Contents

NOTE: A previous version of this report was first released to the HASD&IC Board in September 2018. This version was updated in November 2018, after receiving feedback from the County of San Diego Health & Human Services Agency.

Executive Summary

This point-in-time-analysis was conducted in 2017-2018 to gain a deeper understanding of the behavioral health challenges faced by San Diego's patients. Issues examined included pre-acute, acute, and post-acute services and the impact of social determinants of health on access and outcomes. Ultimately, the findings are intended to support further research efforts and to promote collaboration between San Diego County Behavioral Health Services and other community organizations providing behavioral health services in San Diego.

A mixed methods approach was used to conduct this analysis. Primary data was collected through focus groups and key informant interviews with clinicians and mental health advocates. In addition, a quantitative analysis of hospital discharge data for patients discharged with a mental health disorder diagnosis – from emergency departments and inpatient hospitalizations – was performed.

Throughout the interviews and focus groups, the most consistent theme was that patients and their health care providers are unable to access or are continuously delayed in accessing needed behavioral health services at every point across the continuum. These challenges are demonstrated by the following:

- On a typical day in San Diego County, *more than 50 patients* are being cared for in acute care emergency departments while they wait for up to *36 hours* for a psychiatric inpatient bed to become available.[1]

- In a typical week in San Diego County, *adult patients spend a combined total of more than 250 days in psychiatric inpatient beds*, receiving the highest level of acute care, **after** County Behavioral Health Services determined that the patients *require a less restrictive type of treatment* to address their behavioral health condition.[2]

- In a typical month in San Diego County, Psychiatric Emergency Response Teams respond to more *than 130 behavioral health crises involving children* and *more than 700 involving adults.*[3]

[1] Based on interviews and focus groups conducted in summer and fall of 2017.
[2] Based on County Behavioral Health reports prepared by Optum for FY 17/18. The number of administrative days (days in which care in an inpatient psychiatric setting has been deemed unnecessary) has increased each year since 2013.
[3] Based on County Behavioral Health reports prepared by Optum for FY 17/18. The number of contacts for adults and children has increased each year since at least 2015, due in part to an increasing number of PERT teams.

Summary Findings & Recommendations

Post-Acute Care

Finding	1. ***Services across the continuum for behavioral health patients are deficient.*** The severe lack of post-acute care services for Medi-Cal patients has led to increases in the days patients spend in unnecessary psychiatric inpatient care and, simultaneously, to a greater number of patients being denied inpatient care who need it.
Recommendations	A. Support funding to expand behavioral health services, most urgently for post-acute care services. Request data on any cost savings associated with reduced inpatient days and shorter inpatient length-of-stay resulting from additional long-term care beds or the new Crisis Stabilization Units. B. Support treatment of patients with a purely psychiatric behavioral health crisis (with no medical needs) through further regional expansion of Crisis Stabilization Units.

Psychiatric inpatient Capacity

Finding	1. ***Insufficient inpatient beds are available to Medi-Cal patients who require an immediate acute psychiatric hospitalization.*** The overall number of licensed beds for these patients is decreasing. In addition, facilities are facing growing challenges with safely discharging these patients because of the lack of housing and community resources available to them upon discharge.
Recommendations	A. Support raising Medi-Cal psychiatric inpatient provider payments. Facilities must receive rates adequate to ensure the long-term viability of providing psychiatric inpatient services for Medi-Cal patients.

Systems of Care & Care Coordination

Finding	
	1. ***The divided system of care for Medi-Cal patients creates coverage gaps.*** These gaps leave health providers unable to design clinically appropriate treatment plans based on the patient's current health status and projected trajectory. 2. ***Even when clinical services are available, patients face many challenges to successfully managing their behavioral health conditions on their own.*** Social determinants of health, such as the availability of housing and transportation, inadequate income, and lack of family support, were identified as the most frequent barriers to creating a safe discharge plan. 3. ***County Behavioral Health case management does not adequately support patients being treated for severe mental illness (SMI) or severe emotional disturbance (SED) in community-based settings.*** The most serious SMI and SED patients are often referred to County Behavioral Health from Federally Qualified Health Centers (FQHCs). Significant barriers prevent these individuals from receiving the kind of emergent care they need: inpatient or crisis stabilization services. Delays in treatment for SMI and SED patients in crisis can result in further deterioration of their mental health and a preventable visit to an emergency department. 4. ***County Behavioral Health case management does not accept new patients and connect them to necessary post-acute services in a timely manner.*** The burden of finding appropriate, available, and County Behavioral Health Plan-approved placements and services, therefore, falls on hospital staff, and options are limited. While Medi-Cal inpatients wait for placements and services that have availability and are willing to accept them, they receive what has been deemed an inappropriate level of treatment in an acute care setting. Further complicating this situation, once the patient has been approved for discharge, the psychiatric inpatient provider is subsequently reimbursed for this time at an "administrative days" rate. This reimbursement rate is lower, despite the fact that the hospital continues to provide the patient with the same care, creating a financial burden for the facility.

Systems of Care & Care Coordination

Recommendations	A. Identify best practices in other states or regions that eliminate or reduce gaps between systems of care for Medi-Cal beneficiaries with behavioral health needs. B. Redesign case management services for Medi-Cal patients. Goals should include reducing the unfunded burden on health providers and making it faster and easier for patients to gain access to needed treatment and services. This will entail improving care coordination between community behavioral health care providers and psychiatric inpatient providers. Case management must include evidence-based screening for social determinants of health and a plan to address barriers created by those determinants. C. Prioritize regional efforts to electronically exchange behavioral health information. Information should be integrated into electronic health records and allow health providers, Medi-Cal Managed Care Plans, and the County Behavioral Health Plan to engage in real-time decisions about a patient's treatment plan and document requests for services. D. Focus on opportunities to more fully incorporate and integrate FQHCs in the behavioral health continuum. Support an FQHC role in case management, develop more warm-handoffs to FQHCs from inpatient settings, and address barriers to sharing behavioral health information between health providers.

Workforce

Finding	1. ***Workforce shortages create severe deficits across the behavioral health continuum of care, limiting access to critical services. Recruiting and retaining qualified behavioral health providers is a growing challenge.*** *The shortage of qualified behavioral health professionals narrows the range and availability of behavioral health services. Deficient reimbursement has resulted in a shortage of psychiatrists who accept Medi-Cal in San Diego County. The situation is particularly dire for children in need of psychiatric inpatient services, with the extremely small number of child and adolescent psychiatrists and psychologists who are willing to accept Medi-Cal and work in acute care settings continuing to decline.*
Recommendations	A. Conduct research to determine best practices for addressing the behavioral health workforce shortage. Research should consider

Workforce

	changes to scope-of-practice rules and best practices for recruiting and retaining qualified clinical staff across the behavioral health continuum.

Pediatric and Adolescent Inpatient Trends

Finding	1. ***Preventative and family support services are needed in high-volume months.*** There are seasonal trends in pediatric behavioral health emergency department visits and inpatient admissions, demonstrating the need for increased services to families during these months.
Recommendations	A. Share findings with existing pediatric behavioral health workgroups and solicit recommendations on how to address increased need during high-volume months. Explore additional contracting or funds as possible solutions.

Premise

First and foremost, this document was written in response to the overwhelming need in the County of San Diego for an integrated and effective response to individuals struggling with serious mental illness. The research was designed to provide insight to hospital CEOs, County healthcare providers, and other healthcare systems and entities who care for these vulnerable individuals. This paper shares the many challenges and opportunities identified by organizations, individual providers, and experts who encounter this population daily.

Over the past two decades, Community Health Needs Assessments (CHNAs) conducted in San Diego County have consistently identified mental/behavioral health as one of the top four health needs for residents. This consistent finding over such an extended period is one indication that the problem is systemic. The mental/behavioral health needs of the community are growing and complex, and at a regional level, we have been ineffective in making significant inroads.

Unless noted or cited otherwise, the information presented within this report is based on carefully documented interviews and focus groups with sixty-seven individuals representing: psychiatric inpatient providers (free-standing hospitals and health systems); Federally Qualified Health Centers (FQHCs); and an advocacy group for the mentally ill. Preliminary findings and recommendations outlined in this paper are based on the experiences and sentiments expressed by interviewees; these statements have not been verified through secondary research. In addition, findings are based on a single point-in-time analysis of how hospitals and health systems in San Diego County manage behavioral health patients, specifically Severely Mentally Ill (SMI) adults and Severely Emotionally Disturbed (SED) children.

The bulk of information gathered and presented in this report derives from feedback regarding adult behavioral health treatment issues; however, SED children's needs are equally important and the underlying system limitations are much the same. Although some issues and perspectives regarding children's behavioral health were discussed in interviews and included in this summary report, a much more comprehensive analysis including additional pediatric clinicians, schools, and other children's service providers is merited.

Treating behavioral health conditions and understanding the myriad of program regulations and requirements is complicated – there are multiple perspectives for any given situation. Across the board, interview participants consistently expressed feeling overwhelmed, confused, and frustrated in their ability to provide the best care possible to patients with behavioral health conditions via a divided system of care.

Ultimately, this analysis is intended to initiate conversation on how to address challenges and improve patient care. Additional research will be necessary as the behavioral health continuum of care continues to evolve.

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Purpose & Methodology

Purpose

This point-in-time-analysis was conducted to gain a deeper understanding of the behavioral health challenges faced by San Diego's patients. Issues examined included pre- and post-hospitalization services and the impact of social determinants of health on access and outcomes. Ultimately, the findings are intended to support further research efforts and to promote collaboration between San Diego County Behavioral Health Services and other community organizations providing behavioral health services in San Diego.

Definitions

Key terms used in the analysis are defined below:

Point-in-time analysis: For the purposes of this report, a point-in-time analysis refers to a snapshot of the current state of affairs for behavioral health patients and is not meant to cover historic or future conditions and plans.

Psychiatric Inpatient Providers: For the purposes of this report, Psychiatric Inpatient Providers refers to general acute care hospitals with dedicated psychiatric units and freestanding acute psychiatric hospitals.

Social Determinants of Health: The Centers for Disease Control and Prevention (CDC) definition of the Social Determinants of Health provided guidance for this analysis. The CDC defines Social Determinants of Health as: *Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.*

Serious Mental Illness: There is confusion about the language used to describe people with varying levels of mental illness and substance use related conditions. For the most part, the health providers interviewed for this project referred simply to "patients" or "behavioral health patients."

Many different terms are used to describe the acuity of a person's mental illness. The terms vary depending on what guidance is being followed, e.g. federal regulations, legal requirements, or state guidelines. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) provides the following guidance about the term Serious Mental Illness (excerpt below, full brief in Appendix):

> *Serious mental illness (SMI) and severe and persistent mental illness (SPMI) refer to distinct conditions; this is because, although all forms of serious mental illness may be disabling in some way, they are not always severe and persistent (that is, chronic and always disabling). So, although all severe and persistent mental illness may be serious, not all serious mental illness may be severe or persistent. Many mental health professionals, consumers, peers, and advocates use the term SMI to refer to severe mental illness, while the federal agencies use the term to refer to serious mental illness.*

Methodology

A mixed methods approach was used to conduct this analysis. Primary qualitative data was collected through focus groups and key informant interviews performed between May and August 2017. Focused quantitative data analysis of secondary data was completed utilizing hospital discharge data for individuals discharged with a diagnosis of a mental health disorder. Discharge data from both the emergency department and inpatient hospitalizations were analyzed.

The goals of the key informant interviews and focus groups were to understand:

1. What are hospitals and inpatient facilities doing at the different stages in the continuum of care for behavioral health patients, specifically SMI and SED patients?
2. How does the process of caring for behavioral health patients work?
3. Which processes work well and which need improvement?

Specific topics addressed in the focus groups and interviews included:

- admissions
- care management
- discharge planning
- system and policy level observations/recommendations
- follow-up

Interview questions and participating organizations are included in the Appendix.
Figure 1 (below) is a partial list of the participant titles from focus groups or interviews.

Figure 1. Partial Listing of Titles Included in Focus Groups and Key Informant Interviews

Background

The challenges faced by the behavioral health systems in San Diego County are demonstrated by the following:

- On a typical day in San Diego County, *more than 50 patients* are being cared for in acute care emergency departments while they wait for up to *36 hours* for a psychiatric inpatient bed to become available.[4]

- In a typical week in San Diego County, *more than 250 adults* remain in psychiatric inpatient beds, receiving the highest level of acute care, **after** County Behavioral Health Services *determined that the patient requires a less restrictive type of treatment* to address their behavioral health condition.[5]

- In a typical month in San Diego County, Psychiatric Emergency Response Teams respond to more *than 130 behavioral health crises involving children* and *more than 700 involving adults.*[6]

Due to continued concerns about increasing patient volumes, capacity challenges, and inadequate reimbursement rates, the Hospital Association of San Diego & Imperial Counties (HASD&IC) Board of Directors asked staff to convene discussions among hospital behavioral health providers to review gaps in San Diego County's behavioral health continuum of care and prioritize areas of need.

Soon after these discussions started, HASD&IC learned that additional long-term beds were becoming available and successfully advocated for the County of San Diego to contract for all the beds. Even with these additional beds, however, capacity was still limited, and it quickly became clear that one critical area of need was the inadequate supply of step-down options in San Diego County.

Subsequently, further discussions with the County of San Diego led to the convening of a collaborative, the *Behavioral Health Continuum of Care Collaborative*. HASD&IC and the County of San Diego took on the primary leadership roles in this collaborative and were tasked with examining pre-acute, acute, and post-acute services.

The purpose of the collaborative was to identify existing gaps in services and provide recommendations about how to improve the Behavioral Health System for the San Diego County region. Several meetings were convened with broad groups of stakeholders consisting of hospitals, clinics, advocacy groups, and the County of San Diego. At this point, however, County Counsel raised concern about a potential conflict of interest for the County, and County staff had to recuse themselves from the collaborative.

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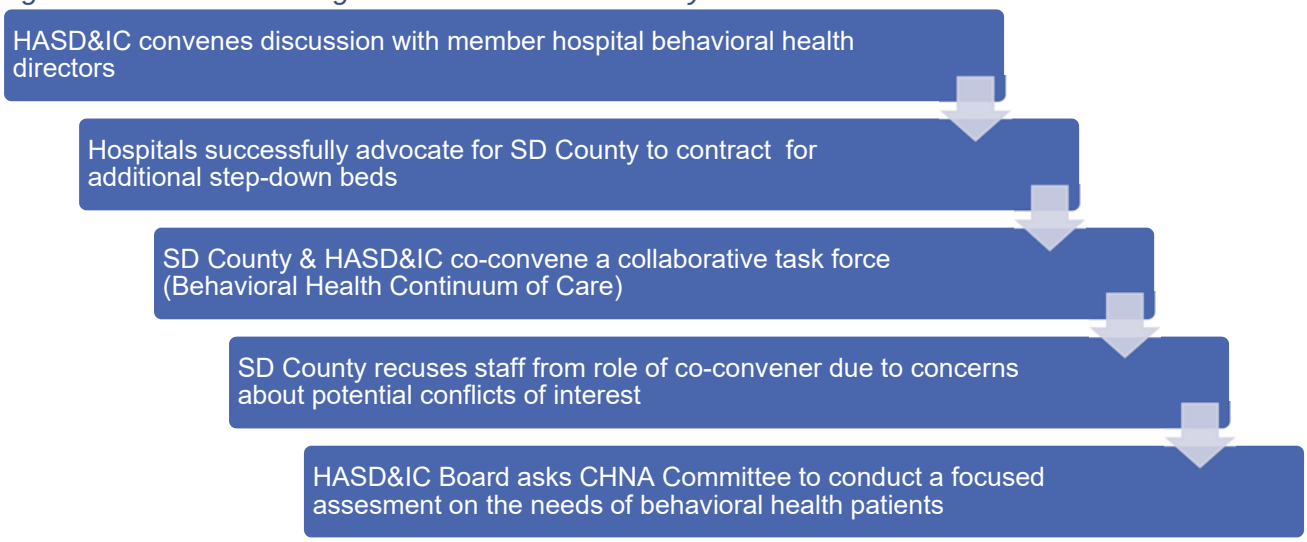
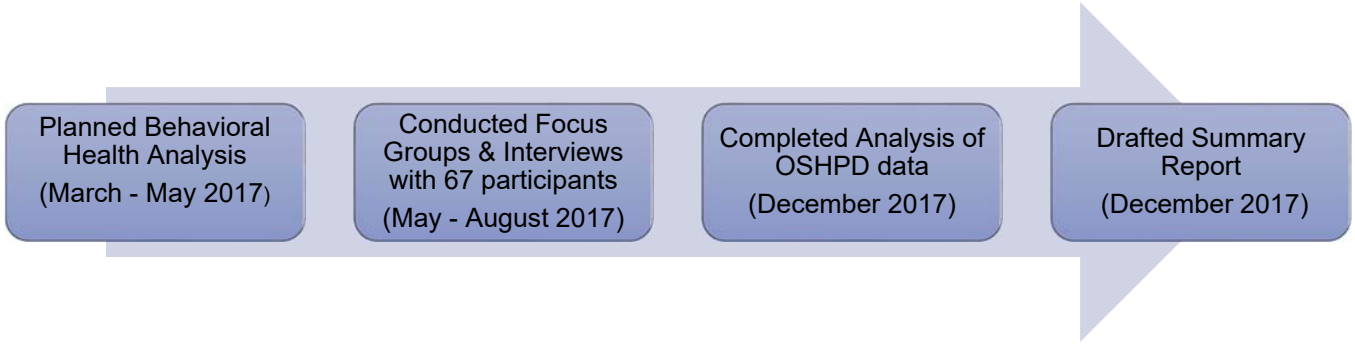
[4] Based on interviews and focus groups conducted in summer and fall of 2017.
[5] Based on County Behavioral Health reports prepared by Optum for FY 17/18. The number of administrative days has increased each year since 2013.
[6] Based on County Behavioral Health reports prepared by Optum for FY 17/18. The number of contacts for adults and children has increased each year since at least 2015, due in part to an increasing number of PERT teams.

Figure 2. Activities Leading to Behavioral Health Analysis



Removal of County leadership led to a narrowed scope of focus. The HASD&IC Board of Directors called upon its Community Health Needs Assessment (CHNA) Committee to conduct a focused analysis of the challenges to treating behavioral health care patients in San Diego. The CHNA Committee adopted a methodology similar to 2013 and 2016 Community Health Need Assessments (CHNAs) that used focus groups, key informant interviews, and hospital data from Office of Statewide Health Planning and Development (OSHPD). The CHNA Committee engaged the Institute for Public Health (IPH) at San Diego State University (SDSU) to conduct the focus groups and key informant interviews and to analyze OSHPD data.

Figure 3. Behavioral Health Analysis Process Outline



The HASD&IC Board of Directors and staff developed this summary report based on the information obtained as part of the Behavioral Health Analysis process with support from the CHNA Committee and the IPH.

Findings

I. Deficiency of Post-Acute Psychiatric Services

FINDING: ***Services across the continuum for behavioral health patients are deficient.*** The severe lack of post-acute care services for Medi-Cal patients has led to increases in the days patients spend in unnecessary in psychiatric inpatient care and, simultaneously, to a greater number of patients being denied inpatient care who need it.

The focus groups and interviews included questions about how treatment in facilities providing psychiatric inpatient services is impacted by insurance or health coverage. Psychiatric inpatient provider staff universally stated that once admitted, all patients receive the same level of care regardless of their insurance coverage. However, access to clinically appropriate post-acute treatment and services varies drastically depending on health coverage or lack thereof. Interviewees overwhelmingly cited finding appropriate behavioral health services in the community for Medi-Cal patients as their most critical challenge.[7] Discharge planners and social workers initiate post-discharge plans immediately upon admission, but the limited availability of step-down facilities stymie these plans.

A San Diego Grand Jury report published in 2016 also documented the need for increased long-term psychiatric beds and step-down facilities. Summary findings are listed below; the full report is included in the Appendix.

San Diego County Grand Jury Report (filed June 2016)

Findings:

1. Revise the contract with Alpine Special Treatment Center to increase the number of long-term beds available to San Diego County residents.
2. Explore options for the closed wing at County Mental Health to provide more long-term psychiatric beds.
3. Explore options using Mental Health Services Act (MHSA) resources to support the establishment of Step-Down facilities for patients leaving long-term treatment centers.

Many of the interviewees had the same general recommendations as the Grand Jury Report; in particular, interviewees frequently asked questions about unused beds at the San Diego County Psychiatric Hospital.

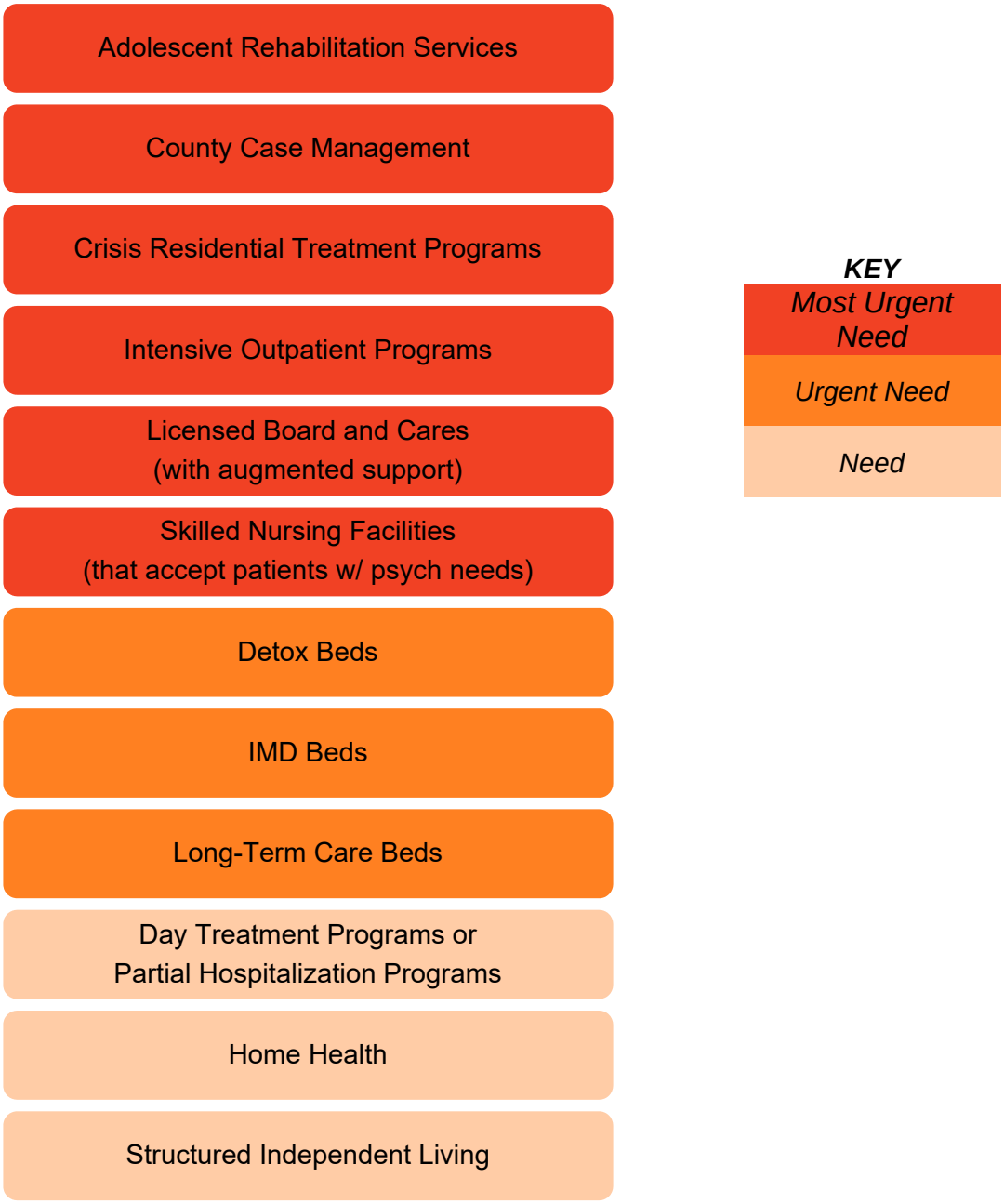
Figure 4 below shows the post-acute care services and resources most frequently cited by interviewees. Interviewers did not offer examples or provide a list of options to choose from; this list is based on open-ended questions regarding the post-acute treatment needs of behavioral health patients.

As noted in Figure 4, there is an urgent need for more long-term care and Institutions for Mental Disease (IMD) beds. Progress has been made in this area over the past 12 months, but more

[7] There was one notable exception. In some specific instances, children and adolescents with Medi-Cal coverage have comparable or better access to post-acute community and outpatient resources than their counterparts with private coverage. This merits additional examination, but is likely due to the different requirements and protections for children with Medi-Cal coverage.

beds are still needed. In general, the additional contracted beds filled within 1 - 2 weeks of becoming available and remain full.

Figure 4. Post-Acute Care Service Needs Identified by Interviewees



Interview participants often cited specific limitations in County and Medi-Cal funding that result in fewer appropriate community resources and treatment options for patients. Specifically, Medi-Cal does not cover the following for SED children and SMI adults:

- Services for dual diagnosis patients, chemical dependency, and substance use disorders for children and adults
- Institutions for Mental Disease (IMD) beds
- Outpatient programs for children and adults
- Intensive Outpatient Programs (IOP)
- Partial Hospitalization Programs (PHP)
- Custodial beds (Some covered by Medi-Cal, but hard to get a patient in for SD county)
- Residential level of care (Specific to Medi-Cal children)

The IMD Exclusion was a frequently expressed concern (see sidebar for background). Several interviewees alluded to the need for advocacy to address this issue. The IMD Exclusion does not actually relieve the State or Counties of financial responsibility over the Medi-Cal SMI; instead, it creates a disincentive to provide that level of care by prohibiting matching federal dollars. The State of California and the counties have interpreted the IMD exclusion in such a way that the County will pay the hospital, but not the physician; thus, it is challenging to have a physician treat a patient for whom they are technically not being paid. To address this issue, hospitals often pay the physician for treating the patient. The reimbursement rate for Medi-Cal patients falls below the administrative costs when taking the physician payment into account.

RECOMMENDATIONS:

1. Support funding to expand behavioral health services, most urgently for post-acute care services. Request data on any cost savings associated with reduced inpatient days and shorter inpatient length-of-stay resulting from additional long-term care beds or the new Crisis Stabilization Units.

2. Support treatment of patients with a purely psychiatric behavioral health crisis (with no medical needs) through further regional expansion of Crisis Stabilization Units.

Institutions for Mental Diseases (IMD) Exclusion

The Medicaid Institutions for Mental Diseases (IMD) exclusion prohibits the use of federal Medicaid financing for care provided to most patients in mental health and substance use disorder residential treatment facilities larger than 16 beds.

The exclusion is one of the very few examples of Medicaid law prohibiting the use of federal financial participation for medically necessary care furnished by licensed medical professionals to enrollees based on the health care setting providing the services.

The exclusion applies to all Medicaid beneficiaries under age 65 who are patients in an IMD, except for payments for inpatient psychiatric services provided to beneficiaries under age 21, and has long been a barrier to efforts to use Medicaid to provide nonhospital inpatient behavioral health services.

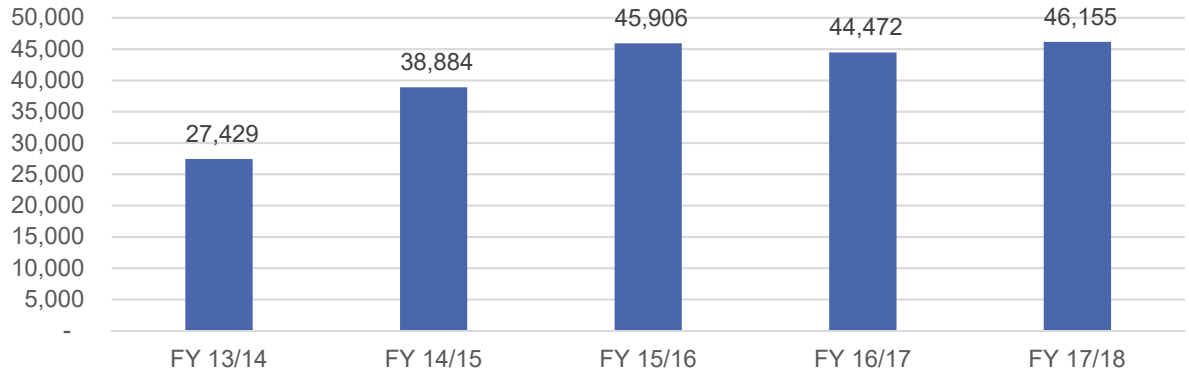
Source: Legal Action Center Fact Sheet https://lac.org/wp-content/uploads/2014/07/IMD_exclusion_fact_sheet.pdf

II. Insufficient Psychiatric Inpatient Capacity

FINDING*: Insufficient inpatient beds are available to Medi-Cal patients who require an immediate acute psychiatric hospitalization.* The overall number of licensed beds for these patients is decreasing. In addition, facilities are facing growing challenges with safely discharging these patients because of the lack of housing and community resources available to them upon discharge.

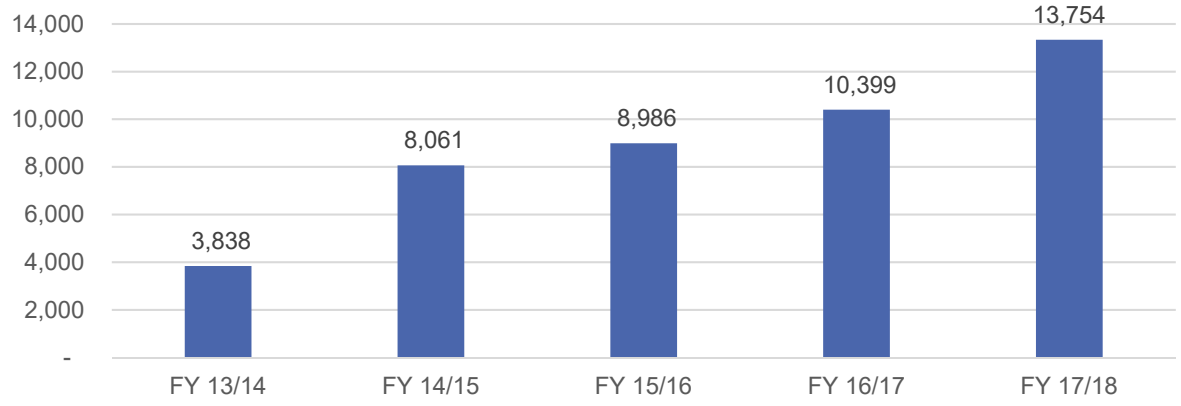
Medi-Cal Psychiatric Inpatient Adults: Acute Days Steady, Admin Days Increasing
Based on the latest data available from County Behavioral Health[8], the volume of Medi-Cal adult psychiatric inpatient acute days has increased over the past five years by 68% since FY 2013/14; however, it has remained relatively stable since FY 2015/16 (see Figure 5).

Figure 5. Inpatient Psychiatric Medi-Cal FFS Adult, Acute Days, FY 2013/14 - FY 2017/18



There has been a significant increase in the number of Medi-Cal administrative days (admin days), with the highest number occurring in FY 2017/18 (13,754). Over the past five years, the number of admin days has increased by 258%. Most recently the number of admin days increased by 28% from FY 2016/17 to FY 2017/18 (see Figure 6 for more details).

Figure 6. Inpatient Psychiatric Medi-Cal FFS Adult, Admin Days, FY 2013-FY 2017/18



[8] *Figures 5 & 6 – Data from the October 2018 County Behavioral Health Dashboard*

Medi-Cal Psychiatric Inpatient Children & Adolescent Acute Days and Admin Days
Based on the latest data available from County Behavioral Health, the volume of Medi-Cal children and adolescent inpatient acute days has been declining since FY 2013/14 (see Figure 7). For more information on trends related to seasonal child & adolescent psychiatric inpatient discharges (including all insurance types) please see Finding VII on page 29. Please note, in both Figure 7 and Figure 8, some of the 2017 data may be impacted due to nine child/adolescent inpatient beds that were temporarily taken off line for planned renovations that occurred between August and December 2017.

Figure 7. Inpatient Psychiatric Medi-Cal FFS Children & Adolescent, Acute Days, FY 2013/14 - FY 2017/18

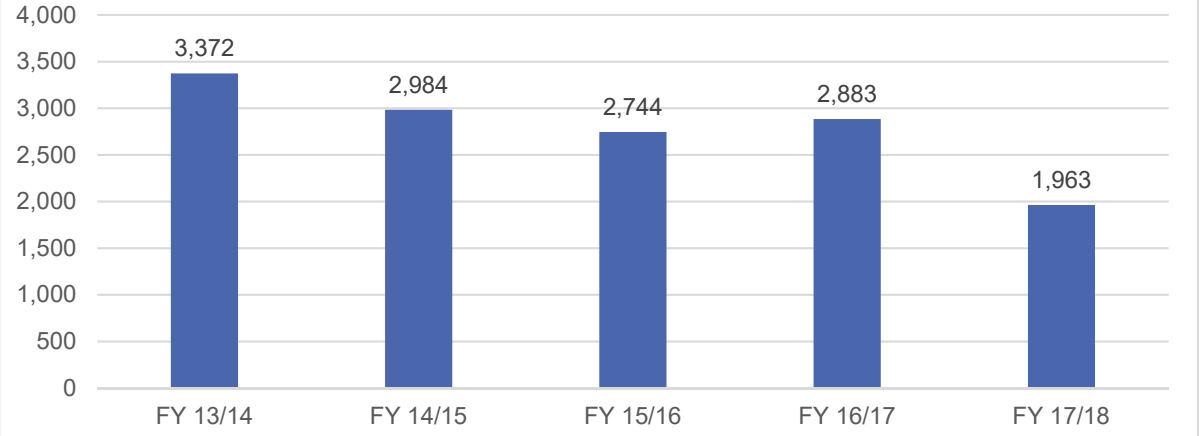
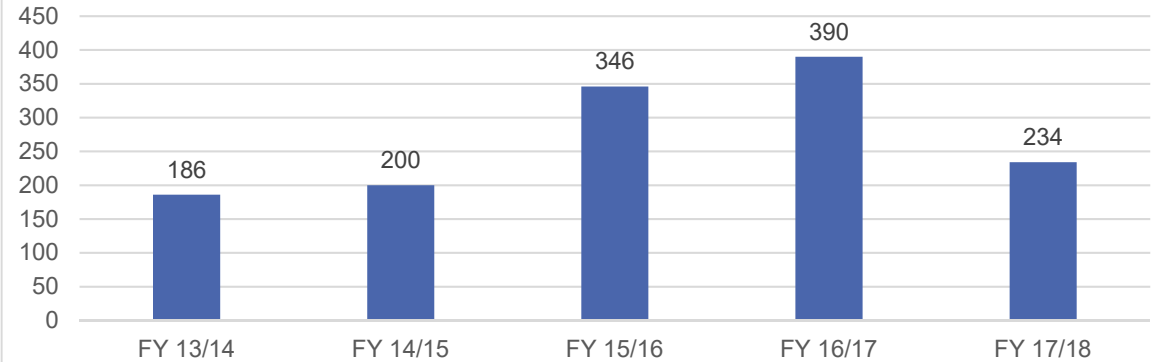


Figure 8. Inpatient Psychiatric Medi-Cal FFS Children & Adolescent Admin Days, FY 2013/14 - FY 2017/18



Findings from Interviews and Focus Groups
Inpatient capacity was frequently mentioned in focus groups and key informant interviews. Behavioral health inpatient capacity was discussed in the following contexts:

1. Inpatient bed capacity challenges;
2. Deficits in post-acute care that exacerbate capacity challenges; and
3. The role of County Behavioral Health in addressing capacity challenges.

Psychiatric Inpatient Capacity Challenges
Psychiatric inpatient providers shared that they were frequently at near or full capacity and unable to accept new patients. At the time of our focus groups and interviews:

- Facilities offering child and adolescent behavioral health services reported being at full capacity and unable to accept new patients on average **50% of the time** depending on the time of the year.
- Adult behavioral health facilities reported being at full capacity and unable to take in new patients on **average 91% of the time**. Free-standing facilities reported being over capacity several times during the month.

Free-standing psychiatric facilities cited their Emergency Medical Treatment & Labor Act (EMTALA) status in further exacerbating their capacity issues. These facilities shared their internal protocols for shifting patients around floors, rooms, or beds, in order to accommodate more incoming patients who meet inpatient criteria.

Deficits in Post-Acute Care Exacerbate Capacity Challenges
Many interviewees shared that inpatient beds were frequently full because of inability to discharge patients to a lower level of care in the community. Community resources, programs, and services are limited, and patients are often ineligible to enroll. Homeless shelters were frequently discussed in this context.

Overall, interviewees agreed that adding inpatient beds would help alleviate some of the daily capacity pressures they feel in their units. However, simply adding additional psychiatric inpatient beds would not address the **downstream impact** of patients who are waiting weeks and sometimes months to be placed in a locked unit or a long-term care facility. As these patients are waiting in acute care beds for extended periods of time, there is reduced capacity for the hospital or facility to accept additional inpatients.

Role of County Behavioral Health in Addressing Capacity
Many interviewees had questions about the funding priorities of the County related to behavioral health services. Several asked specifically if County Behavioral Health Services had conducted an assessment of existing community services and programs and whether these programs and services had been evaluated for outcomes. Interviewees also often asked why more of the County psychiatric hospital beds were not in use.

RECOMMENDATION: Support raising Medi-Cal psychiatric inpatient provider payments. Facilities must receive adequate rates to ensure the long-term viability of providing psychiatric inpatient services for Medi-Cal patients.

III. Divided System of Care and Gaps for Medi-Cal Beneficiaries

FINDING: ***The divided system of care for Medi-Cal patients creates coverage gaps.*** These gaps leave health providers unable to design clinically appropriate treatment plans based on the patient's current health status and projected trajectory.

Under California law since 2014, Medi-Cal beneficiaries receive behavioral health care through two separate systems. Patients considered to be experiencing Mild-to-Moderate mental illness are the responsibility of Medi-Cal Managed Care Plans (Medi-Cal MCPs). Adult patients considered to be experiencing Severe Mental Illness (SMI) or children experiencing Severe Emotional Disturbances (SED) are the responsibility of the County Mental Health Plans (County MHPs). The intent of moving mild-to-moderate benefits into Medi-Cal MCPs was to facilitate better integration of physical and mental health care and to expand available services to Medi-Cal beneficiaries.

Table 1 below demonstrates the confusing and frequently subjective division of behavioral health services. Additional information can be found in the Appendix.

Table 1.
Service Division Between Medi-Cal Managed Care Plans and County Mental Health Plans[9]

Behavioral Health Services Provided by the Medi-Cal Managed Care Plan	Specialty Mental Health Services Provided by the County Mental Health Plan
Covers outpatient treatment for mental health problems that are considered to be **mild to moderate.** Services include but are not limited to: • Outpatient counseling • Group therapy • Psychological testing when it's determined to be appropriate • Visits with a psychiatrist for the purpose of prescribing psychiatric medications • Interpreter services as needed – free of charge.	Covers inpatient and outpatient treatment for Medi-Cal Managed Care Plan members who have a **serious mental health condition** requiring specialized services to recover including ongoing case management. Services include but are not limited to the following: • Inpatient psychiatric hospital treatment • Intensive outpatient or day treatment services • Individual therapy • Medication management with psychiatrist • Crisis intervention • Crisis stabilization • Long-term residential care • Clubhouses • Interpreter services as needed – free of charge

Interviewees were asked if the classification of patients with mental illness into mild, moderate, and severe categories has been of benefit to ensure adequate services are available to these patients. The universal answer was an unequivocal "no." There were three key themes from the comments about the division in responsibility for Medi-Cal patients with behavioral health needs:

[9] HHSA Medi-Cal Member Behavioral Health Quick Guide (HSD BHWG Oct 2017)

1. **The classification of patients into two distinct categories is arbitrary and subjective.** San Diego County Behavioral Health Services has an algorithm that is meant to help health providers identify the appropriate system of care for the patient, but that guidance is also subject to interpretation.

2. **Labeling patients does not provide meaning or value to the clinicians who are treating them.** Patients tend to move back and forth between levels of illness. SMI, SED, and Mild-to-Moderate are not terms that define a pathway or a treatment type for a patient. They are only used for discharge planning because the systems require it to determine the payer source.

3. **Patients and their health providers often get stuck between systems of care.** County MHP and Medi-Cal MCPs Behavioral Health services do not always agree on what entity is responsible for the patient's needed treatment or what treatment is medically necessary (see sidebar).

The confusion about how to label patients leads to problems between the Medi-Cal Managed Care Plans and the County Behavioral Health Plan. Several interviewees expressed that the County MHP has an overly conservative view regarding the acuity of the patient's behavioral health conditions. Patient advocates also noted that the County seemed unnecessarily strict about interpreting the requirements of a gravely disabled designation. Unfortunately, there is no payer with absolute responsibility for patients who fall between the guidelines as interpreted. This is especially problematic for adult patients who are either right on the border of meeting the SMI requirements or who are managing their previously diagnosed SMI condition with some success – a group some interviewees called the "moderately severe."

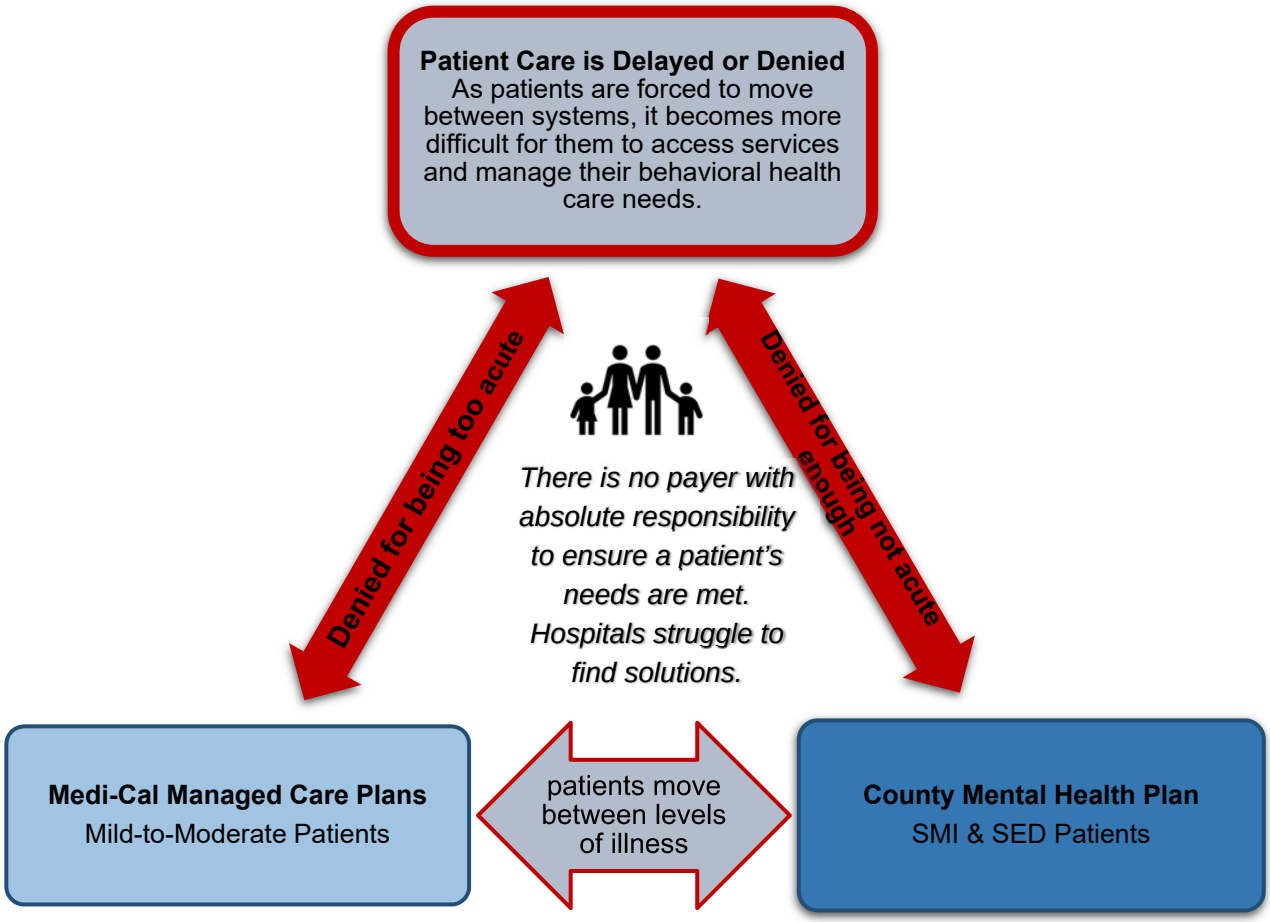
You may have been referred to a County Mental Health Plan provider who evaluates you and determines that you do not have a serious mental health condition. In a case like this, the County Mental Health Plan provider will recommend that you call your Medi-Cal Managed Care Plan to be referred to one of their providers.

Medi-Cal Member Behavioral Health Guide

Healthy San Diego

This gap limits the ability of both inpatient and outpatient providers to meet the needs of their patients. In the case of inpatient hospitals, SMI patients who are unable to discharge to appropriate services remain in psychiatric inpatient beds for weeks or months and are often considered mild-to-moderate by the time they finally leave the hospital. It is the plans, not the health providers, who determine when the patient crosses that threshold between SMI and mild-to-moderate. Even if the discharging hospital recommends that the patient receive continued daily treatment, County Behavioral Health Services may determine that the patient is no longer severe enough. In the case of Federally Qualified Health Centers (FQHCs), the clinicians know that their moderately severe patients need more support than they are able to provide under Medi-Cal payment limitations, but the patient is not able to qualify for County MHP programs.

Figure 9. Medi-Cal Patients Struggle to Access Needed Behavioral Health Services



RECOMMENDATION: Identify best practices in other states or regions that eliminate or reduce gaps between systems of care for Medi-Cal beneficiaries with behavioral health needs.

IV. Inequities in Access and Barriers to Managing Behavioral Health Conditions

FINDING: ***Even when clinical services are available, patients face many challenges to successfully managing their behavioral health conditions on their own.*** Social determinants of health, such as the availability of housing and transportation, inadequate income, and lack of family support, were identified as the most frequent barriers to creating a safe discharge plan.

Many interviewees commented on behavioral health patients' inability to navigate the bifurcated system of care and manage their health. In addition to the lack of behavioral health services in the community, interviewees universally cited circumstances such as insufficient housing, access to care, finances, and family support as barriers to discharge planning and successful treatment. Figure 10 below lists the most frequently cited social determinants of health identified by hospitals, health systems, Federally Qualified Health Centers, and an organization that advocates for people with mental illness.

Figure 10. Social Determinants of Health Limit Patients' Ability to Manage Their Care

Housing

- Lack of housing is a primary challenge for many patients.
- Finding shelter for SMI homeless patient is an immense challenge.
- Some people do not feel safe in shelters or do not want to go shelters.
- SSI income impacts housing options.

Access to Care

- Insurance coverage determines patient access to the appropriate level of care.
- Patients without financial resources have fewer options.
- Needed services do not exist in communities.

Family Support/Conservatorship

- Family support is key, especially for safe discharge.
- Conservatorship slows discharge process - conservator is generally difficult to get in contact with, and often disagrees with discharge plans or other pertinent decisions.

Medication

- Medication adherence is a challenge; patients need assistance to take their medications correctly.
- Costs present another barrier; patients are often unable to afford their medications.
- The preauthorization requirement for some medications from insurance companies complicates treatment. Physicians do not readily have information on which medications fall into either category, but any authorization or delay is significant for a recently discharged patient.
- The approval process for medications between the the insurance company and the doctor's prescription request can take up to 72 hours, during which time patients may return to the ED due to lack of critical medications.

Transportation

- Patients have serious cognitive and resource challenges getting to and from appointments and to a pharmacy to pick-up medication.

Income

- Patients may be unable to miss work to attend appointments or therapy.

RECOMMENDATION: Redesign case management services for Medi-Cal patients. Goals should include reducing the unfunded burden on health providers and making it faster and easier for patients to gain access to needed treatment and services. This will entail improving care coordination between community and hospital behavioral health care providers. Case management must include evidence-based screening for social determinants of health and a plan to address barriers created by those determinants.

V. Insufficient Case Management for Patients with Medi-Cal

FINDING:

1. ***County Behavioral Health case management does not adequately support patients being treated for severe mental illness (SMI) or severe emotional disturbance (SED) in community-based settings.*** The most serious SMI and SED patients are often referred to County Behavioral Health from Federally Qualified Health Centers (FQHCs). Significant barriers prevent these individuals from receiving the kind of emergent care they need: inpatient or crisis stabilization services. Delays in treatment for SMI and SED patients in crisis can result in further deterioration of their mental health and a preventable visit to an emergency department.

2. ***County Behavioral Health case management does not accept new patients and connect them to necessary post-acute services in a timely manner.*** The burden of finding appropriate, available, and County Behavioral Health Plan-approved placements and services, therefore, falls on hospital staff, and options are limited. While Medi-Cal inpatients wait for placements and services that have availability and are willing to accept them, they receive what has been deemed an inappropriate level of treatment in an acute care setting.

   Further complicating this situation, once the patient has been approved for release, the psychiatric inpatient provider is subsequently reimbursed for this time at an "administrative day" rate. This reimbursement rate is lower, despite the fact that the hospital continues to provide the patient with the same care, creating a financial burden for the facility.

Throughout the interviews and focus groups, there was a consistent theme of frustration with the failure of County Behavioral Health to offer timely case management to patients who are ready for discharge. Patients with behavioral health conditions need significant support to navigate the system. They need assistance to figure out where to go and when, find transportation, follow up on instructions about care, and successfully adhere to their treatment plan. These services are very difficult to access.

Access to County Behavioral Health Case Management for Non-Hospitalized Patients
The most serious SMI and SED patients who have been assessed at FQHCs are often referred to County Behavioral Health. Although there are at least two ways to connect with County Behavioral Health services, interviewees explained that both present significant barriers to individuals needing emergent access to inpatient or crisis stabilization services.

1. **In-person option:** The in-person option requires the patient to physically go to one of the two County Mental Health clinics to enroll in case management. The problem with in-person access is that many, if not most, encounter a wait in the clinic that stretches for the entire day, often forcing an ill-equipped patient to leave without being seen. This is a barrier that many patients struggling with behavioral health challenges simply cannot overcome.
2. **Phone call option:** The phone call option requires the patient (or a family member) to reach County Mental Health by telephone and request case management. One problem with this option is phone requests are generally reviewed only once a week.

In either case, delays in treatment for SMI and SED patients who may be in crisis could result in further deterioration of their mental health or a preventable visit to an emergency department.

Role of County BH Case Management in Discharge Planning from Inpatient Settings
Hospital discharge planning teams have the responsibility for identifying and securing appropriate post-acute care services for their patients, and they begin this planning on the first day of admission. These staff expressed that their efforts to implement discharge plans are seriously hindered by an unresponsive County Behavioral Health case management system. Interviewees made the following observations about working with County Behavioral Health case management:

- It can be difficult to get a patient accepted into County Behavioral Health case management services. County Behavioral Health case management will sometimes decline referrals because the patient is getting better and does not need case management services. Even when a patient is accepted, it was reported that County Behavioral Health case management provides minimal support.

- The quality of the County Behavioral Health case management workforce has deteriorated in recent years; it may be that the case managers are less qualified -- in the past, case managers had a Master's degree.

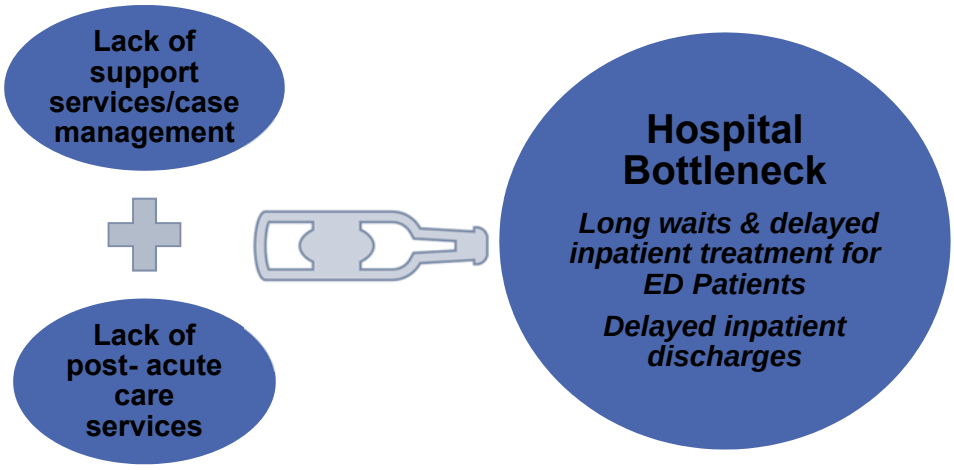
- There is a very high turnover of County Behavioral Health case managers, and patients complain their phone calls are never returned.

To make up for the deficiencies of County Behavioral Health case management support for these patients, interviewees stated that they hire additional staff (such as social workers or discharge planners) to fulfill the role of case manager. These staff coordinate patient discharge plans and make connections to resources. Case management functions in the County Behavioral Health system are not centralized. This has resulted in a fractured and inefficient approach to securing post-acute behavioral health services for Medi-Cal patients.

Many interviewees shared frustration with the amount of staff time required to secure post-acute care and services for their patients. Discharge planning staff must call numerous program or service locations to find and secure a place for their patient. If there is no availability that day, they are required to continue calling the program or service provider every day to ensure ongoing payment (usually at the lower Administrative Day Rate). Interviewees expressed frustration with the task of keeping up with program requirements. For most placements and programs to accept a patient, they not only have to have availability, they also have to ensure that the patient meets their own specific eligibility requirements. This means that the programs may decline to accept the patients even when they have room for them.

All this activity takes up a large proportion of staff time and adds stress to hospital staff who are treating and creating discharge plans for multiple patients. While discharge planning staff are struggling to find programs for their patients, other patients are waiting in the emergency department in dire need of inpatient level treatment. Discharge delays create a circular problem – there is a daily shortage of psychiatric inpatient beds, but the patients who are admitted stay much longer than necessary, further exacerbating the shortage.

Figure 11. Insufficient Case Management Prevents and Delays Patients from Accessing Care



When hospital staff are unable to discharge the patient due to the lack of appropriate step-down options, the County Behavioral Health Plan may deny the daily rate or reduce the rate to an administrative day rate. Although many discharge challenges are a result of the dearth of services and placement availability, interviewees believe these difficulties could be more efficiently addressed with centralized case management support from County Behavioral Health.

Effective Case Management Requires Communication Between Health Providers, County Behavioral Health and the Medi-Cal Managed Care Plans

RECOMMENDATIONS:

1. Redesign case management services for Medi-Cal patients. Goals should include reducing the unfunded burden on health providers and making it faster and easier for patients to gain access to needed treatment and services. This will entail improving care coordination between community behavioral health care providers and psychiatric inpatient providers. Case management must include evidence-based screening for social determinants of health and a plan to address barriers created by those determinants.
2. Prioritize regional efforts to electronically exchange behavioral health information. Information should be integrated into electronic health records and allow health providers, Medi-Cal Managed Care Plans and the County Behavioral Health Plan to engage in real-time decisions about a patient's treatment plan and document requests for services.
3. Focus on opportunities to more fully incorporate and integrate FQHCs in the behavioral health continuum. Support an FQHC role in case management, develop more warm-handoffs to FQHCs from inpatient settings, and address barriers to sharing behavioral health information between health providers.

VI. Workforce Shortages

FINDING: ***Workforce shortages create severe deficits across the behavioral health continuum of care, limiting access to critical services.*** Recruiting and retaining qualified behavioral health providers is a growing challenge. The shortage of qualified behavioral health professionals narrows the range and availability of behavioral health services.

Deficient reimbursement has resulted in a shortage of psychiatrists who accept Medi-Cal in San Diego County. The situation is particularly dire for children in need of psychiatric inpatient services, with the extremely small number of child and adolescent psychiatrists and psychologists who are willing to accept Medi-Cal and work in acute care settings continuing to decline.

Interviewees were asked about broad challenges they faced in providing appropriate care for their behavioral health patients. A universal concern about the inadequate behavioral health workforce emerged, particularly from the health systems providing inpatient care. Below are the key challenges as well as some of the strategies used to mitigate deficits in the behavioral health workforce:

1) **There is a local and statewide shortage of psychiatrists, with an even smaller number who are willing to accept Medi-Cal patients.**
   Many interview participants cited the inadequate number of adult and child psychiatrists working in the San Diego County region (as well as the State) as being one of the main challenges they faced in accessing care for severely mentally ill patients. Furthermore, this shortage is exacerbated by low or non-existent Medi-Cal reimbursement rates. Some facilities adopted a payment practice in which the facility paid the physician a fee for treating Medi-Cal patients, increasing the facility's financial loss for these high-cost and high-need patients.

2) **Most psychiatrists are not looking to work in the inpatient setting.**
   Interviewees stated that not only is there a shortage of psychiatrists in general, but among the limited pool of active psychiatrists, there is a strong preference for working in outpatient settings, in more affluent areas, and with self-pay patients. These preferences conflict with the needs of behavioral health patients who need inpatient treatment, primarily in low-income communities, in a setting that accepts Medi-Cal or unfunded patients.

3) **Health systems use locum tenens and temporary staff, providers, or services when they are unable to fill positions.**
   Hospital based interviewees shared that in order to ensure proper patient care, they substitute particular provider or staff roles with temporary staff, or draw upon psychiatric nurse practitioners or social workers. Some facilities had social workers filling the role of case manager or conservator in coordinating patient discharge plans and making connections to resources. Interviewees expressed that the additional social workers were necessary due to weak support from County Behavioral Health case management.

4) **Health systems need well-qualified behavioral health staff and clinicians with strong experience.**
   Many interviewees expressed that recruitment of qualified behavioral health care providers was particularly challenging. Nurses with behavioral health experience are difficult to find; in general, nurses do not receive sufficient training in behavioral health, and some may not have "real world" exposure to the field. Psychiatric Mental Health Nurse Practitioners were the most difficult to recruit, as cited by one of the interviewees.

Workforce was also a key theme in the focus groups with FQHCs. Many FQHCs struggle to recruit behavioral health clinicians. They have positions that have remained unfilled for years. The rural locations are using TeleMed/TelePsych services.

One FQHC system stated that through constant recruitment efforts over the six months prior to the focus group, they had made significant progress in addressing their shortage of physicians. They have low turnover and a high retention rate for psychiatrists. The recruitment practices that lead to success included the following:

- Contact physicians who have just completed residency program.
- Use current providers to reach out to other colleagues when there is an opening, including referral bonuses for certain critical positions.

Recommendation: Conduct research to determine best practices for addressing the behavioral health workforce shortage. Research should consider changes to scope-of-practice rules and best practices for recruiting and retaining qualified clinical staff across the behavioral health continuum.

Suggestions for Additional Research

Facilitate interviews with residents, medical students, and other master level graduates to learn how to attract recent graduates into needed behavioral health positions.

Conduct research on effective models in other states or regions.

VII. Seasonal Trends in Child and Adolescent Hospital Admissions

FINDING: ***Preventative and family support services are needed in high-volume months.*** There are seasonal trends in pediatric behavioral health emergency department visits and psychiatric inpatient admissions, demonstrating the need for increased services to families during these months.

During the key informant interviews and focus groups, several hospitals spoke to the seasonality of psychiatric inpatient admissions for children and adolescents, stating that April/May and August/September were two of the peak admission times. In order to better understand the seasonality of both Inpatient and Emergency Department (ED) discharges, data was examined from the Office of Statewide Planning and Development (OSHPD) (see appendix for more details) by pulling monthly discharges for mental disorders for ages 0-17 years of age for the years 2013 through 2016. The data was limited to all San Diego County facilities (data on individual hospitals that provide psychiatric inpatient treatment is included in the Appendix).

The total number of inpatient discharges for children and adolescents aged 0 to 17 years from San Diego County hospital facilities for a mental disorder decreased from 2013 to 2016 by 8 percent. The average inpatient discharges for 2013 and 2016 were not statistically different from each other (262.17 in 2013 and 240.42 in 2016). However, when examining seasonality from 2013 to 2016, the first statistical increase among children and adolescents during the school year comes in October (287.00), followed by increases again in April (263.50) and May (281.50). (Please see Figure 12 and Table 2 below for more information).

Figure 12. Inpatient Discharges: San Diego Facility Discharges with a Principal Diagnosis of a Mental Disorder by Month for Ages 0-17 Years of Age, 2013-2016

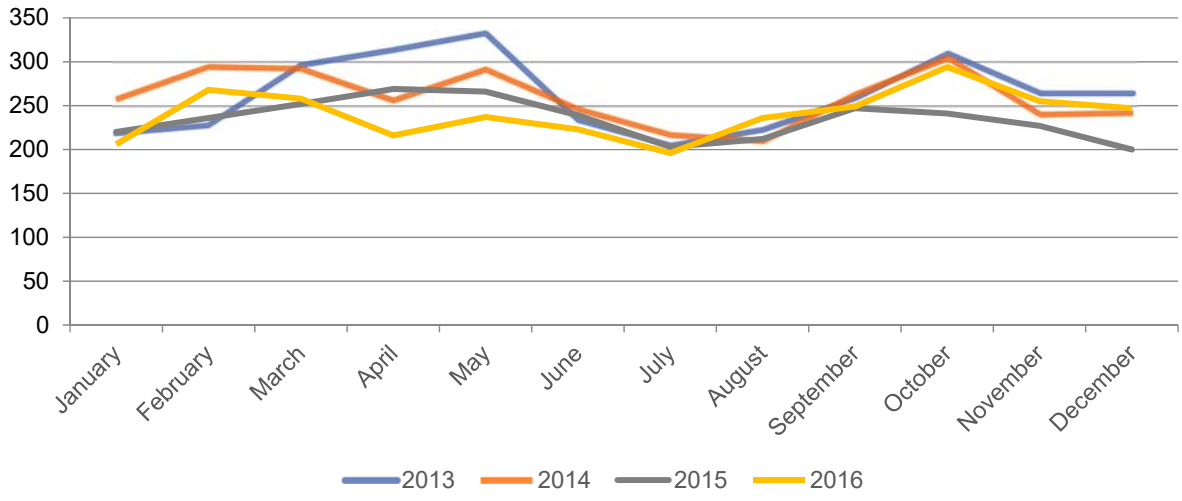


***Table 2. Seasonality Trends for Inpatient Discharges**: San Diego Facility Discharges with a Principal Diagnosis of a Mental Disorder by Month for Ages 0-17 Years of Age, 2013-2016*

Hospital	Month	2013		2014		2015		2016		% Change from 2013-2016
		#	%	#	%	#	%	#	%	
All San Diego Facilities	January	219	7.0%	257	8.3%	220	7.8%	206	7.1%	-5.9%
	February	228	7.2%	**294**	**9.4%**	236	8.4%	**268**	**9.3%**	17.5%
	March	**296**	**9.4%**	**292**	**9.4%**	**252**	**9.0%**	258	8.9%	-12.8%
	April	**313**	**9.9%**	256	8.2%	**269**	**9.6%**	216	7.5%	-31.0%
	May	**332**	**10.6%**	**291**	**9.4%**	**266**	**9.5%**	237	8.2%	-28.6%
	June	234	7.4%	246	7.9%	239	8.5%	223	7.7%	-4.7%
	July	205	6.5%	217	7.0%	203	7.2%	196	6.8%	-4.4%
	August	223	7.1%	210	6.7%	212	7.5%	236	8.2%	5.8%
	September	259	8.2%	263	8.5%	247	8.8%	249	8.6%	-3.9%
	October	**309**	**9.8%**	**304**	**9.8%**	241	8.6%	**294**	**10.2%**	-4.9%
	November	264	8.4%	240	7.7%	227	8.1%	255	8.8%	-3.4%
	December	264	8.4%	242	7.8%	200	7.1%	247	8.6%	-6.4%
	TOTAL	3146	100%	3112	100%	2812	100%	2885	100%	-8.3%

In contrast, the total number of ED discharges for children and adolescents aged 0 to 17 years from San Diego County hospital facilities for a mental disorder increased from 2013 to 2016 by 16% percent. The average inpatient discharges for 2013 and 2016 were statistically different from each other (212.75 in 2013 and 245.75 in 2016). When examining seasonality from 2013 to 2016, the first statistical increase among children and adolescents during the school year comes in September (271.50) and October (293.25), followed by increases again in March (254.75), April (270.00), and May (292.25). (Please see Figure 13 and Table 3 below for more information).

Figure 13. Emergency Department Discharges: San Diego Facility Discharges with a Principal Diagnosis of a Mental Disorder by Month for Ages 0-17 Years of Age, 2013-2016

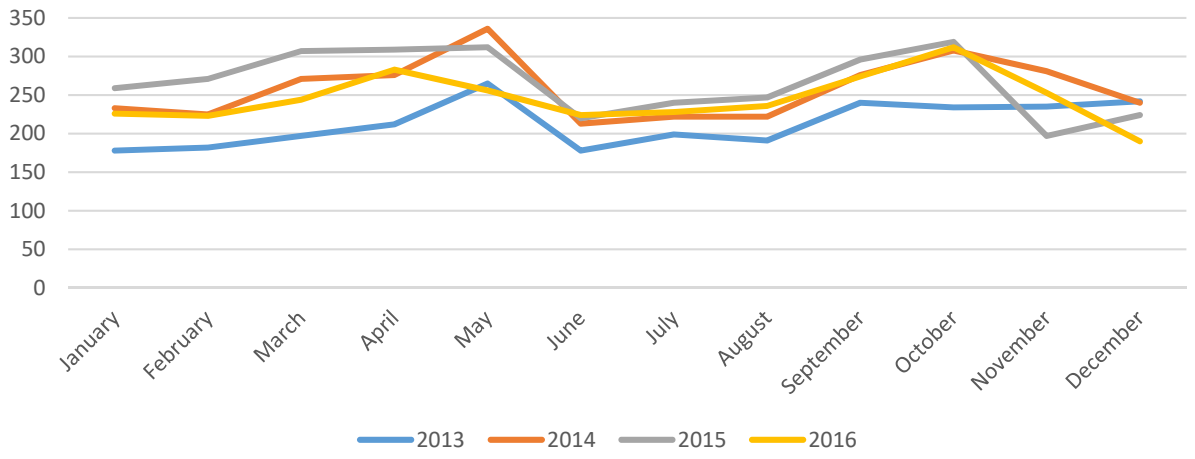


Table 3. Seasonality Trends in Emergency Department Discharges: *All San Diego Facility Discharges with a Principal Diagnosis of a Mental Disorder by Month for Ages 0-17 years of Age, 2013-2016*

Hospital	Month	2013		2014		2015		2016		% Change from 2013-2016
		#	%	#	%	#	%	#	%	
All San Diego Facilities	January	178	7.0%	233	7.5%	259	8.1%	226	7.7%	27.0%
	February	182	7.1%	225	7.3%	271	8.5%	223	7.6%	22.5%
	March	197	7.7%	271	8.7%	307	9.6%	244	8.3%	23.9%
	April	212	8.3%	276	8.9%	**309**	**9.7%**	**283**	**9.6%**	33.5%
	May	**265**	**10.4%**	**336**	**10.8%**	**312**	**9.7%**	256	8.7%	-3.4%
	June	178	7.0%	213	6.9%	220	6.9%	224	7.6%	25.8%
	July	199	7.8%	222	7.2%	240	7.5%	228	7.7%	14.6%
	August	191	7.5%	222	7.2%	247	7.7%	236	8.0%	23.6%
	September	**240**	**9.4%**	276	8.9%	**296**	**9.2%**	**274**	**9.3%**	14.2%
	October	**234**	**9.2%**	**308**	**9.9%**	**319**	**10.0%**	**312**	**10.6%**	33.3%
	November	**235**	**9.2%**	**281**	**9.1%**	197	6.2%	253	8.6%	7.7%
	December	**242**	**9.5%**	240	7.7%	224	7.0%	190	6.4%	-21.5%
	TOTAL	2,553	100%	3,103	100%	3,201	100%	2,949	100%	15.5%

RECOMMENDATION: Share findings with existing pediatric behavioral health workgroups and solicit recommendations on how to address increased need during high-volume months. Explore additional contracting or funds as possible solutions.

Growing Challenges to the Behavioral Health Continuum of Care

Many additional challenges were cited in the focus groups and interviews. These key issues warrant further research.

- Co-occurring mental illness and substance use disorders are incredibly difficult to treat.
- There is a serious and growing need for family support and respite care.
- There are problems with independent living facilities that are not well regulated are often dangerous places for vulnerable patients.
- Several interviewees mentioned the role of health plans for dual-eligible patients who are enrolled in the Coordinated Care Initiative. Additional interviews could provide more information on how that program is helping or hindering patient care.
- Appropriate care for children on the Autism spectrum with behavioral health problems is nearly impossible to find.
- Based on preliminary OSHPD analysis for the 2019 CHNA, there are some very concerning trends for children and adolescents:
    - The rate of hospitalization for self-inflicted injury among children 0-14 years old increased by 86% in San Diego from 2012-2016.
    - Rates of discharge from in-patient treatment related to anxiety among children (0-14) have increased by 60% from 2012-2016.
    - Rates of discharge from emergency departments for self-inflicted injury have increased by 19.6% for young adults 15-24 years old from 2012-2016.
    - From 2012-2016, hospitalization rates for acute substance abuse increased most (201%) among 15-24 year olds.

Appendix Items

(as of September 2018)

Due to the large size of the appendix, a separate file with the following items is available upon request.

Appendix A:

- HASD&IC Behavioral Health Services Task Force Recommendations

County of San Diego Grand Jury Report 2015-2016

- Long-Term Psychiatric Beds in San Diego County
- Mental Health Services Act in San Diego County
- Response to 2015-2016 Grand Jury Reports

Hospital Data

- Hospital Dashboard Fiscal Year 2015- 2016, San Diego County Health and Human Services
- County of San Diego Behavioral Health Services, Inpatient Psychiatric Summary for Medi-Cal FFS Children & Adolescents, for discharges through the month of June 2016
- Preliminary Hospital Discharge Data Analysis within San Diego County Facilities and San Diego County Residents

HHSA County Data

- HHSA Ten Year Roadmap Behavioral Health Services
- County of San Diego MHSA Fiscal Year 2016 - 2017 Annual Update
- HHSA Ten Year Roadmap Behavioral Health Services: Accomplishments Year One

Key Informant Interviews

- Preliminary Information from Behavioral Health Analysis KI and Focus Group Interviews: Questions for San Diego County Behavioral Health Services (BHS) and Medi-Cal Managed Care Plans
- Focus Group and Key Informant Interview Participants