	3
His Sheltering Arms, Inc.	11101 South Main Street, Los Angeles, CA 90061	(323) 755-6646	ASAM 3.1	18 through 65 years old	19	16	2	6
House of Hope Foundation, Inc.	235 West 9th Street, San Pedro, CA 90731	(310) 831-9411	ASAM 3.1, 3.2, 3.5	18 years and older	8	8	4	8
JWCH Institute, Inc.	303 East 52nd Street, Los Angeles, CA 90011	(323) 918-2139	ASAM 3.1, 3.5; ASAM 3.1/Perinatal, 3.5/Perinatal	18 years and older	31	31	2	6
Little House	9718 Harvard Street, Bellflower, CA 90706	(562) 925-2777	ASAM 3.1, 3.5	18 years and older	28	24	4	7
Los Angeles Centers for Alcohol and Drug Abuse	10425 Painter Avenue, Santa Fe Springs, CA 90670	(562) 906-2685	ASAM 3.1, 3.2, 3.5	12 years and older	55	41	4	7

Agency Name	Address	Phone Number	LOC	Age Group	Licensed Beds	Contracted Beds	SUP	SPA
Palm House, Inc.	2515 East Jefferson Street, Carson, CA 90810	(310) 830-7803	ASAM 3.1	18 years and older	16	16	2	8
Penny Lane Centers	15302 Rayen Street, North Hills, CA 91343	(818) 892-3423	ASAM 3.1, 3.5	12 years and older	50	50	3	2
People Coordinated Services of Southern California	1319 South Manhattan Place, Los Angeles, CA 90019	(323) 734-1143	ASAM 3.1	18 years and older	40	24	2	4
People Coordinated Services of Southern California	4771 South Main Street, Los Angeles, CA 90037	(323) 734-1143	ASAM 3.1	18 years and older	40	24	2	6
Phoenix Houses of Los Angeles, Inc.	11600 Eldridge Avenue, Lake View Terrace, CA 91342	(818) 686-3000	ASAM 3.1, 3.2, 3.5	12 years and older	140	40	2	1
Phoenix Houses of Los Angeles, Inc.	503 Ocean Front Walk, Venice, CA 90291	(310) 392-3070	ASAM 3.1, 3.2, 3.5	12 years and older	53	53	3	5
Principles, Inc.	1680 North Fair Oaks Avenue, Pasadena, CA 91103	(626) 798-0884	ASAM 3.1, 3.2, 3.5	18 years and older	130	98	5	3
Safe Refuge (Original Name: Substance Abuse Foundation of Long Beach, Inc.)	3111 East Seventh Street, Long Beach, CA 90804	(562) 987-5722	ASAM 3.1, 3.2, 3.5	18 years and older	6	3	4	8

Agency Name	Address	Phone Number	LOC	Age Group	Licensed Beds	Contracted Beds	SUP	SPA
Safe Refuge (Original Name: Substance Abuse Foundation of Long Beach, Inc.)	3113 East Seventh Street, Long Beach, CA 90804	(562) 987-5722	ASAM 3.1, 3.2, 3.5	18 years and older	4	2	4	8
Safe Refuge (Original Name: Substance Abuse Foundation of Long Beach, Inc.)	3115 East Seventh Street, Long Beach, CA 90804	(562) 987-5722	ASAM 3.1, 3.2, 3.5	18 years and older	6	5	4	8
Safe Refuge (Original Name: Substance Abuse Foundation of Long Beach, Inc.)	3119 East Seventh Street, Long Beach, CA 90804	(562) 987-5722	ASAM 3.1, 3.2, 3.5	18 years and older	2	1	4	8
Safe Refuge (Original Name: Substance Abuse Foundation of Long Beach, Inc.)	3125 East Seventh Street, Long Beach, CA 90804	(562) 987-5722	ASAM 3.1, 3.2, 3.5	18 years and older	6	3	4	8
Safe Refuge (Original Name: Substance Abuse Foundation of Long Beach, Inc.)	3131 East 7th Street, Apt.1, 3, 4, 5, 6, Long Beach, CA 90804	(562) 987-5722	ASAM 3.1, 3.2, 3.5	18 years and older	18	7	4	8

Agency Name	Address	Phone Number	LOC	Age Group	Licensed Beds	Contracted Beds	SUP	SPA
Safe Refuge (Original Name: Substance Abuse Foundation of Long Beach, Inc.)	718 Freeman Avenue, Long Beach, CA 90804	(562) 987-5722	ASAM 3.1, 3.2, 3.5	18 years and older	6	3	4	8
Safe Refuge (Original Name: Substance Abuse Foundation of Long Beach, Inc.)	719 Obispo Avenue, Apts. 1-10, Long Beach, CA 90804	(562) 987-5722	ASAM 3.1, 3.2, 3.5	18 years and older	19	12	4	8
Safe Refuge (Original Name: Substance Abuse Foundation of Long Beach, Inc.)	727 Obispo Avenue, Long Beach, CA 90804	(562) 987-5722	ASAM 3.1, 3.2, 3.5	18 years and older	4	2	4	8
Safe Refuge (Original Name: Substance Abuse Foundation of Long Beach, Inc.)	728 1/2 Freeman Avenue, Long Beach, CA 90804	(562) 987-5722	ASAM 3.1, 3.2, 3.5	18 years and older	4	2	4	8
Safe Refuge (Original Name: Substance Abuse Foundation of Long Beach, Inc.)	728 Freeman Avenue, Long Beach, CA 90804	(562) 987-5722	ASAM 3.1, 3.2, 3.5	18 years and older	6	4	4	8

Agency Name	Address	Phone Number	LOC	Age Group	Licensed Beds	Contracted Beds	SUP	SPA
Safe Refuge (Original Name: Substance Abuse Foundation of Long Beach, Inc.)	728-A Freeman Avenue, Long Beach, CA 90804	(562) 987-5722	ASAM 3.1, 3.2, 3.5	18 years and older	2	1	4	8
Safe Refuge (Original Name: Substance Abuse Foundation of Long Beach, Inc.)	729 Obispo Avenue, Long Beach, CA 90804	(562) 987-5722	ASAM 3.1, 3.2, 3.5	18 years and older	6	3	4	8
Shields for Families, Inc.	801 West 70th Street, Los Angeles, CA 90044	(323) 759-0340	ASAM 3.1, 3.5	12 years and older	46	46	2	6
Social Model Recovery Systems, Inc.	155 South Bimini Place, Los Angeles, CA 90004	(213) 388-1937	ASAM 3.1, 3.5	12 years and older	84	18	2	4
Social Model Recovery Systems, Inc.	17719 East Cypress Street, Covina, CA 91722	(626) 858-4920	ASAM 3.1, 3.5	12 years and older	6	5	5	3
Social Model Recovery Systems, Inc.	17727 East Cypress Street, Covina, CA 91722	(626) 858-4920	ASAM 3.1, 3.5	12 years and older	12	5	5	3
Social Model Recovery Systems, Inc.	23701 East Fork Road, Azusa, CA 91702	(626) 250-3291	ASAM 3.1, 3.5	12 years and older	38	7	5	3
Social Model Recovery Systems, Inc.	3430 Cogswell Road, El Monte, CA 91732	(626) 453-3406	ASAM 3.1, 3.3, 3.5	12 years and older	18	10	1	3

Agency Name	Address	Phone Number	LOC	Age Group	Licensed Beds	Contracted Beds	SUP	SPA
Social Model Recovery Systems, Inc.	360 South Westlake Avenue, Los Angeles, CA 90057	(213) 483-9202	ASAM 3.1, 3.5	12 years and older	115	31	1	4
Social Model Recovery Systems, Inc.	4439, 4445, and 4455 Burns Avenue, Los Angeles, CA 90029	(323) 664-8969	ASAM 3.1, 3.5	12 years and older	76	24	3	4
Social Model Recovery Systems, Inc.	453 South Indiana Street, Los Angeles, CA 90063	(323) 266-7726	ASAM 3.1, 3.5	12 years and older	13	11	1	4
Southern California Alcohol and Drug Programs, Inc.	10603 Downey Avenue, Downey, CA 90241	(562) 622-2268	ASAM 3.1, 3.2, 3.5	18 years and older	6	6	4	7
Southern California Alcohol and Drug Programs, Inc.	10615 Downey Avenue, Downey, CA 90241	(562) 622-2268	ASAM 3.1, 3.2, 3.5	18 years and older	6	6	4	7
Southern California Alcohol and Drug Programs, Inc.	10621 Downey Avenue, Downey, CA 90241	(562) 622-2268	ASAM 3.1, 3.2, 3.5	18 years and older	6	6	4	7
Southern California Alcohol and Drug Programs, Inc.	16316, 16316 1/2, 16318, 16322, 16322 1/2 and 16322 7/8 Cornuta Avenue, Bellflower, CA 90706	(562) 461-9272	ASAM 3.1, 3.5	18 years and older	30	30	4	7

Agency Name	Address	Phone Number	LOC	Age Group	Licensed Beds	Contracted Beds	SUP	SPA
Southern California Alcohol and Drug Programs, Inc.	8332 Iowa Street and 11501 Dolan Avenue, Downey, CA 90241	(562) 923-7894	ASAM 3.1, 3.2, 3.5	18 years and older	47	47	4	7
Tarzana Treatment Centers, Inc.	18646 Oxnard Street, Tarzana, CA 91356	(818) 996-1051	ASAM 3.1, 3.2, 3.3, 3.5; ASAM 3.1/Perinatal, 3.2/Perinatal, 3.3/Perinatal, 3.5/Perinatal	All Ages	152	88	3	2
Tarzana Treatment Centers, Inc.	2101 Magnolia Avenue, Long Beach, CA 90806	(562) 218-1868	ASAM 3.1, 3.2, 3.3, 3.5; ASAM 3.1/Perinatal, 3.2/Perinatal, 3.3/Perinatal, 3.5/Perinatal	18 years and older	84	22	4	8
Tarzana Treatment Centers, Inc.	44447 North 10th Street, Building B, Lancaster, CA 93534	(661) 726-2630	ASAM 3.1, 3.2, 3.3, 3.5; ASAM 3.1/Perinatal, 3.2/Perinatal, 3.3/Perinatal, 3.5/Perinatal	18 years and older	40	13	5	1
Tarzana Treatment Centers, Inc.	44447 North 10th Street, Building C, Lancaster, CA 93534	(661) 726-2630	ASAM 3.1, 3.5	12 years and older	40	38	5	1
The Salvation Army, A California Corporation	3107 South Grand Avenue, Los Angeles, CA 90007	(213) 748-0391	ASAM 3.1	18 years and older	56	20	1	6
The Salvation Army, A California Corporation	5600 Rickenbacker Road, Building 2A-B, Bell, CA 90201	(323) 263-1203	ASAM 3.1, 3.5	18 years and older	75	50	1	7

Agency Name	Address	Phone Number	LOC	Age Group	Licensed Beds	Contracted Beds	SUP	SPA
The Teen Project, Inc., D.B.A. FREEHAB	8140 Sunland Boulevard, Sun Valley, CA 91352	(818) 582-8832	ASAM 3.1, 3.2	18 years and older	74	40	3	2
Van Ness Recovery House	1919 North Beachwood Drive, Los Angeles, CA 90068	(323) 463-4266	ASAM 3.1, 3.5	18 years and older	20	15	3	4
Volunteers of America of Los Angeles	515 East 6th Street, 9th Floor, Los Angeles, CA 90021	(213) 489-3786	ASAM 3.1, 3.2	18 years and older	48	48	2	4
Watts Healthcare Corporation, D.B.A. House of UHURU	8005 South Figueroa Street, Los Angeles, CA 90003	(323) 568-5400	ASAM 3.1, 3.5; ASAM 3.1/Perinatal	18 years and older	66	66	2	6

APPENDIX C

BED EXPANSION CALCULATIONS

Examples are provided below to illustrate the model to calculate estimated bed expansion.

Specialized Subacute – Illustration of Bed Expansion Formula

Step 1: Unique Users (FY 2017) X (expected growth rate)
892 unique users + [.04 growth rate or 1,800 new users] X .018 proportion of all individuals utilizing facility type during FY 2017 = 32 additional projected users x 3 years (FY 2018, FY 2019 and FY 2020) = expected growth of 96 additional users.

892 + 96 = 988 expected users

Step 2: Number of users waiting for facility (FY 2017) (+) expected users
508 unique users during FY 2017 placed on waitlist for specialized subacute X 45.6 average days to place = 23,165 days to place all individuals waiting/365 days or 63.46 users placed per year.

508 unique users – 63.46 unique users placed = 444.54 adjusted number of persons waiting.

444.54 number of persons waiting subtract .28 that don't get placed = 320 adjusted users waiting.

988 (expected users) + adjusted number of individuals waiting for care setting (320) = 1,308 expected user demand.

Step 3: Calculating expected bed days per year
Expected users = 1,308

1,308 X 365 days = 477,420 expected bed days per year

Adjustment to achieve/maintain 90% occupancy rate = 525,162 expected bed days per year

Step 4: Calculate FY 2017 occupancy rate against all operating beds
52% or .52 (FY 2017 occupancy rate of all operating beds) X (1,058 operating beds) = 550 beds utilized during FY 2017.

Step 5: Calculate beds needed to accommodate expected users (90% occupancy rate)
525,162 expected bed days (see Step 3) / 365 days = 1,439 beds needed.

Step 6: Calculate the estimated expansion of bed capacity if maintaining existing bed utilization
1,439 beds needed – 550 beds utilized during FY 2017 (see Step 4) = **889 additional beds needed** [assumes that the occupancy rate is maintained at 52% of the original operating bed capacity (n=1,058)]. If more of the original operating beds can be utilized, the need to expand beds will decrease accordingly.

For facility types that have shorter lengths of stay (e.g., acute psychiatric hospital care settings), the formula was adjusted to reflect the reality that a bed will be available to multiple users over the course of the year. Below is an illustration of the calculation used for computing estimated bed expansion for Short-Doyle facilities and ASAM LOC 3.1, Low Intensity Residential + Perinatal.

Short-Doyle Facility – Illustration of Bed Expansion Formula

Step 1: Unique Users (FY 2017) X (expected growth rate)
2,062 unique users + [.04 growth rate or 1,800 new users] X .040 proportion of all individuals utilizing facility type during FY 2017 = 72 additional projected users x 3 years (FY 2018, FY 2019 and FY 2020) = expected growth of 216 additional users.

2,062 + 216 = 2,278 expected users

Step 2: Calculating users per bed per year (FY 2017)
2,062 unique users (FY 2017) / 82 contracted beds = 25.1 users per bed, per year

Step 3: Calculating expected users per bed per year
Expected users = 2,278
2,278 expected users / 25.1 users per bed, per year = 91 beds

To accommodate an occupancy rate of 90%, bed totals would be increased to accommodate 228 more users or an additional 9 beds.

Step 4: Calculate the estimated expansion of bed capacity if maintaining existing bed utilization or adjusting to 90% occupancy
100 beds needed to accommodate FY 2020 expected users subtract 82 current County exclusive beds = **18 (90% occupancy rate) additional beds needed**

ASAM LOC 3.1 – Low Intensity Residential + Perinatal

Step 1: Unique Users (FY 2017-2018) X (expected growth rate)
8,178 unique users + [.08 estimated growth rate or 867 new users] X .75 proportion of all individuals utilizing SUD residential facility type category during FY 2017-2018 = 650 additional projected users x 2 years (FY 2019 and FY 2020) = expected growth of 1,300 additional users.

8,178 + 1,300 = 9,478 expected users

Step 2: Calculating users per bed per year (FY 2017-2018)
8,178 unique users (FY 2017-2018) / 2,083 contracted beds = 3.92 users per bed, per year

Step 3: Calculating expected users per bed per year
Expected users = 9,478
9,478 expected users / 3.92 users per bed, per year = 2,418 beds

To accommodate an occupancy rate of 90%, bed totals would be increased to accommodate 241 more users or an additional 62 beds.

Step 4: Calculate the estimated expansion of bed capacity if maintaining existing bed utilization and adjusting to 90% occupancy

2,480 beds needed (2,418 + 62 = 2,480) to accommodate FY 2020 expected users subtract 2,083 current County exclusive beds = **397 (90% occupancy rate) additional beds needed**

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