THE BOARD OF SUPERVISORS OF THE COUNTY OF STANISLAUS
ACTION AGENDA SUMMARY

DEPT: Health Services Agency **BOARD AGENDA #** B-8

Urgent ☐ **Routine** ☒ **AGENDA DATE** May 13, 2008

CEO Concurs with Recommendation YES ☒ **NO** ☐ **4/5 Vote Required YES** ☐ **NO** ☒
(Information Attached)

SUBJECT:

Approval of the Two-Year Pilot Program for Mental Health Care for Eligible Indigents

STAFF RECOMMENDATIONS:

1. Approve the Two-Year Pilot Program for Mental Health Care for Eligible Indigents.
2. Authorize the Director of Behavioral Health and Recovery Services, the Managing Director of the Health Services Agency and the Director of the Community Services Agency to take action necessary to implement and support the Pilot Program.
3. Authorize the Health Services Agency to incrementally implement the mental health care related Board action pursuant to the 6:35 p.m. Public Hearing held on March 18, 2008, in coordination with the implementation of this Pilot Program, in an effort to reasonably minimize the impact on established patients.

FISCAL IMPACT:

The county cost of this Pilot Program is estimated to be $204,763 to $269,763 in the first twelve months of full implementation and $104,261 to $166,511 in the second twelve months of operation. Through a reconciliation process, the total cost of the Pilot Program would be split equally between the Health Services Agency Clinic and Ancillary budget and the Behavioral Health and Recovery Services budget.

(Continued on Page 2)

BOARD ACTION AS FOLLOWS:

No. 2008-342

On motion of Supervisor O'Brien **, Seconded by Supervisor** Monteith
and approved by the following vote,
Ayes: Supervisors: O'Brien, Grover, Monteith, DeMartini and Chairman Mayfield
Noes: Supervisors: None
Excused or Absent: Supervisors: None
Abstaining: Supervisor: None

1) X **Approved as recommended**
2) _____ **Denied**
3) _____ **Approved as amended**
4) _____ **Other:**
MOTION:

Christine Ferraro

ATTEST: **CHRISTINE FERRARO TALLMAN, Clerk** **File No.**

FISCAL IMPACT (Continued):

This cost would be in lieu of the $280,384 that the Health Services Agency has been incurring to provide serious mental illness prescription medications. The net effect of this Pilot Program in the first twelve months of full implementation would be a savings to the County of $10,621 to $75,621.

To consider the impact by the department budgets involved, for the Health Services Agency, rather than saving the projected $280,384 (as contained in the staff recommendations presented on March 18, 2008), the Health Services Agency savings is estimated to be $145,503 - $178,003, after the reconciliation with Behavioral Health and Recovery Services.

For Behavioral Health and Recovery Services, the estimated increase in cost would be $102,382 to $134,882, and would be funded by the use of departmental fund balance in the first year of implementation.

If these staff recommendations are approved, the estimated budget adjustments will be included in the Proposed Budget for Fiscal Year 2008-2009 to be presented to the Board of Supervisors on June 10, 2008.

DISCUSSION:

On March 18, 2008 the Health Services Agency (HSA) asked the Board of Supervisors to eliminate the provision of no cost mental health benefits including psychotropic drugs, from the Clinics and the Medically Indigent Adult (MIA) program. The Health Services Agency had estimated that 157 residents would be impacted by this proposal based on the Fiscal Year 2006-2007 prescription drug dispense volume by the Agency's pharmacy of psychotropic drugs. The proposal was not only based upon the absence of a mandate to provide this care and the cost to the County, but also an inappropriate scope of practice issue in which Health Service Agency Primary Care Physicians were essentially expected to fulfill the role of a Psychiatrist, which is an area of Specialty care and beyond the scope and training of a Primary Care Physician. Currently there is no process or funding available for MIA patients who present with serious mental illness symptoms or history and no other physical health issues (approximately 157 annually) to be referred into the Behavioral Health and Recovery Services (BHRS) system of care (with the exception of crises requiring hospitalization). Unlike the physical health mandate for indigents, there is no mental health mandate or funding for non-crisis care.

During the public hearing, the Board heard from numerous community members of the need for some type of mental health program for MIA patients. The Board, on a 3-2 vote approved the recommended action and asked HSA and BHRS to develop program options to serve the population with a serious mental illness who qualify for the Medically Indigent Adult program, and who have no other access to mental health care, and to return to the Board within 60 days to present the options.

HSA, BHRS, CSA and Chief Executive Office (CEO) have met regularly to develop program options that will provide some level of consultation/treatment for those patients

currently seen by the HSA Primary Care Physicians and that require assessment, treatment or follow-up for mental illness. As part of these discussions, the initial patient population was reviewed by BHRS to more clearly define the scope of their illness. The following table describes the estimated ratios of mental and/or behavioral health issues associated with these patients:

Probable illness	**Percentage**
Serious mental illness (SMI)	19
Co-occurring disorders – Individuals with both a mental illness and an alcohol or other drug problem	36
Mostly an alcohol or drug problem	25
Moderate/mild mental illness typically treated by primary care physicians	20

Additionally, of the initial 157 patients, about 11% are currently participating in BHRS programs. It is anticipated that 20% of patients may be able to remain under the care of HSA physicians with little to no assistance from a psychiatrist, and that 27% would benefit from alcohol and drug treatment alone. Unfortunately, individuals needing alcohol and drug treatment would encounter access problems with county programs operating at capacity already. Additionally, for those individuals with alcohol and/or drug abuse problems, psychotropic drugs may be ineffective and thus avoidable for those who continue to abuse alcohol and/or drugs.

A work group consisting of BHRS, CSA, HSA and CEO representatives explored several solutions and projected cost and feasibility, including availability of required staffing and providers. General assumptions of what would be included in a proposed program have been made and are as follows:

1. An outreach/advocacy component to assist appropriate individuals to apply for and be granted Social Security and/or Medi-Cal benefits to secure a payor source whenever possible;
2. A Gatekeeper component at HSA to pre-screen and limit referrals and to prepare comprehensive referral information to enable the most efficient use of psychiatry capacity; and
3. Integrated system components involving BHRS, CSA and HSA to most effectively utilize County resources and expertise.

<u>Proposed Pilot Program</u>
HSA and BHRS clinical staff would screen and assess the eligible indigent patients and refer to community psychiatrist(s) on contract, for consultation either in-person or through telepsychiatry or a combination thereof in an effort to achieve needed capacity. The psychiatrist would consult with the primary care physician using a drug formulary that would be obtainable from low cost pharmacy options. If patients appeared to be eligible for disability, the psychiatrist would provide the required documentation to be used by SSI Advocates to get these patients covered by Medi-Cal. The amount of psychiatry time estimated in this pilot is based on a further review by mental health

clinicians of the MIA patient population. Not all MIA patients are patients of both the HSA and BHRS, therefore some assumptions had to be made to make this estimate.

A funding stream to support the outreach/advocacy and patient assessment components of this program is accessible by pass-through from the Community Services Agency. Staff would complete time studies to document this work effort and in accordance with current Federal/State rules, reimbursement would be available at a rate of 50% for the outreach/advocacy work of non-licensed personnel and 75% for the screening/assessment/consultation work of licensed personnel. This advocacy effort may involve staff time at each of the three departments (BHRS, CSA and HSA). Additionally, for those patients who were made eligible for Medi-Cal, retroactive Medi-Cal reimbursement would be sought for the actual medical care and prescriptions drugs costs incurred. CSA can assist with obtaining prior Medi-Cal benefits through provision of a Letter of Authorization justifying services over one year. As the eligibility process can take generally between 6 and 18 months, there would be a significant lag in expense recovery making this pilot at least a two-year project in order to measure effectiveness.

Challenges associated with this pilot program include the availability of qualified personnel. To date, BHRS has been unable to attract any new psychiatrists to this area. The doctors serving patients at the local psychiatric inpatient hospital are locum tenens, meaning they come only for short periods of time, i.e., two months or so, and then move on to another area of the country. Presently, BHRS has no unutilized psychiatric time that could be made available for this pilot. BHRS' outpatient psychiatrists' capacity is just adequate to provide for regulatory obligations. For this reason, the possibility of telepsychiatry was considered. This may be available either by contract or perhaps through purchase of the required equipment and the establishment of the presentation capability within County services. There may be an additional cost to provide for the necessary equipment if telepsychiatry is necessary to fulfill capacity needs.

As a matter of implementation, the Board action of March 18, 2008 which directs the Health Services Agency (HSA) to eliminate the provision of no cost mental health benefits including psychotropic drugs, from the Clinics and the Medically Indigent Adult (MIA) program would be incrementally made effective as the pilot is implemented.

Specifically, the HSA would continue to provide the medications as written by the HSA Primary Care Physician until a screening, assessment and/or psychiatric consultation or treatment was made available for the patient. Thereafter medications would continue unless such screening, assessment or psychiatric consultation or treatment directed otherwise. Medications under this pilot program would continue to be provided through the HSA pharmacy and would be obtained through manufacturer free drug programs whenever possible. Drugs, which HSA would have to purchase, would be purchased whenever possible, at the 340B federal discount pricing made available by the Federally Qualified Health Center Look-Alike designation.

Trained Volunteer Peer Support

This pilot would also explore the possibility of securing trained peer support personnel that could be available in the HSA clinics. Oftentimes, these individuals (the volunteers), who have experienced many of the behavioral health problems that MIA patients have, are able to assist others in getting into recovery. They may be very effective with the group of individuals that have been identified as having mild to moderate mental health issues. Sometimes with this type of support, these individuals are able to rely less on medications and more on peer support. Information could be available for family members regarding resources available to help family members.

Financial Projections of the Pilot Program

The following table illustrates the projections of the expenses and available recovery of expenses of this pilot program. It is important to note that the projections assume the program is fully implemented and illustrates the expenses once all existing patients have been assessed and corresponding medications adjusted as appropriate. Once implementation of the pilot has started, it is anticipated that the current annual psychotropic drug rate would incrementally decrease from the $280,384 level to the $110,890 level.

	Year 1		Year 2	
Expenses		w/telepsych & treatment		w/telepsych& treatment
HSA Gatekeeper Screening by Licensed Clinical Social Worker	41,400	41,400	43,470	43,470
BHRS Pre-Screened by a Mental Health Clinician	48,840	48,840	51,282	51,282
SSI/Medi-Cal Application Outreach/Advocacy	30,000	30,000	31,500	31,500
Psychiatrist Contract Services	49,000	49,000	51,450	51,450
Psychiatry Disability Evaluations	16,500	16,500	16,500	16,500
Telepsychiatry Equipment and or Services		65,000		35,000
Medications	110,890	110,890	116,435	116,435
Annual Expenses	296,630	361,630	310,637	345,637
Potential Revenue and Recovery				
Medi-Cal Outreach/Advocacy Reimbursement through CSA program	91,868	91,868	96,461	96,461
Medi-Cal Reimbursement if converted to Medi-Cal Eligibility	0	0	73,915	82,665
Annual Revenue to Offset Expenses	91,868	91,868	170,376	179,126
Forecasted Annual County Expense	$204,763	$269,763	$140,261	$166,511
(make take more than one year to recover some expenses)				

* Year 1 begins at full implementation, after all established patients have been assessed and medications adjusted.

The primary difference between the low and high forecasts given for each year is the potential expense of the equipment necessary to provide telepsychiatry and the expanded access that may be needed for treatment. The low projection ($49,000) for psychiatry services assumes patients will either be assessed and become eligible for an existing BHRS program, or can be managed by the Primary Care Physician with the compliment of psychiatry consultation but not psychiatry treatment. If through this pilot some patients fall between a BHRS program and the scope of the Primary Care Physician, access may be necessary beyond the capacity provided within the $49,000 projection.

Given that assumptions were made to develop this projection, the actual experience could vary. However, considering that the current expenditure level for psychotropic drugs dispensed for this population is approximately $280,000, this pilot would suggest that although the County would not save the full $280,000, a more effective integrated service could be provided for less that the current level of expenditure.

The Cost of Non-treatment

The ability of HSA to continue the status quo is not an option, given the scope of practice issues and what has been recently identified about ineffective drug dispensing. It is anticipated that elimination of the mental health benefit as recommended to the Board on March 18, 2008 would have a cost impact on the County, although the full cost is unknown. Of the 157 initial patient population, 29 were hospitalized at SBHC or SRC during the time they were receiving mental health services/drugs from the Clinics, at a cost of $224,769. It is likely that hospitalizations and cost would increase if these patients were not receiving mental health services/drugs from the Clinics, but there are no clear means to accurately estimate by what amount. It is also not clear what costs might arise from increased law enforcement demand as this information was not available due to issues with confidentiality.

Attempts to identify relevant published research that would provide a measure on the likelihood of incarceration if treatment were not continued was not helpful. One study was reviewed of Serious Mentally Ill inmates revealed almost an equal split between those that stated they had received treatment during the twelve month period leading up to their offense and those that had not.

"Since admission, 61 percent of the mentally ill inmates in state prison and 41 percent of mentally ill detainees in local jails reported that they had received treatment for a mental health problem, including counseling, medication, or other mental health services." Source: Federal Probation a journal of correctional philosophy and practice, September 2006 Newsletter, Volume 70 Number 2.

Most other studies found were related to those already incarcerated and treatment protocols, so did not contribute to this project.

POLICY ISSUE:

Approval of this item supports the Board of Supervisors' priorities of a healthy community and efficient delivery of public services, by leveraging the resources and expertise within three county departments to provide appropriate mental health care to eligible indigents while minimizing the financial impact to the County.

STAFFING IMPACT:

The staffing impact related to this Pilot Program would be accommodated by the use of extra help or Personal Services Contracted personnel. In some cases, full time staff may perform work in this Pilot Program, however the time made available for this Pilot would be filled by an extra help or Personal Services Contracted individual, when necessary.

Stanislaus County
Striving to be the Best

MENTAL HEALTH BOARD

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Phone: 209.525.6225 Fax: 209.558.8233

May 9, 2008

The Honorable Thomas W. Mayfield, Chairman
Stanislaus County Board of Supervisors
1010 Tenth Street
Modesto, CA 95354

Dear Supervisor Mayfield:

In our letter to you of March 14, 2008, the Mental Health Board voiced concerns with regard to the Health Services Agency's (HSA) proposed enforcement of the benefits policy excluding coverage for mental health and substance abuse treatment under the Medically Indigent Adult (MIA) program. Mental Health Board members, along with other community members, also expressed their concerns at the Public Hearing held on March 18.

Following approval of the HSA recommendations with a 3-2 vote, the Board of Supervisors instructed staff from HSA and Behavioral Health and Recovery Services (BHRS) to develop program options to serve individuals with a serious mental illness who qualify for the MIA program and have no other access to mental health services. Staff were to present the program options to the Board of Supervisors within 60 days.

Subsequent to this, the Mental Health Board requested that the recommendations be presented to them for input prior to the presentation to the Board of Supervisors. This occurred at a special meeting of the Mental Health Board held yesterday. Following the presentation of the recommendations and extensive discussion, the Mental Health Board voted unanimously to support the proposed recommendations.

On behalf of the Mental Health Board, I would like to express our appreciation for the consideration you gave to our concerns and comments. We also appreciate your commitment to providing access to much needed services for individuals with serious mental illnesses. Further, we want to commend staff of HSA, BHRS and the Community Services Agency for their thoughtful efforts with regard to this issue.

Sincerely,

Robert Angell
Chair

B-8

NAMI Stanislaus
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(209) 558-4555

May 12, 2008

The Honorable Thomas W. Mayfield, Chairman
Stanislaus County Board of Supervisors
1010 Tenth Street
Modesto, CA 95354

Dear Supervisor Mayfield:

The Stanislaus Chapter of the National Alliance on Mental Illness would like to encourage the approval of the two-year pilot program for mental health care for the Medically Indigent Adults (MIA) that are affected by cuts proposed by the Health Services Agency.

Our officers have attended meetings to discuss options and feel that people who are diagnosed with severe mental illness should be treated by psychiatrists and not physicians. We believe that providing assistance to "fast track" qualifying for SSI and Medi-Cal will provide the best avenue to pay for treatment.

A concern would be using volunteer peer support. They would need to be well trained and provided with good resources to be effective.

On behalf of family members who find it difficult to find effective treatment for our loved ones, we hope you will provide funding necessary to treat them and not let them be another casualty of budget cuts.

Sincerely,

Lynn Padlo
Joyce A. Plis

Lynn Padlo, President
Stephanie Madearos, Vice president
Bob Madearos, Treasurer
Joyce A. Plis, Secretary

NAMI
National Alliance on Mental Illness