

**CALIFORNIA MENTAL HEALTH PLANNING COUNCIL
Policy and System Development Committee**

MEETING HIGHLIGHTS

June 16, 2010

Hilton Oakland Airport
One Hegenberger Road
Oakland, CA 94621

Planning Council Members Present

Barbara Mitchell, Vice-Chair
Sophie Cabrera
Marissa Lee
Carmen Lee
Lin Benjamin
Joe Mortz
Jonathan Nibbio
Adrienne Cedro-Hament
R. Grant Jordan
Linné Stout
Mark Refowitz
Nadine Ford
Grant Jordan, MD

Others in Attendance

Planning Council Staff Present

Andi Murphy, Staff

Presenters

The Building Blocks of State Mental Health Data, *Ann Arneill-PY, Ph.D., Executive Officer, CMHPC,*
Mental Health Funding Primer, *Andi Murphy, Staff, CMHPC*
Bonita House Supported Housing Programs, *Rick Crispino, Executive Director, Bonita House*

Issue Requests

No issue requests were presented to the committee.

Welcome and Introductions

Barbara Mitchell called the meeting to order at 8:30 a.m. Members and guests introduced themselves.

The Building Blocks of State Mental Health Data

Ann Arneill-Py provided an overview and description of the data systems used by the Department of Mental Health. The overview included the pros and cons of using the data systems and explains how the data flows between the systems. There are eight data systems used by DMH:

Client Services Information (CSI)	County CSI Reporting Systems
Data Collection and Reporting (DCR) <i>(Full Service Partnership Outcomes)</i>	Web-based Data and Reporting System <i>(Consumer Perception Survey Data)</i>
Short-Doyle Medi-Cal Approved Claims Files	Medi-Cal Eligibility File
MHSA Revenue and Expenditure Reporting	MHSA Exhibit 6 Quarterly Reporting

The CSI system employs unique identifying County Client numbers that link data to other systems. It gathers encounter data out of each county's data collection system using the program that each county prefers, and captures demographic, service records, and quality of life indicators. The county reports are fed into the DMH CSI system monthly. While it does report services rendered, the system does not link to reimbursements, and the quality of life and demographic fields are poorly reported and inconsistent with annual updates.

Data Collections and Reporting Systems (DCR) use three types of forms – specific to age group - that are used to track key events in the lives of full-service partners. The three forms are designed to capture initial intake and assessment data (Partnership Assessment Form); records changes in employment, residence status, emergency interventions, criminal justice (Key Event Tracking Form); and, periodic updates/status checks (Quarterly Assessment). It uses an XML database which is very user friendly and compatible with electronic health data records, and also links to other data systems using the County Client Numbers. Many counties prefer to use their own systems, such as CAMINAR, due to process issues (county contractors cannot access/input the system, etc.). It is very comprehensive in some respects, but for a relatively small population (FSPs).

Web-Based Data and Reporting System (WBDRS) also links to CSI for demographics, and surveys families, youths (15 – 18), adults, and older adults on client satisfaction and perception of care. The survey dimensions include client satisfaction, cultural competency and language competency. Previously, the county surveyed twice a year for two week sample periods, but the state is in the process of converting to random sampling preferred by SAMHSA.

Short-Doyle Medi-Cal Approved Claims measure service delivery but not necessarily effectiveness of services received. While it is one way to measure prevalence and penetration, it is hampered by significant lags between when services were rendered and for when they were billed, and service records are confined to specialty mental health services. Like the DCR and the WBDRS, it links to the CSI system for demographics (as well as the Medi-Cal Eligibility database).

Medi-Cal Eligibility Files (MEFs) are maintained by the Department of Health Care Services. DMH is able to access eligibility and demographic information but other access is limited because they contain protected health information.

MHSA Annual Revenue and Expenditure Reports disclose revenue expenditure for each MHSA program/component by county on a quarterly basis. Formatting standards can be inconsistent across counties resulting in inaccurate information, and client-level cost information is not broken out. Current efforts are aimed at adapting the format to enable statewide data aggregation.

MHSA Exhibit 6 Quarterly Reports provide aggregated counts on the number of people receiving MHSA services by program and service category, but do not include demographic information. The counts of people are not unduplicated because they may be counted in the General System Development, and again in Outreach and engagement and the Community Services and Supports. Service category counts are broad and do not include the depth or types of services provided within the category.

The MHSA Annual Revenue and Expenditure and the MHSA Exhibit 6 reports link to each other but neither of them link to the CSI or other data systems.

Arneill-Py pointed out that CSI data displays have not always accurately reflected the actual client counts or rendered services accounted for in other data systems. The SD/MC system showed a jump between the FY 06-07 (\$680 m) and the FY08-09 (\$760 m) in paid claims, and EPSDT clients served showed a proportionate similar increase. However, the CSI client counts differed dramatically between FY06-07 (591 thousand clients) and FY 08-09 (433 thousand clients),

showing a substantial decrease rather than the increase you might expect based on the SD/MC adult and EPSDT client counts and expenditure. Some of this discrepancy might be due to the fact that the reporting requirements coincided with the counties switching over their data reporting systems.

There are also issues of inconsistent demographic counts and reconciliation shown in client records. The percentage of client records displaying as “invalid race” in FY07-08 was nearly 18.5% and somewhat improved in FY08-09 to nearly 12%. Even amongst the MHSA population Data bases, the counts on Active Unduplicated FSP partners vary between the DCR and the Exhibit 6.

- M. Refowitz The data is only as good as what the clinician puts on the form, and may be reluctant to ask, or leaving that decision to somebody at the front desk.
- J. Mortz A major thread of yesterday’s discussion at the Cultural Competency committee was the sense that reporting was burdensome to some directors.
 My sense from yesterday’s meeting was that there seems to be kind of a disconnect
- A. Cedro-Hament between the data requirements that the state requests and that counties report, and the data the state reports back - it does not truly reflect the counties.

Mental Health Funding Primer

Andi Murphy presented a CMHDA PowerPoint on the sources and history of Mental Health Financing that included some of the following points:

In 1965, Congress passed Titles 18 and 19, which called for providing medical services for the elderly, certain disabilities, and the poor. This was also when the IMD exclusion was instituted, which specifically prohibits states or counties from drawing matching federal Medicaid funds for mental health services to adult populations. (Children and the elderly were exempted through later legislation, at the discretion of the state). IMDs have 16 or more beds, with 51% of the population receiving mental health services. The IMD exclusion was specifically instituted in order for the federal government to avoid the financial responsibility of caring for institutionalized mentally ill or prisoners.

In 1966, California implemented the Medi-Cal program, using a “Fee for Service” Reimbursement model. These services included psych inpatient hospital services, nursing facility care, and psychiatrists and psychologists’ services.

In 1971, California added Short Doyle Medi-Cal community mental health services into mental health funding, which required counties to obtain the reimbursements through negotiated rates approved by the DMH, known as the State Maximum Allowance (SMA), which is updated annually. This shift also broadened the array of services to include inpatient hospital services delivered in acute care facilities, outpatient individual, group, or family therapy, and partial or full day treatment programs.

This is essentially the crux of why Counties always struggle with providing mental health services. Meanwhile, the services categories kept increasing. In 1984, AB 3632 was enacted, and mandated that counties provide mental health services to students (Fed IDEA – Individuals with Disabilities Education Act.) paid through State General Fund, but not matched. Although well intended, the funds counties received have never matched what they spent. In 1988, Targeted Case Management Services were added to SD/MC drawing on State General Fund (SGF) and Federal Financial Participation (FFP).

Recognizing that Mental Health Services funding was inequitable due to its “non-mandated” status, the Legislature passed the Bronzan-McCorqudale Act in 1991, which identified permanent funding streams through vehicle licensing fees and ½ cent sales tax. This officially established the Realignment program – costs for care of Medi-Cal and indigent people shifted to counties, funded through a formula of state sales tax and vehicle

license fees. However, due to Mental Health services' status as a "non-entitlement" (covered under Titles VIII or IX), the funding is soon consumed by Social Service programs such as in-home support & foster care. This is essentially the crux of why Counties always struggle with providing mental health services. One of the key considerations of this is a factor of additional realignment is the growth of social services caseloads – they have to be funded first- so any additional money over the base funding goes to Social services first. It is worse when economic times are bad, since the money is based on the sales tax. We are presently back at 99-2000 levels. Vehicle license fees are a very small part of the financing. The IHHS has become a huge draw on the funds, due in part to the growth of the program and the recent decision to unionize the home health workers. Three different fund allocations come from the Department of Finance based on formulas for Public Health (includes health care for indigents¹), Social Services, and Mental Health, and counties can reassign up to 10% of their funds from one allocation to another.

The entitlement issue begs the question – why isn't mental health an entitlement? The short answer is that it is an entitlement for those who qualify for Medi-Cal services or EPSDT. For Medi-Cal mental health services, medical necessity criteria must be met, a valid treatment plan must be developed, etc. The uninsured do not have these benefits.

The Rehabilitation Option was added in 1993, which enhanced community-based (non-clinic) services, expanded service provider types from the "big 5" and permitted additional services, including long –term community care. The Bush administration tried to eliminate the Rehab option from Medicaid funding, but Obama rescinded it. The California budget May revise proposed eliminating the funding for rehab services, and there was talk about amending the State Plan to modify the Rehab option to conform exactly to federal standards. The final outcome won't be known until the FY2010-11 budget is passed.

After Realignment and inclusion of the Rehabilitation Option came "Consolidation" (Medi-Cal Specialty Mental Health Services Consolidation program) in 1995, enabled, in part by the 1915(b) Freedom of Choice Medicaid waiver, which permitted the state to consolidate SD/MC (county contractors) and FFS/MC (DHS certified providers). Under Consolidation, each county was now its own "Mental Health Plan" (MHP), a single, integrated source solely responsible for mental health care for its beneficiaries, including responsibility for inpatient hospitals and outpatient specialty mental health professional services previously shouldered by the state DHS. Under Certified Public Expense, the burden is on the county to provide the service, pay the contractor, and then request reimbursement from the state before the federal financial participation can be requested.

Bonita House Supported Housing Programs:

Rick Crispino, Executive Director, and Mark Shotwell, Program Director for the Homeless Outreach and Stabilization Team (HOST) Full Service Partnership program of Oakland's Bonita House presented on the history and outcomes of their program. Bonita House has been operating since it bought its first program house in 1970s. In 1991 it narrowed its focus on adults between the ages of 18 and 59. It has operated continuously through a patchwork of HCD, HUD, and MHSA housing programs and scattered site housing and collaborates with a variety of partners throughout Alameda county. All sites have rental subsidies through Section 8, Shelter + Care, MHSA, and tenants pay 30% of their own income toward the rent.

¹ This will be interesting to watch in 2014 when under national health care reform the federal government assumes the cost of caring for the medically indigent.

The HOST officially opened in Spring of 2007 and has enrolled 90 people to date. It has outreached to over 360 people since opening and establishes familiarity and trust building by providing water, food, hygiene kits and service referrals. Each partner gets to meet prospective landlords and visit rental units prior to deciding where they would like to live. It takes approximately 2 to 3 months to move from emergency to permanent, supported housing. Partners pay their rent to the program and the program pays the landlord. This has been very successful at earning and keeping the trust of the landlords, thereby ensuring that they will be open to keeping their units available to HOST partners. Should problems arise with collecting the Partner's share of the rent, eviction proceedings are handled between the Partner and the Program. The program has had a 96% retention rate and has locations in Berkeley, Alameda, Oakland, and Hayward.

Once established, residents have the option of receiving employment training or education through HOST's supported employment program. The program is consumer-driven, emphasizes choice, and has one full-time Supported Employment Specialist. It also has a self-paced college educational/vocational program that offers distance learning in several certificate programs such as cashier, administrative assistant, forklift driver, and warehousing. Forty-seven percent of the HOST partners are enrolled in training and 60% are either seeking employment, interns, or are actively employed.

- J. Mortz Is there a commonality of traits in the landlords who participate in your programs? Is it the solid business people who tend to be hot?
- R. Crispino It is more of a gradual relationship building and the bonus of not having to deal with evictions and guaranteed rent, and mostly it is word of mouth from other landlords. It is the larger, more solid business people and non-profits who are the coldest, because they have been burned before.
- C. Lee What do the owners/landlords get out of it?
- R. Crispino Aside from guaranteed rent and eviction services, they get supportive services to ensure good tenancy. It has been a soft market, so they have a quick turnaround on filling the units. Also, if something happens to the unit, we deploy our own staff to make repairs and restore the unit, regardless of their intent to rent to us again. We want the good reference for the next landlord.
- M. Shotwell Also, we are available to tenants and landlords 24/7 so we can do phone coaching or counseling, or go out if we need to. We follow through, we show up. The property managers don't have any resources. We are a resource for them, and the police too.
- Is Section 8 available?
- R. Crispino Right now the Section 8 wait list is closed. It is 5 or 6 years to even sign up to be on the waitlist. That's why you'll see 1,000 people show up for 80 vacancies. The new Alameda county program should help a little. People can rise up to the top of the wait list based on their circumstances.
- How do you deal with "not in my back yard"
- M. Shotwell We try not to set people up and to provide them with high quality, affordable housing. We try to match people that might need more tolerance with more tolerant neighborhoods, and they will move sometimes as many four times as they progress in their recovery.
- M. Lee What about TAY populations? Are there any special programs or considerations?
- R. Crispino Right now Alameda County has two TAY programs, and our focus is on adults between 18 – 59, so we don't see too many TAY in our programs.
- B. Mitchell Do you keep people in your program indefinitely if you have to wait for five years for the Section 8 waiting list to open up again?
- R. Crispino I don't think Alameda county is going to put a time limit on the rent subsidies. But, I do think that people can do with a lower level of care. We focus so much on employment in part because the wait list does take so long. People can start working from day one if they want to, just working at the \$10 an hour to start. We have lots of internal job opportunities too, preparing outreach packets, and moving services, Our education program is very robust.

- B. Mitchell Do you have any contractual obligations to enroll a certain number of people?
- C. Lee Have you had any problem with encouraging people to become partners?
- R. Crispino We've had people enroll and accept services, but not want housing and that is fine. He'll accept housing in extreme weather conditions, but otherwise not. Another gentleman prefers to live outside, but was getting hassled so much that we convinced him that if he cleaned his clothes and himself he'd look a lot less like a homeless person and wouldn't be such a target. We rented him a hotel room for 30 days out of the month, and he spent a few nights there at first, but he gradually warmed up to the place.
- R. Crispino We have a new program opening up in Alameda County, CHOICES for community living program. All FSPs serve folks that are new to the system, but there is a need for a way to exit or graduate mental health programs. It provides a recovery and support system to people who are presently well served for three to five years with a goal of them exiting the system and opening up their housing and services to others. It is a county-wide collaborative of pooled resources, and we provide the housing services. There is a very significant evaluation component to it because the theory has yet to be proven, and when it is, it will be able to be replicated.
- M. Refowitz Is this a CSS funded program or Innovation?
- R. Crispino This is through CSS and it was kind of a hassle to get it approved initially because the state didn't view it as an FSP because of the collaborative nature and because there was so much emphasis on housing, and also because this was a target population of people who were already considered "served" and living in dependent housing, like Board and Care and ready to be more independent. It operates on a three year (\$600 a month) or five year (\$360) rental subsidy. Partners work with the program to determine which meets their needs the best (longer term is better for completing an education and maybe having a roommate). It is web-based so that documentation is available to all of the partners – daily triage, treatment planning, progress notes, outcomes is posted, to ensure information is shared, with the whole team meeting weekly. Each service team is in many respects "FSP – like" but is limited due to client load.

Meeting Evaluation and Agenda Development for October 2010

The meeting was informative, but the complexity and potential application of the knowledge made the time allotted to the topics, made it feel like more time on them would have been helpful, particularly in regard to data. More dialogue with the people involved with Data (DMH, counties) would also be helpful in order to really understand the complexities and context of it. Sometimes the information was flowing so fast, that simply slowing down, and explaining acronyms to newer members would have been helpful.

Joe Mortz wanted to investigate Health Reform and its effect on mental health. He also felt that there should be a collaboration with the Judicial Council to establish a policy to mandate Mental health courts. Also an update on 1115 waiver and the 75 page concept paper sent to CMS and its response, if any, back to the state. If the state budget is passed by October, its impact on state and local mental health services programs is likely to be substantial and should be explored. Sacramento non-profit contractors now have to accept county employees in their programs under "71 J". Also, an update from HCD on the State vision for state supported housing now that 1C and Prop 46 monies are dwindling down as well as outcomes to date.

Respectfully submitted,

Andi Murphy, Staff, Policy and System Development Committee