COUNTY OF SAN DIEGO

AGENDA ITEM

DRAFT

DATE: **September 27, 2022** **XX**

TO: Board of Supervisors

SUBJECT

UPDATE ON ADVANCING THE BEHAVIORAL HEALTH CONTINUUM OF CARE, RECALIBRATING LONG-TERM CARE THROUGH THE OPTIMAL CARE PATHWAYS MODEL (DISTRICTS: ALL)

OVERVIEW

Under the leadership of the San Diego Board of Supervisors (Board), behavioral health care in San Diego County is in the midst of a profound transformation. The County of San Diego (County) is taking action and making strategic investments to move the local behavioral health care delivery system from a model of care driven by crises, to one centered on continuous, coordinated care and prevention. These efforts, broadly referred to as the Behavioral Health Continuum of Care (Continuum of Care), are guided by data, focused on equity and designed to engender collaborative work across silos, within and outside of government.

Today's update to the Board includes outlines the progress that the Behavioral Health Services (BHS) department continues to make to advance work across the Continuum of Care. It also brings forward bold new strategies and solutions to further reform the behavioral health system by addressing underlying challenges and symptoms, specifically within the lack of specialized long-term, community-based care, and crisis diversion care capacity across the region. This requires us to *redefine long-term care* by expanding it to include community-based care services that provide continuous care and housing to people with behavioral health conditions who may have other complex health conditions.

Redefining long-term care also requires incorporating enhancements to community crisis diversion services through the addition of new peer crisis respite and transitional residential services to ensure new care pathways are available to divert individuals from unnecessary utilization of expensive acute care. These community crisis diversion services are part of a full crisis continuum that includes existing crisis stabilization units (CSUs), mobile crisis response teams (MCRTs), and crisis residential services.

To accelerate this transformation, BHS developed the Behavioral Health Continuum of Care Optimal Care Pathways model, a data-informed algorithm that quantifies optimal utilization across

service areas across the system. The optimal model recalibrates and expands current services along with adding new services to optimize care pathways, removes barriers to care, reduce per capita cost, and most importantly, connect individuals to the care they need, when they need it to meet their unique needs long term.

This item supports the County's vision of a just, sustainable, and resilient future for all, specifically those communities and populations in San Diego County that have been historically left behind, as well as our ongoing commitment to the regional *Live Well San Diego* vision of healthy, safe, and thriving communities. This will be accomplished by working across systems to support better care of individuals, better health for local populations, and more efficient health care resourcing.

RECOMMENDATION(S)
CHIEF ADMINISTRATIVE OFFICER

1. Receive an update on Advancing the Behavioral Health Continuum of Care.

EQUITY IMPACT STATEMENT

The County of San Diego (County) Health and Human Services Agency Behavioral Health Services (BHS) serves as the specialty behavioral health plan for Medi-Cal eligible residents within San Diego County who are experiencing serious mental illness or serious emotional disturbance, and the service delivery system for Medi-Cal eligible residents with substance use disorder care needs. As a steward of public health for the region, BHS must ensure that the resources and services offered through County-operated and contracted programs promote equitable outcomes, advance wellness across the continuum of need, and are equitably distributed based on the needs of the Region's diverse communities.

In support of these efforts, BHS utilizes a population health approach, incorporating evidence-based practices and robust data analysis, to identify need and design services that are impactful, equitable, and yield meaningful outcomes for clients. This includes facilitating ongoing engagement and input from the community, stakeholders, consumers, family members, community-based providers, and healthcare organizations through formal and informal convenings, along with cross-collaboration with other County departments and community partners. Additionally, through the establishment of the Community Experience Partnership, in collaboration with the University of California, San Diego, BHS is leading the development of the Behavioral Health Equity Index, a tool to help measure behavioral health equity that will inform program planning, siting of services, and allocation of resources in a way that supports the most pressing community needs.

If approved, today's actions will set a course for the Region's behavioral health system by progressing crisis and diversionary services, addressing the lack of step-down capacity, and supporting efforts to enhance care for youth. These actions will ultimately aim to reduce behavioral health inequities among the Region, advancing services that will impact vulnerable populations including individuals experiencing homelessness and those with justice involvement.

SUSTAINABILITY IMPACT STATEMENT

SUBJECT: UPDATE ON ADVANCING THE BEHAVIORAL HEALTH CONTINUUM OF CARE, RECALIBRATING LONG-TERM CARE THROUGH THE OPTIMAL CARE PATHWAYS MODEL (DISTRICTS: ALL)

Transforming the behavioral health continuum of care in San Diego County will result in sustainability enhancements in terms of health, wellbeing, and equity as we advance the regional distribution of services that will allow individuals to receive care that is in close proximity to their support systems and provides a wider availability and range of connections to care.

Today's actions will transform our approach to supporting individuals with behavioral health conditions in need of long-term community-based care and housing to address the barriers and parity issues that have historically prevented individuals from receiving the right care at the right time. Additionally, BHS will continue to explore thoughtful and sustainable building design for facilities outlined in Attachment A in alignment with the County's Sustainability Vision and Goals.

FISCAL IMPACT
TBD

BUSINESS IMPACT STATEMENT
N/A

ADVISORY BOARD STATEMENT
At their regular meeting on September 1, 2022, the Behavioral Health Advisory Board voted to _____ these recommendations.

BACKGROUND
Under the leadership of the San Diego Board of Supervisors (Board), behavioral health care in San Diego County is in the midst of a profound transformation. The County of San Diego (County) is taking action and making strategic investments to move the local behavioral health care delivery system from a model of care driven by crises to one centered on continuous, coordinated care and prevention. These efforts, broadly referred to as the Behavioral Health Continuum of Care (Continuum of Care), are guided by data, focused on equity, and designed to engender collaborative work across silos, within and outside of government.

Today's update to the Board includes a summary of progress of the portfolio of Continuum of Care projects that are bringing this transformation to life reported within the domains of Crisis and Diversionary Services; Inpatient Hubs and Care Coordination; and Residential and Long-Term Care, further detailed on *Attachment A*.

Today's update will also offer bold new recommendations to further reform the behavioral health system by addressing tow of the domains outlined within the Continuum of Care – *Crisis and Diversionary Services and Long-Term Care* – and the underlying challenges and symptoms across the system that continue to paralyze the region, specifically within the lack of step-down capacity, including long-term and community-based care for Medi-Cal eligible individuals who have behavioral health conditions. The Behavioral Health Continuum of Care Optimal Care Pathways (OCP) model outlined today identifies that optimal capacity needed to transform the system by prioritizing the unique needs of clients with behavioral health needs by offering new pathways to provide clinically effective care in the least restrictive environment. It also supports establishing

new care pathways that divert people from unnecessary utilization of expensive acute care and supports them long-term as they transition across settings.

Finally, BHS recognizes that the primary focus of much of the Continuum work over the last few years has been to address the behavioral health needs of adults. Today's update will outline efforts currently underway to develop a broad strategy to advance the behavioral needs of children, youth, and transition age youth across the region to support this vulnerable population.

Building on Transformative Efforts Currently Underway

In 2018, BHS began work to transform the behavioral health continuum of care with a particular focus on addressing the immediate needs for individuals experiencing behavioral health crises, which has resulted in major investments in:

- Psychiatric acute inpatient beds to support the increasing number of people in need of hospitalization;
- Regionally distributed crisis stabilization units (CSUs) to divert individuals experiencing a behavioral health crisis from unnecessarily utilizing emergency departments; and,
- The implementation of mobile crisis response teams countywide to provide immediate response in the field to individuals who are experiencing a behavioral health crisis with a team of behavioral health professionals rather than unnecessarily deploying law enforcement personnel.

The County has invested significantly in establishing access to outpatient treatment and crisis response services over the past few years to meet the urgent needs of the community and though they are critical aspects of our Continuum of Care, expansion of these services is just the beginning of a broader effort to shift toward more thoughtful upstream prevention by establishing a broader network of community-based care and housing that addresses the unique needs of individuals on a long-term basis.

To continue the transition from a system of crisis to one driven by upstream prevention and continuous care, the system must shift the focus from primarily mitigating symptoms to solution-based strategies that include a commitment to increasing the capacity of lower levels of ongoing care and housing to meet the unique needs social, environmental, and physical health needs of individuals. Outlined today is a proposal to *redefine and transform long-term care* within San Diego County to be more client-centered and support the social, environmental, and physical health needs of individuals in the least restrictive environment. Through a broad and comprehensive analysis, the Behavioral Health Continuum of Care Optimal Care Pathways (OCP) model outlines the need to establish new care pathways that better meet the long-term care needs of individuals through community-based care, along with a focus on services that divert individuals from unnecessary utilization of acute care.

Highlights from the Optimal Care Pathways Model - Achieving an Optimal Future State
The Behavioral Health Continuum of Care Optimal Care Pathways (OCP) model was developed to identify, with specificity, the current capacity and utilization of care for individuals within our

system, along with the optimal future state required to support people who continue to lack options for placement due to complex needs, lack of existing services in the continuum, inadequate capacity, and/or other barriers to care.

To address these challenges utilization capacity across the system *must be recalibrated to focus on growth within* lower levels of short-term community crisis diversion, sub-acute care, and community-based care if the goal is to alleviate the existing bottlenecks, reduce unnecessary utilization of higher levels of care, and connect individuals to the care they need.

Within the OCP model there are three distinct service areas, each of which comprise an array of services and reflect varying levels of utilization change to achieve the projected optimal model, as outlined in the table below, including community crisis diversion, sub-acute services and community-based care.

Services within the Optimal Care Pathways Model

Service Area	*Community Crisis Diversion*	*Sub-Acute Services*	*Community-Based Care*
Service Array	• Crisis Stabilization Units (CSUs) • Mobile Crisis Response Teams (MCRTs) • Crisis Residential • Short-Term Crisis Respite	• Mental Health Rehabilitation Centers (MHRCs) • Institutions of Mental Disease (IMDs) • Skilled Nursing Facility (SNF) Special Treatment Programs (STPs) • Department of State Hospital (DSH)	• Adult Residential Facilities (ARF) • Residential Care Facilities for the Elderly (RCFEs) • Augmented Services Program (ASPs) • Recuperative Care

To achieve the optimal utilization across long-term care, as outlined in the OCP model substantial recalibration across the three service areas will be necessary, along with a more intentional effort to shift toward preventative and diversionary care to avoid utilization of acute inpatient care and other higher levels of care, which are expensive and often unnecessary

Increasing care pathways is anticipated to decrease the average cost per bed day across the system. This radical change will occur because care pathways will be established to connect individuals in crisis, to the care they need in the least restrictive setting thereby reducing the unnecessary utilization of acute inpatient service. This transformation will likely take years and can only be achieved through a long-term commitment and coordinated efforts with facility operators, community partners, hospitals, and other stakeholders.

BHS has already commenced work across many of these service areas to make meaningful progress in advancing toward the optimal state; however, ongoing funding, dedicated infrastructure, and strong advocacy at the State and federal level will be necessary to fully build out the long-term care continuum to meet the community need.

Redefining and Recalibrating Long-Term Care to be Client-Centered

The Behavioral Health OCP model redefines long-term care, which has been historically narrow in referring to beds within locked and secure facilities and institutions and expands it to be more comprehensive of community-based care settings. Community-based care provides Medi-Cal

eligible individuals with care and support through services such as adult residential facilities (ARFs), residential care facilities for adults (RCFEs), and recuperative care, which is a post-acute step-down service that supports individuals in sustaining stabilization following acute care. All are further described below and all are necessary to ensure individuals have care over their lifetime.

The model also emphasizes the need for short-term community crisis diversion services, which include both clinical and non-clinical services, to support individuals in crisis in receiving the services they need outside of an acute care setting. Community crisis diversion services include existing clinical services such as crisis stabilization services, mobile crisis response teams (MCRTs), and crisis residential services, along with a non-clinical service called short-term crisis respite, which does not currently exist within the continuum of care.

These community-based care pathways allow people to step down from higher levels of care and support diversion from unnecessary utilization of acute care, which is far more expensive and not the appropriate level of care for many individuals. These care pathways are all are necessary to ensure individuals have care over their lifetime.

Ongoing Barriers and Parity within Care
Historically, California has lacked parity as it relates to care and supervision for people with serious mental illness (SMI). Across the State and locally the resources dedicated to support essential community-based care for individuals with SMI have been inadequate due to insufficient federal and State reimbursement rates. This has disincentivized insurance systems, including Medi-Cal, from placing clients in community-based care resulting in profound gaps that are reflective of the current state our system which have had adverse impacts to our clients. It has also disincentivized facility operators from taking clients with behavioral health conditions who are Medi-Cal eligible or from continuing to operate altogether.

Over the last decade, BHS has experienced significant capacity loss across community-based care within adult residential facilities (ARFs), also known as board and care facilities, residential care facilities for the elderly (RCFEs), and augmented service programs (ASPs), which has negatively impacted service delivery across the continuum, especially within acute care and subacute care settings. ARFs, RCFEs, and ASPs, in combination with concurrent specialty mental health services, offer care and housing to clients with SMI in need of supervision in the least restrictive care environment.

ARFs are residential homes for adults ages 18 through 59 with mental health care needs or who have physical or developmental disabilities and require or prefer assistance with care and supervision. RCFEs are assisted living facilities that provide housing to individuals 60 years of age or over with varying levels of care, supervision, and personal care based on a person's unique needs. ARFs and RCFEs are licensed through the State's Community Care Licensing Division (CCLD). ASPs provide onsite support within licensed ARFs and RCFEs with the goal of enhancing and improving recovery to specific individuals living in specific board and care facilities to support the development client strengths, symptom management, and self-sufficiency.

Currently, BHS contracts with ARFs and RCFEs that accept the federal rate (SSI) to provide additional individualized services to adults with SMI who are open to case management or assertive community treatment (ACT) services, and services are reimbursed through a daily rate via the ASP program. Establishing adequate community-based care capacity is critical to shifting away from unnecessary utilization of high acuity services utilization and high-cost crisis care.

A 2018 report released by the California Behavioral Health Planning Council (CBHPC) cited insufficient funding, staffing, and "Not in My Back Yard (NIMBY)"ism as the most common factors contributing to the loss of licensed beds, with funding highlighted as the most significant issue. ARFs accepting the federal SSI rate, which in 2021 was slightly over $1,200, were typically unable to support the costs to staff a facility on a 24/7 basis, training, insurance, licensure, utilities, food, transportation, routine maintenance, and other costs necessary to license and operate an ARF, thus causing ARFs to typically operate at a loss unless they received substantial patch funding. Additionally, ARFs serving more than six residents are subject to zoning and permitting requirements, which is where NIMBYism presents a barrier.

Locally, the majority of ARF operators in San Diego County either do not accept the insufficient federal rate opting instead serve private pay clients at more lucrative rates that may exceed $6,000 per month, *nearly five times the federal reimbursement rate.* Facilities also may opt to serve individuals with physical or developmental needs due to the higher tiered funding. The Lanterman Developmental Disabilities Services Act guarantees services and supports to individuals with developmental disabilities through regional centers who may place clients in ARFs and RCFEs at reimbursement rates ranging from $1,211/month (Level 1) to $9,891/month (Level 4) depending on level of acuity. In contrast, as mentioned above, adults with SMI who are Medi-Cal eligible only receive reimbursement of the federal SSI rate of slightly over $1,200 making placement in these settings challenging. The outcome is often individuals with behavioral health needs that left homeless, institutionalized, and/or on extended stays in acute care settings all resulting in poor health outcomes.

These challenges combined with the escalating cost of real estate have incentivized or forced community-based care facilities to close their doors thereby reducing capacity across the region hindering individuals from accessing proper care and housing. RCFEs are assisted living facilities that provide housing to persons 60 years of age or over where varying levels and intensities of care and supervision, protective supervision, or personal care are provided, based upon their varying needs, as determined in order to be admitted and to remain in the facility. As illustrated above, many of the ARFs and RCFEs do not serve Medi-Cal eligible individuals because of the low reimbursement rates. The decreasing number of ARF and RCFE facilities paired with the even fewer that accept individuals who are Medi-Cal eligible continues to be a barrier to client flow across all levels of care often leaving people unable to step down out of higher levels of care.

Symptoms of Inequity and Parity in an Unbalanced System

One of the more palpable symptoms that continues to plague our region and illustrates the need for expanded step-down and community-based care is the disproportionate rate of psychiatric acute inpatient administrative days (Admin Days), which occur when a patient is no longer in need of acute hospital care is unable to step down into subacute or long-term care due to the lack of

available beds in the community. Essentially, they remain stuck in acute care. Additionally, on the front end as diversion from higher levels of care, the lack of community-based care placement options has resulted in missed opportunities for diversion unnecessary utilization of acute care. Consistent overutilization of administrative days across the system is directly indicative of a lack of community-based care beds within the County.

Another profound symptom is the number of individuals with complex needs who continue to wait for placement in the State hospital. And finally, a symptom of the lack of sub-acute, community-based care and community-crisis diversion services available is demonstrated by the disproportional rate of individuals with SMI who are experiencing homelessness or who are incarcerated, which is even more disproportional for communities of color.

To effectively rebalance our system, a commitment is required to address the historical inequity and parity, along with the existing financial, capacity, infrastructure, and administrative barriers that have led to disproportionately poor health outcomes for people with behavioral health conditions. This includes advocacy at the local, State, and federal level to support adequate infrastructure development, maintenance, and reimbursement for community-based care programs that serve individuals with behavioral health conditions. To begin this transformation, BHS will outline a data-informed algorithmic model, referred to as the OCP model, that is guiding the development of solutions and recommendations to enhance support long-term care across the region.

Assessing the Need and Available Care Pathways Across the System
To begin addressing these challenges, BHS has been engaged in rigorous efforts, in partnership with Public Consulting Group (PCG), to research and compile national, State, and local data to develop a comprehensive assessment of our local system and formulate the OCP model that quantifies the optimal capacity required across each level of care to build a system that meets the unique needs of individuals with behavioral health conditions. BHS assessed utilization, capacity, and need across four service areas, including community crisis diversion, acute care, subacute care, and community-based care in the San Diego region to outline a strategy that recalibrates and shifts the system toward a more client-centered model to meet the individual needs of clients at the lowest level and at the right level of care on a long-term basis.

To develop the broader strategy for San Diego County, BHS utilized key concepts from the *Crisis Resource Need Calculator* within the *Crisis Now* model, which is a community-based crisis care model with a "no wrong door" philosophy of integrated crisis care as outlined in the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit. The model outlines high-level estimates in key critical areas and explores different system-design scenarios for the provision of behavioral health crisis care, including inpatient and emergency department (ED) resources, and estimated potential healthcare costs and resource requirements for each scenario. It also incorporates key components, including demand for in-person crisis services, resource capacity for in-person, utilization patterns and annual healthcare costs to meet these needs. As part of the development of the OCP model BHS utilized these concepts to analyze the current state of the system and develop the projected optimal need across specific service lines within community-based care.

BHS also reviewed the recent RAND study commissioned by the California Mental Health Services Authority (CalMHSA) titled *Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California—2021,* which evaluated adult psychiatric bed needs across California and offered 5-year bed projections by geographical region and outlining key findings across the state. The study included a projected shortfall of psychiatric beds statewide across inpatient, subacute, and residential levels of care, including approximately 1,971 beds at the acute level (6.4 additional beds required per 100,000 adults), 2,796 subacute beds (9.1 additional beds required per 100,000 adults), excluding state hospital beds and 2,963 community residential beds, with significant regional differences in the estimated shortfalls within each level of care. Adding an additional layer of intricacy is the difficulty in placing individuals with complex conditions, including those with justice system involvement, who often do not have long-term options for care and housing. Though helpful in outlining the broad psychiatric acute care needs across the State and locally, the RAND study included information for Imperial County, beds inclusive of all payors, and narrowly focused recommendations on a few categories of services to mitigate immediate pain points within the system.

Those studies do not attempt to outline an ideal model rather they point to the most near-term means to address system pain points. Building upon these studies, BHS opted for a more comprehensive approach in developing the OCP model to assess and quantify the needs and barriers across the system, focusing specifically on Medi-Cal eligible individuals within San Diego County. The approach addressed the needs across all levels of care and within broader context that considers social determinants of health and larger system challenges. It also outlines client care pathways and the development of infrastructure beyond psychiatric beds to include subacute care, community-based care, and community crisis diversion services, including services that are not available to BHS clients.

The OCP model focuses significantly on diversion to the least restrictive environment and opportunities to serve individuals with medical, social, and environmental needs more effectively through whole person care and supports. The model utilizes assumptions for crisis diversion and re-entry into acute care developed as part of the *Crisis Now* model, along with anticipating the needs of individuals experiencing barriers to care, including those experiencing justice-involvement and homelessness.

BHS' broader and more comprehensive effort assesses the current state of community crisis diversion, acute care, subacute care, and community-based care infrastructure and services, along with identifying gaps and bottlenecks that have led to an unbalanced system characterized by restricted client flow across key points of transition. The analysis also maps clinical pathways to determine where clients with behavioral health conditions are entering from, which levels of care they are going to, what barriers stand in their way and prevent them from receiving optimal care, and identified common characteristics and specialty needs amongst clients. Finally, it identifies missed opportunities that would have prevented acute admissions, along with excessive lengths of stays in restrictive settings for clients waiting for lower levels of care.

To inform the OCP model BHS developed an algorithm that utilized local data, including point-in-time utilization, average length of stay, waitlist, and capacity data, which account for concurrent referrals and data mis-categorization, along with acute inpatient administrative day data, clinical data, and other key information to quantify the need with a focus on addressing the unique needs of individuals across the region.

To address the imbalance and barriers within the system, the model quantifies the optimal utilization needed across the various levels of care and specifically demonstrates the urgent need to develop and expand dedicated community-based care and community crisis diversion services, inclusive of infrastructure and services, specifically for Medi-Cal eligible clients who have behavioral health needs to facilitate acute and subacute step downs and diversion from higher levels of care. The model also outlines the need to shift capacity and specialized care within and across service areas as new services and capacity become available. Implementation of this strategy is anticipated to rebalance utilization across the system and the capacity necessary to ensure individuals are connected to the right level of care.

Quantifying Optimal Utilization in a Balanced System

The proposed recalibration of long-term care, as outlined in the OCP, provides current bed day utilization data and the proposed future bed day utilization projections if the optimal capacity is established across three key service areas – *community crisis diversion, sub-acute services, and community-based care*. Within these service areas the total utilization will need to meet the needs of all individuals who are currently on waitlists, languishing in acute care, waiting to step down to lower levels of care, or not receiving care at all. However, to address capacity challenges and alleviate administrative days the solution is *not to increase acute inpatient psychiatric bed capacity* but rather to recalibrate and establish new capacity in subacute, community-based care, and community crisis diversion services that more effectively meet the unique needs of individuals in the least restrictive setting and can be offered at a substantially lower cost.

Increase Capacity and Utilization of Community Crisis Diversion Services
Community crisis diversion services include both respite and treatment services that divert individuals in crisis from higher levels of care when their needs can be addressed via a lower level of care. Services include existing treatment programs such as crisis stabilization services, mobile crisis response teams, crisis residential services, and transitional residential services, along with short-term crisis respite services, which doesn't currently exist within the continuum of care.

Short-term crisis residential treatment programs provide crisis services to adults with SMI who have high clinical needs as an alternative to hospitalization or to adults stepping down from acute inpatient care. Services and housing are provided within a welcoming environment in community-based setting by a multidisciplinary team of clinical staff and peers. Individuals are stabilized and connected to other community supports to help them transition back into the community. According to SAMHSA report titled *Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies* crisis residential services are an effective alternative to acute inpatient care at improving a clients symptoms and functioning, and overall costs are less than inpatient care.

Also within the community crisis diversion service area is short-term crisis respite services, which provide short-term behavioral health crisis services for adults experiencing a behavioral health crisis in a peer-operated setting or a hybrid setting that includes peers and clinical staff. Services are voluntary and provided in a supportive residential environment as an alternative to psychiatric emergency services. Short-term crisis respite services are a critical care pathway within the behavioral health continuum because they divert individuals in crisis from unnecessarily hospitalization, and instead provide support in a less acute setting by peers and/or clinical staff. These services can also be utilized by individuals stepping down from CSUs. A SAMHSA presentation titled *Peer-run Respites: An Effective Crisis Alternative* indicates that respite guests were 70% less likely to use inpatient or emergency services, and respite days were associated with significantly fewer inpatient and emergency service hours.

Both short-term crisis respite services and crisis residential services complement the array of community crisis diversion services already existing within the continuum, including the five CSUs located throughout the County, which offer short-term crisis stabilization and connection to community-based care for adults, MCRTs, which provide an in-person, non-law enforcement response individuals experiencing a behavioral health crisis, and crisis residential services, as outlined above. Clients may utilize multiple crisis services in a single episode. These services offer care in a less acute setting that better meet the needs of the clients and are substantially less expensive than acute inpatient care. To be effective the crisis continuum needs the entire array of services that work together continuously to respond to and stabilize adults experiencing a behavioral health crisis.

Recalibrate and Increase Utilization of Sub-Acute Services
Sub-acute care is the service area that has historically associated with long-term care within the San Diego region and is provided to individuals who are stepping down from acute psychiatric care or for individuals whose acuity may have intensified and therefore they need a higher level of care. Sub-acute care is provided in locked facilities, and includes Skilled Nursing Facilities (SNFs), Department of State Hospital (DSH) beds, SNF-Specialized Treatment Programs (STP) beds, County-funded SNFs, Mental Health Rehabilitation Centers (MHRCs), and SNF Neuro-Behavioral Health (NBH) beds. Within sub-acute care, challenges continue with identifying care options for individuals who are incompetent to stand trial, forensic patients, and those waiting for State Hospital placement.

SNF patches are an enhanced daily rate paid to SNFs that provide mental health services to Medi-Cal eligible individuals on LPS conservatorship who cannot safely receive care in a less restrictive level setting due their acuity. SNF patches offer residential care is provided full time and includes both a nursing and a clinical support within these facilities.

County-funded SNFs provide nursing care, rehabilitation, custodial care, and other related health services to adults with a primary mental health condition who do not require hospitalization and for whom other types of less restrictive care has not met their needs.

Institute of Mental Disease (IMD) facilities that provide treatment to individuals with mental health conditions in facilities that have more than 16 beds. SNF-STPs are IMDs that provide mental

health services for patients who have a diagnosed chronic a psychiatric condition and whose adaptive functioning is moderately impaired.

Mental Health Rehabilitation Centers (MHRC) are also IMDs that provide 24-hour intensive support and rehabilitative services to adults with mental illness who would have been placed in a state hospital or another mental health facility to develop skills to become self-sufficient and capable of increasing levels of independence and functioning.

Department of State Hospital (DSH) are State operated psychiatric hospital for adults that provide evaluation and treatment for individuals with SMI and is the highest level of care available within subacute care serving clients who are unable to have their needs met in other settings. Adults in State Hospital care are on permanent LPS conservatorship and may be harmful to themselves or others.

SNF-NBH beds provide specialized neurobehavioral treatment and care to individuals who are Medi-Cal eligible and diagnosed with Traumatic Brain Injury (TBI) or Neuro-Cognitive Impairment (NCI) and SMI. An additional daily rate is paid to the facility by San Diego County. As with the SNF patch, individuals are on conservatorship and unable to safely receive care in a lower level of care.

Increase Utilization of Community-Based Care Services
As outlined previously, community-based care provides Medi-Cal eligible individuals with care and support through services such as ARFs, RCFEs, and recuperative care, which is a post-acute step-down service that supports individuals in sustaining stabilization following acute care, all of which are necessary to ensure individuals have care over their lifetime. The historical parity and inequity that has plagued this level of care specifically for those with behavioral health conditions, continues to have devastating impacts resulting in people who remain in unnecessary higher levels of care, individuals who continue to be stuck in a cycle homeless because they do not have housing options, individuals who are incarcerated, and individuals who are unable to get care at all.

As demonstrated within the OCP model, a dramatic shift will be necessary to achieve the optimal state within community-based care, specifically within ARFs, RCFEs, ASPs, recuperative care, and transitional residential care. Recuperative care provides adults with behavioral health conditions who are experiencing homelessness a safe place to be discharged following hospitalization, when they would otherwise be transitioning in and out of expensive and unnecessary hospital care. This service provides short-term housing for adults to recover while receiving case management and connection to primary care, behavioral health services, and other supportive services, including transportation, food, and housing. Transitional residential care provides a therapeutic environment to support adults in acquiring and applying interpersonal and independent living skills, while supporting the development of a personal community support system to minimize the risk of hospitalization.

Supporting enhancements and expansion within community-based care will not only result in optimal care that better meets the needs of adults in the least restrictive setting on a long-term basis, but also supports individuals with SMI who are experiencing homelessness by providing

housing. Additionally, community-based care services cost substantially less than services within higher levels of care.

The Impact: A Dramatic Decrease in Unnecessary Utilization of Acute Inpatient Services
Acute inpatient care, the most intensive level of care, provides crisis care to Medi-Cal eligible adults with acute symptoms of mental illness in need of 24-hour observation and intensive treatment in a locked hospital setting. Services are available residents countywide and include diagnosis, care, and treatment of acute episodes in an inpatient psychiatric setting that offers a secure environment where adults can regain their functioning and establish an aftercare plan before transferring to a lower-acuity level of care. Within acute care is where perhaps the most dramatic shift is projected to occur if all of the other lower levels of care are fully realized. While extremely critical to the most acute clients within the system, acute inpatient care is often utilized because of the lack of community crisis diversion services, subacute care, community-based care.

If the optimal system is fully built out, a dramatic decrease is anticipated due to utilization of new care pathways that allow individuals to receive care in the least restrictive setting. This shift across the system can only occur if a long-term commitment is made to recalibrate and establish adequate ongoing resources that support the expansion of community crisis diversion, community-based care, and subacute services and infrastructure.

Strategies to Achieve an Optimal System

To achieve the optimal future state a shared vision and commitment from the County, in partnership with the community and stakeholders, that includes substantial investments in community-based care and housing infrastructure and ongoing funding for services that to support equitable and sustainable payment structures. It will also require a significant policy focus on community crisis diversion and community-based care that supports placement of individuals with SMI in the least restrictive setting, along with strong and ongoing advocacy to ensure sustainable reimbursement rates and infrastructure investments are a priority at the State and federal level. BHS is recommending a long-term approach that utilizes strategies and tactics to recalibrate the local system to support the optimization of services.

Advancing Equity Through Advocacy and Collaborative Partnerships

To ensure services are regionally distributed and built to meet the needs of populations who have been disproportionally underserved, BHS will thread the work outlined within the OCP model to efforts currently underway through the Community Experience Partnership (CEP). The CEP is collaboration between BHS and the University of California San Diego (UCSD) to integrate data and community engagement to advance behavioral health equity. The Behavioral Health Equity Index allows the public to view behavioral health equity data through dashboards that include data from surveys, vital records, hospitalization, and emergency departments, along with service and outcome data for individuals receiving services through BHS. It also includes indicators of equity over time and across neighborhoods by race/ethnicity, gender, sexual orientation, age, justice involvement and more.

BHS will pursue efforts to connect the Behavioral Health Equity Index work to the OCP model integrating two immensely impactful bodies of work to inform where the highest priority area of future investment to address inequity that currently exists. This will support regional distribution of services across the communities most in need to ensure they have access to behavioral health care in close proximity to where they live.

Ongoing Evolution of the Optimal Care Pathways Model

The Behavioral Health OCP model provides a baseline analysis that projects optimal capacity targets, and recommendations for achieving balance across the system of care at this critical point in time. While this model is based on an extensive analysis that includes both historical and current data, BHS recognizes modeling as a continuous and iterative process that is centered on ongoing review of data to adjust and recalibrate based on a dynamic environment. It is imperative that efforts to recalibrate and enhance the availability of care across the four service areas be done collaboratively and partnership with facility operators, hospital systems, community-based providers, and other key stakeholders across sectors and settings, to ensure care is client-centered and to support a system that is nimble and equipped to adapt to current and impending legislative mandates and initiatives.

Several critical bodies of work are already anticipated to impact care across the OCP model. Under Community Assistance, Recovery and Empowerment (CARE) Court adults with behavioral health conditions who are experiencing from homelessness or incarceration will be connected with a court-ordered Care Plan for up to 12 months, with the possibility to extend for an additional 12 months. Individuals with a clinically appropriate, community-based set of services and supports including short-term stabilization medications, wellness and recovery supports, and connection to social services, including housing. CARE Court is an upstream diversion program that prevents more restrictive conservatorships or incarceration. California Advancing and Innovating Medi-Cal (CalAIM) is also anticipated have a substantial impact on the OCP utilizing a population health approach that prioritizes prevention and whole person care that integrates health services and adds new benefits and social supports.

The OCP model is expected to evolve and may grow proportionally based on the impact of the enormous bodies of work under CalAIM and CARE Court as the number of individuals in need of community-based care increases. This will require a commitment to lean into this dynamic health care environment supported by continuous data reviews, iterative system modeling and forecasting, ongoing advocacy, intensive process reviews that build on successes, and engagement with the community.

SUBJECT: UPDATE ON ADVANCING THE BEHAVIORAL HEALTH CONTINUUM OF CARE, RECALIBRATING LONG-TERM CARE THROUGH THE OPTIMAL CARE PATHWAYS MODEL (DISTRICTS: ALL)

Children and Youth: Continuum of Care Updates and Strategies

According to the U.S. Department of Health and Human Services, 1 in 5 children 17 and under experience a mental or emotional disorder, with 50% of mental illness beginning around age 14. Data also demonstrates there has been a steady increase in suicide rates among youth on a national level. Locally, we see indications in screening data that demonstrate our youth are vulnerable to future behavioral health conditions. Middle schoolers (ages 12-14) in particular, have 200% higher rates of psychological distress compared to adults (ages 18+).

Strengthening and innovating services to children and youth remains one of the County's highest priorities as we know implementing earlier interventions in their lives is the best way to prevent behavioral health injury. The sections below provide an update on current projects, as well as a look toward future strategies.

Current Youth Efforts

The table below reflects current bodies of work within the Continuum of Care portfolio supporting children and youth:

Children's Behavioral Health Hub On March 10, 2020 (04), the Board approved actions to begin the process of evaluating and potentially developing a behavioral health hub in North Central Region in partnership with Rady Children's Hospital (Rady) which would provide an array of services designed to meet the needs children and youth. Services for this hub include: • Inpatient and acute care services • Crisis stabilization services • Partial hospitalization • Care coordination services • Medical and transitional care services for the County's Juvenile Hall Since the update on May 4, 2021 (11), the land use feasibility study has been completed and additional actions to move toward building design and permitting approvals are underway. Construction is estimated to begin in 2025.
Screening to Care On June 8, 2021 (3), San Diego County Board of Supervisors (Board) approved a final American Rescue Plan Act (ARPA) funding framework to support the residents of San Diego County. The approved funding framework included the use of ARPA funding to address the behavioral health services needs of children, youth and families which were identified as high priority. On December 7, 2021, the U.S. Surgeon General issued an Advisory on Protecting Youth Mental Health (Advisory) to highlight the urgent need to address the nation's youth mental health crisis. The Advisory called for a swift and coordinated response to this crisis as the nation continues to battle the COVID-19 pandemic and provided the following recommendations that individuals, families, community organizations, technology companies, governments, and others can take to improve the mental health of children, adolescents, and young adults.

To advance recommendations outlined in the Advisory, and in alignment with other efforts to support youth, the *Screening to Care* initiative was created to address mental health treatment needs for middle school students in partnership with the San Diego County School Board Association and school districts across the county with services that will use a multi-tiered approach which includes universal screening of students facilitated by middle school staff, regardless of the child's insurance status.

Based on the screening results, students will be stratified into three different tiers of intervention: school community and classroom-based intervention which is known as Tier 1; small group intervention which is known as Tier 2; and referral to treatment level services known as Tier 3 which will leverage the BHS-operated SchooLink programs.

These services are aimed at preventing more severe behavioral health conditions seen among high school students, and will attend to addressing stigma, promote acceptance, empathy, and compassion and be delivered in a culturally competent manner in alignment with BHS' long-term commitment to creating and maintaining a culturally relevant and culturally responsive system of care.

Expansion to elementary and high school students shall be determined as service effectiveness is evaluated. *Screening to Care* services will be initially funded through ARPA funding for three years, with plans to explore funding opportunities to sustain the program on a long-term basis.

Parks After Dark
In partnership with the City of San Diego Parks and Recreation, the Parks After Dark program occurred throughout July and August with outdoor family programing to promote wellness and health of community members. Tenets of this community-based program were built on the foundation that connects physical and social community interaction to promote confidence, sense of responsibility, while building self-image and instilling hope and positive connections.

Looking Forward
Children are recognized as tomorrow's adults and as holding our collective future. While children are growing, they have distinct needs which require strategic considerations different from how we approach the care of adults reflected in the three Strategic Domains below.

Strategic Domain #1: Treatment for Families and Social Determinants of Health Supports
Children thrive under the support and safety that the adults who care for them provide. Developing a strong sense of self and resiliency is nurtured in a caring environment. However, as the stressors of a family unit grow, the more intentional supports are needed to foster resiliency. Results from the National Survey of Children's Health indicate that 1 in 14 youth have a parent who has poor mental health and that those youth are more likely to have poor general health or have a mental health or behavioral disorder themselves. Focusing on social drivers of health and intentional promotion of therapeutic supports through a family lens is an important emphasis for optimal health of a child.

Critical to mental health development in children is parent and caregiver engagement. Parenting and caregiver skill development and strengthening engagement of fathers have been demonstrated as practices which support positive childhood experiences and reduction of the impacts of adverse childhood experiences (ACEs). The impacts of the COVID-19 pandemic over the past several years have contributed to increases in youth and adult anxiety, depressive symptoms and family stress. In alignment with efforts to support youth and families, BHS has provided parenting and caregiver skills development services and services to improve attitudes towards fathering and strengthening engagement of fathers in their children's lives to prevent and address risks associated with Adverse Childhood Experiences (ACEs). These services have been provided through contracts for the Positive Parenting Program and the Father 2 Child Program.

In collaboration with community partners, BHS has commenced planning to conduct a community engagement and program development process to include focus group discussions with parents and caregivers of young children, and mental health and child development professionals to identify innovative, new approaches and best practices to build stronger resiliency in children, supports for parents and caregivers and increase family involvement and engagement to strengthen emotional wellness in children and activate protective factors for children and their families. Culturally and community specific services will inform the development of prevention and early intervention efforts.

Strategic Domain #2: School-Based Universal Screening with Expanded Early Intervention, Care Linkages, and Treatment

Nationally, an estimated 1 in 5 children ages 3 to 17 have a mental, emotional, developmental, or behavioral disorder and as early as 7th grade, 1 in 8 youth report having suicidal thoughts. Building a strong foundation of prevention and early intervention through social emotional supports for children and youth yields tremendous lifelong benefits and minimizes human suffering and costs associated with future care. In addition to the *Screening to Care* initiative described in the previous section, continued leveraging of existing tools are needed to evaluate the needs of children which allow for timely and targeted interventions that focus on skill building and natural supports. Creating a strong emotional foundation in kids builds protective factors and minimizes the need for future interventions.

Strategic Domain #3: Health Integration

Accessing care early and at the lowest level of need is important in promoting positive outcomes. At times, stigma, fear, and the unknown can stand in the way of care. Locally, in 2020 1 in 3 teens reported needing help for an emotional/mental health problem yet over a fifth of those did not receive counseling in the past year. Many families trust and access physical health care for their children who can offer an integrated access to behavioral health services when needed. Creating a strong connection and pathways to behavioral health through the physical health care system can improve the family experience, lead to earlier intervention, and yield better outcomes.

SUBJECT: UPDATE ON ADVANCING THE BEHAVIORAL HEALTH CONTINUUM OF CARE, RECALIBRATING LONG-TERM CARE THROUGH THE OPTIMAL CARE PATHWAYS MODEL (DISTRICTS: ALL)

Attachment A Content

BEHAVIORAL HEALTH SERVICES
CONTINUUM OF CARE KEY UPDATES

September 27, 2022

Under the leadership of the San Diego Board of Supervisors (Board), behavioral health care in San Diego County is in the midst of a profound transformation. The County of San Diego (County) is taking action and making strategic investments to move the local behavioral health care delivery system from a model of care driven by crises to one centered on continuous, coordinated care and prevention. These efforts, broadly referred to as the Behavioral Health Continuum of Care (Continuum of Care), are guided by data, focused on equity, and designed to engender collaborative work across silos, within and outside of government. All Continuum of Care capital projects are designed thoughtfully to be a welcoming environment that is conducive to wellness and healing for the individuals and families who visit.

Today's update to the Board includes the following summary of progress of the portfolio of Continuum of Care projects that are bringing this transformation to life reported within the **domains of Crisis and Diversionary Services; Inpatient Hubs and Care Coordination; and Residential and Long-Term Care**.

Diversionary Services
Regional Crisis Stabilization Units On March 26, 2019 (02), the Board approved a recommendation to establish regional mental health crisis stabilization units (CSUs) that provide 24/7 walk-in mental health and substance use disorder services for those in behavioral health crisis. Services in these CSUs include law enforcement drop-offs as a safe alternative to a jail or hospital, psychiatric services, medication, peer support, and transition planning, with stays of less than 24 hours. Since the last update to the Board on May 4, 2021 (11), the North Coastal Community-Based CSU in Vista became operational on October 1, 2021, as did the North Coastal Live Well Health Center Community-Based CSU in Oceanside which open its doors on April 25, 2022, bringing the total number of County-funded CSUs to six. Since becoming operational through September 5, 2022:

- The Vista CSU has had over _____ admissions, __% were referred through law enforcement, and of clients admitted __% were referred to community-based care.
- The Oceanside CSU has had over _____ admissions, __% were referred through law enforcement, and of clients admitted __% were referred to community-based care.

On April 10, 2022, the Oceanside Crisis Stabilization Unit (CSU) project was selected for Project of the Year Award in the Structures category by the American Public Works Association (APWA). Following the award, a ribbon cutting ceremony was held on April 18 to mark the County of San Diego's commitment to make mental health and substance use services a priority.

New Community-Based CSU in East Region with Co-located Sobering Services
On October 19, 2021 (3), the Board directed a series of actions focused on creating alternatives to incarceration, and on February 8, 2022 (11), a preliminary report on data-driven alternatives to incarceration was presented to the Board with initial recommendations, including strategies to support alternatives to incarceration and connections to services for people with substance use, alcohol, and public conduct-related non-violent misdemeanor charges. The Board also authorized the Chief Administrative Officer to explore further integration of substance use and mental health services, including sobering services, in future crisis stabilization units.

On June 28, 2022 (5), the Board authorized a competitive solicitation for the procurement of community-based crisis stabilization services with co-located sobering services in the East Region. The East County Community-Based CSU site has been chosen in the city of El Cajon. The project is currently in the programming phase with services estimated to begin Fall 2024. When operational, this facility will have about 12 recliners and along with sobering services.

On June 28, 2022 (5), the Board approved $1.0 million for planning and design of the East Region CSU with co-located sobering services. Due to the cost of inflation and the projected expanded size of the facility to include sobering services, additional funding of $3.0 million is needed to complete the design and permitting process within the initial phase.

To support the capital costs for this project, BHS will apply for Round 5: Crisis Continuum of the Behavioral Health Continuum Infrastructure Program (BHCIP) grant funding when the Request for Application (RFA) opens later this calendar year and return to the Board at a future date if funding is awarded.

Mobile Crisis Response Teams
On June 25, 2019 (1), the Board approved a recommendation to enhance the crisis intervention options available to the community by establishing a non-law enforcement Mobile Crisis Response Teams (MCRT) pilot program, in coordination with the County's Health and Human Services Agency, Behavioral Health Services, the San Diego County Sheriff's Department, and the San Diego County District Attorney, with initial efforts focused in the North Coastal Region. On June 23, 2020 (26), the Board expanded MCRT by approving an expedited rollout of MCRTs countywide; and on April 6, 2021 (9), the Board further affirmed their commitment

to strengthen MCRT by approving recommendations for a public awareness campaign, outreach to key stakeholders for continued engagement, and other key actions.

MCRT services are designed to help people who are experiencing a mental health or substance use crisis by dispatching behavioral health experts to emergency calls instead of law enforcement, when appropriate, with teams dispatched primarily by calls made to the Access and Crisis Line (888-724-7240) though law enforcement agencies can also refer calls they receive to MCRT. See below for key updates since the last update presented to the Board on June 30, 2022.

MCRT Key Data Points
Since the MCRT program launched in January 2021 through September 5, 2022:

- MCRT has responded to over ____ calls referred through the Access and Crisis Line (ACL) and Law Enforcement Agencies (LEA). Of the ____ calls responded to, ___ referrals were received directly from LEA.
- Of the individuals who received an MCRT service, approximately __% were stabilized in the field with referrals to ongoing care and without the need for additional transport, reducing the need for law enforcement services and utilization of more expensive, and acute services.
- Approximately __% of clients self-reported that they were homeless at the time of assessment.
- Approximately __% either refused a service or had left the location by the time MCRT arrived. On these occasions, MCRT still provided resources to the individual or family members who may be receptive to services in the future.

Stakeholder Engagement
On July 7, 2022, an update was provided to the Behavioral Health Advisory Board from a panel of program staff and law enforcement providing updates on 9-1-1 dispatchers who refer calls to MCRT. On August 15, 2022, an update on key MCRT program data was presented to the Human Relations Commission. BHS and MCRT program staff continue to be responsive to requests for information and interviews.

In a parallel effort, the County continues community-based outreach and engagement through a contract with Jewish Family Service's Breaking Down Barriers program. Breaking Down Barriers is a prevention and early intervention program providing outreach and education to reduce stigma around mental illness through trusted community partners.

Since March 2022, the contractor has reached over ____ community members through outreach events, presentations, community conversations, flyer dissemination, posters placed in community locations, outreach to local businesses and social marketing. The MCRT flyers used to support this effort are available in multiple threshold languages, have been disseminated by the contractor and can also be found on the MCRT website; stakeholders are being encouraged to reference and print as needed for their individual outreach efforts.

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Media Campaign Update
A general media campaign was launched as live in market from January 31, 2022 to May 29, 2022, with an initial objective to inform and educate San Diegans about this valuable new program. The campaign reached people of all ages in San Diego County and included messaging in various languages (English, Spanish, Farsi, Arabic, Tagalog, Vietnamese, and Chinese) to broaden the delivery of the message.

Through a multimedia approach that included out-of-home ads (billboards and place-based posters), radio ads, digital ads, and search ads, the campaign delivered over 91M impressions across San Diego County which indicates success in promoting awareness of the MCRT service. Moreover, the campaign received 13.3M engagements which indicates the target audience interacted with the campaign's message to learn more. Among the various media channels, each channel met or exceeded its respective benchmark goal for a successful media campaign.

Based on the performance of this initial campaign, additional public messaging is planned for the remainder of FY2022-23. BHS will work with its media contractor to expand media to include print ads, over-the-top TV (OTT), connected TV (CTV), social media ads, and bus shelter ads to reach even more San Diegans throughout the County and ensure they are aware of the services MCRT provides. Media channels previously leveraged for the first phase of messaging, such as radio, place-based print materials, and digital ads, will continue to be activated. Subsequent phases of the campaign will incorporate input received by the department through a series of community conversations and focus group discussions with stakeholders. Messaging will be tailored to better resonate and reflect groups with a shared community identity, as well as incorporate best practices and lessons learned from recent public communication on the SARS-CoV-2 virus. With the goal of reaching the most vulnerable, underserved, and/or unserved populations, strategies and related materials to promote the MCRT program will continue to evolve as education and outreach efforts transform to meet changing communication preferences of the community.

988 Launch – New Option for Behavioral Health Crisis Care
In 2020, Congress designated the new 988 dialing code to operate across the country. In July 2022, the U.S. transitioned to using the 988-dialing code, an easy to remember number that directly links someone in a behavioral health related crisis to immediate care and support. Locally, when someone with a San Diego area code dials 988, they will be seamlessly connected to the Access and Crisis Line and a trained counselor.

Over time, the vision for 988 is to have additional crisis services available in communities across the nation, much the way emergency medical services work. In the short-term, efforts are focused on strengthening and expanding the current crisis call center infrastructure and capacity to ensure trained crisis counselors are available to quickly respond to 988 via call (multiple languages), text or chat (English only). In the longer term, the vision is to build a robust crisis care response system across the country that links callers to community-based providers who can deliver a full range of crisis care services.

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The County is working closely with the BHS Administrative Services Organization and behavioral health crisis services providers on the planning and implementation phases in alignment with the vision. BHS is ensuring the capacity to respond to calls received and availability of local crisis resources, as well as the development of internal technological infrastructure to support the long-term goals. Information on 988 was added to the BHS website, paired with the Access and Crisis Line information, with clarification between these two resources.

Inpatient Hubs and Care Coordination

Tri-City Psychiatric Healthcare Facility
In a series of actions to meet the urgent behavioral health needs in North San Diego County, the Board approved final agreements January 14, 2020 (11) between the County and Tri-City for the development and operation of a 16-bed psychiatric healthcare facility on vacant land located at the Tri-City Medical Center campus in Oceanside. In February 2022, community engagement efforts were conducted to solicit community input on the project before the submission of the plans to the Oceanside City Planning Commission, which was approved unanimously at their meeting on June 13, 2022.

Edgemoor Acute Psychiatric Unit
On August 16, 2022 (7) the Board approved authorization to accept one-time Behavioral Health Continuum Infrastructure Program (BHCIP) Round 3: Launch Ready grant funding in the amount of approximately $12.4 million to fund the construction of the 12-bed acute psychiatric facility located within the existing Edgemoor Distinct Part Skilled Nursing Facility (DPSNF) campus. Initially, the total estimated cost of this project is approximately $13.4 million, inclusive of $12.4 million funded by BHCIP Launch Ready Grant and $1.0 million County match requirement funded by Realignment.

Construction of this new acute psychiatric unit will allow residents to continue to receive the appropriate specialty psychiatric care without requiring them to transfer out of their residence. The new facility will serve residents countywide as needed but will increase accessibility to vulnerable individuals within the East Region, which currently has limited behavioral health infrastructure. The acute psychiatric unit may also be able to serve other area skilled nursing facilities (SNFs) with patients in need of stabilization, thus reducing the need to transport these patients to hospital emergency rooms. The acute psychiatric unit will also provide local connections to inpatient services for those requiring higher levels of care.

The County's Department of General Services and an independent architect, with the guidance of OSHPD liaisons, are assisting with a review of options to meet design requirements for this type of facility. The project is currently in the design phase, with construction is scheduled to begin in 2023, and slated for completion in late 2025. This project, along with the Crisis Stabilization Unit with co-located sobering services in East Region (El Cajon), will bolster the region's psychiatric capacity while maintaining Edgemoor's DP licensure.

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Alvarado Inpatient Acute Psychiatric Services
On August 30, 2022 (16) the Board _____ recommendations to enter into a contract with Alvarado Hospital for Medi-Cal managed care inpatient acute psychiatric services, and emergency psychiatric and crisis stabilization services. Through approval of these actions, the County is able to substantially increase capacity for these critical service lines by adding 44 new dedicated psychiatric acute inpatient beds and emergency psychiatric and crisis stabilization services for individuals who are Medi-Cal eligible, improving access to critical inpatient and stabilization services for vulnerable adults countywide who are experiencing a behavioral health crisis. This collaboration with Alvarado Hospital will also involve medical oversight and leverage academic leadership from University of California San Diego (UCSD) Health and the UCSD Department of Psychiatry and it aligns with the principles of behavioral health hubs articulated in previous actions brought before the Board.

Third Avenue and San Diego County Psychiatric Hospital Updates
On October 29, 2019 (31), the Board was informed that development of a vacant, County-owned parcel of land located on Third Avenue, San Diego, was feasible for a variety of mental health services. Based on the recent partnership with Alvarado, BHS will be coming forward in a future Board meeting to make recommendations for the array of services provided at Third Avenue.

Additionally, the collaborative efforts with Alvarado described above will enable the County to shift acute inpatient care provision from the San Diego County Psychiatric Hospital (SDCPH), an Institution of Mental Disease (IMD) revenue-excluded facility, to Alvarado, a General Acute Care Hospital, allowing the County to realize operational efficiencies and optimize available revenues.

Hospital Rates and Incentive Development
Acute Psychiatric Inpatient Services
In a collaboration with providers, BHS has implemented new value-based reimbursement approaches for inpatient services which includes the development of baseline per-diem rate(s) and establishing additional incentive-based payment opportunities. Shifting toward value-based reimbursement for behavioral health services ahead of planned, statewide reimbursement changes under California Advancing and Innovating Medi-Cal (CalAIM) will help San Diego County effectively prepare for – and keep pace with – changes happening across California and nationally. Value-based reimbursement represents a paradigm shift in the way providers operate.

BHS is advancing value-based reimbursement by utilizing a base rate plus the potential to earn additional dollars if a provider is able to achieve certain outcomes related to the improvement of client care. The base rate is the minimum reimbursement amount that the provider will be paid and has been developed for several services, including hospital acute psychiatric inpatient care, based on actual provider costs, modifiers due to projected inflation, and other publicly available data from CMS cost reports.

BHS has completed extensive initial research and modeling to understand the impact of these payments and will continue working closely with the provider community to define performance measures and associated goals for these incentive payments. The chosen measures will support broader goals to improve behavioral health for San Diego and may include efforts to expand access, better coordinate care, and help people maintain recovery.

Naloxone Distribution in Hospitals

The Continuum of Care strategy aims to promote population health efforts at hospitals that will improve behavioral health outcomes in the community. An immediate priority is to reduce morbidity and mortality related to opioid use disorder. To achieve this aim, BHS implemented rate enhancements at participating hospitals in July 2022 (i.e., increases in the administrative day rate established by the State of California for acute care psychiatric services) for participation in two population health qualifying activities: Department of Health Care Services' Naloxone Distribution Project (NDP); and CA Bridge. Organizations participating in the NDP dispense naloxone directly to patients who are at risk of experiencing or witnessing an overdose prior to discharge. Organizations participating in CA Bridge offer the following services through emergency departments: medications for addiction treatment (buprenorphine), support from a peer navigator, and a warm handoff to community partners. As of August 15, 2022, a total of nine (9) San Diego County hospitals have signed on to participate in the population health activities (all nine of these hospitals will be participating in the NDP; 7 will also be participating in CA Bridge).

Long-Term Care

Step-Down and Long-Term Care Investments

As detailed in the main body of the Board Letter, BHS is proposing actions to redefine and transform long-term care in San Diego County through the development of a new OCP model designed to establish new care pathways that better meet the needs of individuals through community-based care, along with a focus on services that divert individuals from unnecessary utilization of acute care.

Through a broad and comprehensive analysis, the model has determined an optimal future state that is required to support people who continue to lack options for placement due to complex needs, lack of existing services, inadequate capacity, and/or other barriers to care. To achieve this optimal future state, capacity across the system must more than double and be recalibrated to focus on growth across the following three lower levels of care service domains:

- Community crisis diversion
- Sub-acute services
- Community-based care

The impact of building capacity across these three service domains is anticipated to result in decreased utilization of acute inpatient services and, more importantly, will connect people to the care they need in the least restrictive setting.

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Additional Updates in Support of Continuum of Care Efforts
Behavioral Health Impact Fund On April 7, 2020 (03), the Board, in partnership with the City of San Diego (City), established a Behavioral Health Impact Fund (BHIF) with appropriations of $25 million for capital projects to support community-based behavioral health organizations in increasing their capacity to support long-term treatment. One-time funds for capital projects through a competitive procurement process will strengthen the regional Continuum of Care. The BHIF request for proposal (RFP) was issued in May 2020, inviting offerors to submit proposals for capital funds to support the following critical service areas: • Licensed adult residential facilities, also known as board and care facilities; • Temporary and transitional housing and support for people with substance use disorders consistent with recovery residence settings; • Residential mental health treatment services, including crisis residential programs for homeless populations and transition age youth; • Residential substance use disorder treatment programs, inclusive of withdrawal management and detoxification services; • Other temporary and transitional housing for homeless populations with behavioral health needs that may include a focus on youth who are victims of commercial sexual exploitation; and • Information technology to support telehealth, data integration and innovation to optimize access and care for individuals with behavioral health care needs. The County has issued notices of intent to award BHIF projects as outlined in the County's website (click here).

LINKAGE TO THE COUNTY OF SAN DIEGO STRATEGIC PLAN

Today's proposed actions support the County of San Diego's (County) 2022-2027 Strategic Plan initiatives of Equity (Health) and Community (Quality of Life) as well as the regional *Live Well San Diego* vision, by reducing disparities and disproportionality of individuals with mental illness and substance use disorders and ensuring access to a comprehensive continuum of behavioral health services administered through accessible behavioral health programs.

Respectfully submitted,

USE "INSERT PICTURE" FUNCTION TO INSERT SIGNATURE

HELEN N. ROBBINS-MEYER
Chief Administrative Officer