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A Call for State Action:
Invest in Mental Health Services for Community Wellness

California is on the cusp of full implementation of the federal Affordable Care Act. Legislation to reform the individual insurance market, as well as reform and expand the Medi-Cal Program, will be enacted in 2013. Covered California, our health benefit exchange marketplace, is poised to commence pre-enrollment of eligible people by October 1, 2013, with health care coverage for all commencing January 1, 2014.

While the federal Affordable Care Act, coupled with the Mental Health Parity and Addiction Equity Act of 2008, provide enormous potential and opportunity for increased behavioral coverage, we need to acknowledge that access to mental health treatment services and supports is a substantial barrier.

Objectives

The Objectives of this call to action are to:

- Add 25 Mobile Crisis Support Teams and at least 2,000 Crisis Stabilization and Crisis Residential Treatment beds over the next two years to expand community-based resources. These resources would provide a comprehensive continuum of services to address short-term crisis, acute needs, and the longer-term ongoing treatment and rehabilitation opportunities of adults with mental health care disorders.
- Add at least 200 triage personnel over the next two years to specifically assist several thousand high-need individuals to access medical, specialty mental health care, alcohol and drug treatment, social, educational and other services.
- Capitalize on opportunities presented with implementation of federal Affordable Care Act and enroll uninsured eligible Californians into health care coverage.
- Reduce unnecessary hospitalizations and inpatient days by appropriately utilizing community-based services and access to timely assistance.

- Reduce recidivism and mitigate unnecessary expenditures for local law enforcement.
- Reinforce prevention and early intervention efforts to mitigate stigma and discrimination and facilitate people in need into assistance.
- Maximize federal funding opportunities, local realignment dollars, Proposition 63 Mental Health Services Act Funds, foundation grant funds, and State General Fund monies.

A. Enrollment in Coverage & Triage Case Management Assistance

Statewide expansion of Medi-Cal to include low-income adults will provide significant policy benefits, including increased access to health care coverage, improved health outcomes for over a million Californians, and an infusion of new federal funds which can be substantially leveraged. Our Special Session legislation—SB X1 1 (Hernandez and Steinberg) and AB X1 1 (Perez)—is proceeding for full implementation.

Individuals not eligible for Medi-Cal may be eligible to purchase subsidized coverage through Covered California. Our Special Session legislation—SB X1 2(Hernandez) and AB X1 2 (Pan) has been sent to the Governor for his signature.

Research has shown that health care coverage is associated with increased use of preventive care, increased access to health care treatment and decreased mortality. The majority of people with behavioral health concerns first seek assistance in the primary care settings with about half of all care for common psychiatric disorders delivered by a primary care provider.

Adults with mental health needs were 1.5 times more likely to have a co-occurring chronic disease (high blood pressure, heart disease, or asthma) or to be diagnosed with two or more of these chronic conditions as compared to the general population. Further, individuals with severe mental health disorders served by public mental health systems have rates of co-occurring chronic conditions two to three times higher than the general population, with a corresponding life expectancy of 25 years less.

To facilitate enrollment into health care coverage, a streamlined enrollment approach, along with assistors and navigators is needed. A "no wrong door" action plan needs to be embraced to bring eligible people into coverage, to maintain continuity of coverage as appropriate, and to keep administrative costs efficient.

Actions to be taken:

1. *Medi-Cal Enrollment and Outreach Assistance.* Adopt Budget trailer bill language and funding to establish Medi-Cal enrollment assistance payments, and outreach and enrollment grants focused on reaching people who have special needs, including people with behavioral health needs, the homeless and transitioning populations from institutions such as county jail and state prison.

Leverage $26.5 million approved by The California Endowment to draw federal funds to provide a total of $53 million for this purpose. Of this total amount, $25 million will be specifically focused on reaching people who have special needs as noted above, to enroll in coverage and begin to obtain needed behavioral health services.

This partnership with The California Endowment will enable more than 500,000 individuals to be enrolled, or re-enroll, in coverage as appropriate. There is no impact on the State's General Fund.

2. *Facilitate Linkage to Services with Triage Personnel.* Adopt statutory language to comprehensively utilize targeted case management services available for Medi-Cal reimbursement to assist individuals in gaining access to needed medical, mental health treatment, substance use disorder assistance, social support services, rehabilitative services, educational services and other community services.

   Add at least 200 triage personnel in select urban and suburban regions over a two-year period for this purpose. Tens of thousands of high-need clients could be served annually by triage personnel. Triage personnel would be available at various points of access, such as at designated community-based service points, clinics, and homeless shelters.

   Community triage planning, led by County Mental Health Departments with a local designated workgroup, would be at the core of this process to identify priorities and key use of personnel. Where applicable, these personnel can be used in conjunction with hospital presumptive eligibility enrollment as discussed below to direct high need clients into appropriate care settings and reduce unnecessary hospitalizations

   These targeted case management services can be provided face-to-face, by telephone, or by telemedicine with the Medi-Cal enrollee or significant support person and may be provided anywhere in the community. The service activities include (1) communication, coordination, and referral; (2) monitoring service delivery to ensure the individual accesses and receives services; (3) monitoring the individual's progress; and (4) providing placement service assistance and service plan development.

   Various funding sources can be used for this purpose including County Realignment Funds, federal funds, Mental Health Services Act funds, and certain designated funds from hospitals.

3. *Hospital Presumptive Eligibility for Medi-Cal Enrollment.* Adopt statutory language to implement presumptive enrollment in hospital settings. This will enable hospitals to enroll individuals as appropriate into Medi-Cal coverage at the point-of-service. Presumptive eligibility is recognized as an effective tool in connecting uninsured individuals into coverage. This can facilitate getting individuals more readily into assessment, diagnosis and treatment as needed.

B. Expand Network Capacity for Continuum of Care

A renewed investment in community-based treatment options is imperative. Recent reports have called attention to a continuing problem of inappropriate and unnecessary utilization of hospital emergency rooms in California due to limited mental health services for individuals in psychological distress and acute psychiatric crisis.

For people with severe mental health care disorders, almost one-fifth visit a hospital emergency room *at least* once a year. If an adequate array of crisis services is not available, it leaves an individual with little choice but to access an emergency room for assistance and potentially an unnecessary inpatient hospitalization. However many of these individuals could be served very effectively in focused community-based programs. In addition, there has been a notable reduction in the number of private and public psychiatric hospital beds over the past several years and this continuing decline is leaving individuals with even fewer options.

Community-based treatment options, including crisis intervention through Mobile Crisis Support Teams, crisis stabilization or urgent care, and crisis residential treatment serve to mitigate the unnecessary utilization of hospital emergency rooms and limited psychiatric beds, and can serve to divert people from incarceration. These options offer a broader continuum of care and are proven models of care. In addition, as the costs for inpatient treatment continue to rise, the need to expand an appropriate array of treatment settings becomes more urgent.

Mobile Crisis Support Teams can be utilized to provide crisis intervention, family support, and Section 5150 evaluations. These Teams can meet law enforcement in the field and, among other things, provide diversion into appropriate treatment arrangements. Involvement of Peer Counselors, in addition to designated professionals, facilitates the team approach. These teams have been used in several areas across the State and have served to facilitate people into assistance as well as mitigating law enforcement expenditures.

Crisis Stabilization is an expedited service lasting less than 24-hours on behalf of a client for an urgent condition requiring immediate attention. The goal of crisis stabilization is to avoid the need for inpatient services which, if the symptoms are not treated, present an imminent concern to the client or others and increases the risk of the client becoming gravely disabled. Crisis stabilization must be provided on site at a licensed 24-hour health care facility or as designated by the Department of Health Care Services.

Crisis Residential Treatment Services are provided in a non-institutional residential setting which provides a structured program as an alternative to hospitalization for clients experiencing an acute psychiatric episode or crisis that do not have medical complications requiring nursing care. Programs provide crisis stabilization, medication monitoring, and evaluation to determine the need for the type and intensity of additional services to achieve wellness and recovery. This residential program typically serves from ten to sixteen clients in a home-like environment with professional personal and is required to meet specified requirements.

All of the above models of care are well defined in State statute and regulation and have been evaluated for their efficacy. All of these services would be provided within the scope of practice by professional staff as contained in existing State statute and regulation. These models of care serve as key components to the public mental health system and are all reimbursable by the Medi-Cal Program.

Actions to be taken:

1. *Grants to Expand Community Capacity.* Provide grant funds of up to $500,000 as applicable to leverage other public, non-profit, and private funding sources to develop infrastructure and provide start-up costs specifically for Mobile Crisis Support Teams, Crisis Stabilization, and Crisis Residential Treatment Services. The structure of these grants would be flexible to allow for regional development in rural areas, as well as to provide for unique and variable needs and geographic locations.

   For example, a community capacity grant could be used towards the following purposes:

   - Purchase of vehicles for Mobile Crisis Support Teams;
   - Purchase of living space to convert into Crisis Residential Treatment;
   - Remodeling of property for Crisis Intervention and Crisis Residential Treatment;
   - Assistance in meeting various licensing and certification requirements; and
   - Purchase of furnishings for Crisis Residential Treatment.

   Legislation will be forthcoming with designated funds being identified at the May Revision. Contingent upon funding opportunities and partnerships, a goal of adding at least 2,000 more Crisis and Crisis Residential beds to the public mental health system over the next two years is achievable. This will require working closely with local community leaders to partner in their development regarding siting, licensing and certification arrangements.

   Mobile Crisis Support Teams are more flexible by design but also need to be part of a continuum of care. Depending on regional needs and access to other services, a goal of implementing at least 25 new Mobile Crisis Support Teams over the next two years is achievable. These Teams can be particularly effective in partnership with local hospital systems and local law enforcement.

   Community capacity grants have been effective in other areas, including community clinic expansions and resource development for Regional Center services, and are much needed for mental health service capacity. There are proven models which the State has used to administer these types of community capacity grants and as such, an allocation process can be quickly implemented.

2. *Enact SB 364 (Steinberg).* Among several other aspects, this legislation broadens the types of facilities a county can designate for 5150 purposes to include licensed facilities, such as such as Psychiatric Hospital Facilities, free-standing Acute Psychiatric Hospitals and Psychiatric units in general hospitals, as well as certified facilities such as Crisis Stabilization Units. This will provide counties with more options for assisting clients with significant and grave needs, can assist in alleviating emergency room wait times for this client population, and most importantly, can offer a less restrictive environment for a client to receive necessary assistance. All of these services would be provided within the scope of practice by professional staff as contained in existing State statute and regulation.

C. Linkage with Public Safety Realignment

Research shows that people with mental health disorders are over-represented in the offender population, are twice as likely to have their community supervision revoked, and have more risk factors for recidivism. With the continued implementation of the 2011 Public Safety Realignment, additional focused mental health treatment services are imperative.

With the Medi-Cal expansion to include low-income adults, it is anticipated that the majority of the parolee population will be newly eligible for Medi-Cal and 100 percent federal financing (for three years declining to 90 percent in 2019) as part of the expansion. Enrollment into Medi-Cal for inmates leaving State Prison and county jails is fundamental to ensuring that mental health treatment can be provided readily upon release into the community. This presents an opportunity to restructure State provided services to save General Fund monies and reinvest into additional services.

The expanded network capacity as referenced in item B, above, will also be available to this population in the community. This expanded community-based assistance will serve to reduce the criminalization of mental health by providing treatment alternatives to reduce crisis situations and mitigate the potential for compulsive acts.

Actions to be taken:

1. ***Linkage between State Departments.*** Adopt statutory change to require the Department of Health Care Services (DHCS) and the California Department of Corrections (CDCR) to integrate the CalHEERS (Covered California eligibility system) web portal into its pre-release Medi-Cal application process. This will save General Fund support and serve to expedite Medi-Cal or Covered California enrollment as appropriate.

   Adopt statutory change to require the DHCS and CDCR to proceed with a federal waiver to obtain approval for Parolee Outpatient Clinics to become Medi-Cal providers which will save General Fund support.

D. Prevention and Early Intervention

One of the most ground-breaking elements of California's Mental Health Services Act is a requirement that 20 percent of funds allocated to counties be spent on Prevention and Early Intervention (PEI) programs. Both universal and selective approaches to prevention and early intervention efforts are used, including population-based approaches, and people identified as having the greatest risk based on specific symptoms or signs. The overall purpose of PEI is to prevent mental illnesses from becoming severe and disabling.

Actions to be taken:

1. *Statewide Projects.* Adopt statutory language to provide for certain prevention and early intervention projects to be conducted on a regional and statewide basis. This could include certain types of crisis intervention training such as for police officers and certain professional staff, as well as mental health first aid training. This would assist in addressing mental health issues as more of a public health concern and would provide focused value for the funds that may be available.