EXHIBIT A: TARGET POPULATIONS BAI

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Agenda Item

DATE: July 17, 2007

TO: Board of Supervisors

FROM: Giang T. Nguyen, Director, Department of Behavioral Health
Catherine A. Huerta, Interim Director, Department of Children and Family Services

SUBJECT: Approve Policy Recommendation Regarding Priority Target Populations that Local Mental Health Programs are Mandated to Serve

RECOMMENDED ACTION:

Approve the policy recommendation for Fresno County mental health services provision regarding priority target populations that local mental health programs are mandated to serve, to conform their services with the California Welfare and Institution Code Section 5600.1 and 5600.2.

Approval of the recommended action will allow the Departments of Behavioral Health and Children and Family Services to focus provision of mental health services to those populations the County is mandated to serve while maximizing funding, with no increase in net County cost.

FISCAL IMPACT:

There is no increase in net County cost associated with the recommended action. In FY 2005-06, the Department of Behavioral Health (DBH) spent an estimated $2.4 million for adult outpatient services to non-Medi-Cal, non-severely mentally ill consumers.

IMPACTS ON JOB CREATION:

The recommended action has no impact on the Regional Jobs Initiative.

DISCUSSION:

The Fresno County Departments of Behavioral Health (DBH) and Children and Family Services (DCFS) are dedicated to providing quality services to the priority target populations identified within the Bronzan-McCorquodale Act (Welfare and Institution Code Section 5600.1 and 5600.2) and to all County residents who are Medi-Cal beneficiaries and meet the State Department of Mental Health's medical necessity criteria.

In accordance with Welfare and Institution Code Sections 5600.1 and 5600.2, the County is mandated to

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BOARD ACTION: DATE _____ APPROVED AS RECOMMENDED _____ OTHER _____

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FC-017 (eForms-0904)

provide mental health services to adults with severe and disabling mental illness (SMI) and children who are severely emotionally disturbed (SED) regardless of financial means. The priority population criteria and eligibility for the adult target population is outlined in Attachment A and for the children/youth in Attachment B. These regulations require that local mental health program's first priority will be to provide an array and intensity of services required by the State for the priority target populations. County residents who are Medi-Cal beneficiaries must meet the State Department of Mental Health's medical necessity criteria established in the Welfare and Institutions Code Section 5777 and Section 1830.205 of Title 9 of the California Code of Regulations. The Medi-Cal Managed Care Medical necessity criteria is outlined in Attachment C.

Historically, the Departments have provided mental health services to a broader population than that mandated under the California Welfare and Institutions Code Section 5600.1 and 5600.2 and the State Department of Mental Health's mental health managed medical necessity criteria. This was accomplished through the use of both budgeted and unbudgeted General Fund revenues that are no longer available. This recommended policy change will establish the County's mission and the priority mental health target populations to be served in conformance with existing state law.

The transition plan regarding the adult populations is illustrated in Attachment D and will effect 650 clients annually. Non-Medi-Cal eligible non-SMI consumers will continue to provide outpatient services for a maximum of twelve months until the consumers are stabilized on medications and/or from receiving counseling services. If appropriate, DBH will provide a transfer of services to a community provider as outlined in the adult transition plan, Attachment E. Providing a higher and more concentrated level of services to the adult SMI populations will reduce the use of acute inpatient services and the number of consumers who are subsequently placed on conservatorship and experience long term institutional care.

The DCFS estimates 48 children will be effected if the recommended action is approved. There are 244 children receiving services from DCFS that have private insurance; of those 189 are served by the Department's crisis division and 7 receive services from court services. Both of these populations would continue to be services regardless of payor status.

Crisis intervention services will continue to be provided to all County residents, as mandated by Welfare and Institutions Code section 5600.2(d), regardless of financial means, who as a result of their mental illness are determined to be a danger to their self or others or are gravely disabled and require acute services.

OTHER REVIEWING AGENCIES:

The item was reviewed by County Counsel and discussed with the Fresno Chapter of the National Alliance for the Mentally Ill (NAMI) Executive Committee. On June 27, 2007, the Mental Health Board approved the proposed policy and transition plan and concurred with presentation to your Board for consideration.

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TARGET POPULATION FOR ADULT SERVICES

PRIOIRTY POPULATION CRITERIA

The priority target population is to individual with a severe and persistent mental illness. The criteria utilized are that the individual suffers from (1) a severe psychiatric impairment (Axis I and II), (2) exhibit an impaired level of functioning that prevents them from sustaining themselves in the community without treatment, supervision, rehabilitation and supports, and (3) whose illness and impaired level of functioning is persistent in duration. Excluded from this criterion are individuals who have a primary diagnosis of substance abuse and those individuals with a sole diagnosis of developmental disabilities. The criteria also exclude individuals with a primary diagnosis of organic brain syndrome.

OPERATIONAL DEFINITION

Individual who are considered to be severe and persistently mentally ill must meet the following criteria to be eligible for services:

Criteria A

At least one of the following diagnoses as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorder IV-TR:

Schizophrenia
295.1 Disorganized
295.2 Catatonic
295.3 Paranoid
295.4 Residual
295.5 Undifferential

Schizoaffective Disorder
295.70

Bipolar Disorders
296.0x Bipolar I
296.4x Manic
296.5x Depressed
296.6x Mixed
296.7 Most Recent Episode, Unspecified
296.80 Bipolar Disorder Not Otherwise Specified
296.89 Bipolar II Disorder

Major Depression
296.3x Recurrent

Delusional Disorder
297.1

Psychotic Disorder Not Otherwise Specified
298.9

Criteria B:
A Global Assessment Functioning Scale with a score of 60 or lower

Criteria C:
The client's actual Functional Impairment(s) must be specifically identified and documented in writing in the chart and the notation must indicated how they have limited or impacted the individuals daily functioning.

TARGET POPULATION FOR CHILDREN/YOUTH SERVICES

PRIORITY POPULATION CRITERIA

The priority population of children and youth are permanent residents of the County or Medi-Cal beneficiaries of Fresno County and who meet the following criteria:

- Children/Youth who are beneficiaries of Medi-Cal, Healthy Families or Healthy Kids insurance and who meet the State-defined medical necessity criteria for specialty mental health services including services to children and youth who are severely emotionally disturbed (SED).
- Any Fresno County resident who is a ward or dependent of the court.
- Children and Youth determined to eligible for services under Government Code Section, Title 1, Division 7, Chapter 26.5.
- Children/Youth in psychiatric crisis.

OPERATIONAL DEFINITION

Individuals who are considered to be included with the target population must meet the following criteria:

Criteria A

Included diagnoses include at least one of the following as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorder IV-TR:

- Pervasive developmental Disorder (except Autistic Disorder)
- Attention Deficit and Disruptive Behavioral Disorders
- Schizophrenia and Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Eating Disorders
- Impulse-Control Disorders, not classified elsewhere
- Adjustment Disorders
- Personality Disorder (except Antisocial Personality Disorder)
- Other Disorders of Infancy, Childhood or Adolescence

Criteria B

At least one of the following current degrees of impairment:

- Either a significant impairment in an important areas of life functions, or
- A probability of significant deterioration in an important area of life functioning, or
- There is a probability that the child/youth will not progress developmentally as individually appropriate.

Criteria C

At least one of the following degrees of risk as demonstrated:

- Significant Risk of out of home placement or failed school placement.
- Past/present psychiatric emergency visits and hospitalizations that indicate a high probability of current risk, unrelated to substance abuse, medical conditions or cognitive impairment.
- Significant degree of current risk of self-injurious behavior or injury to others as a result of an included diagnosis, as demonstrated by:
    - Recent serious thoughts of harming self/others, or
    - Recent significant injurious behaviors

STATE DEPARTMENT OF MENTAL HEALTH
MEDI-CAL MANAGED CARE
MEDICAL NECESSITY CRITERIA

Medical necessity for managed care specialty mental health services which are the responsibility of the County mental health plan must meet the three following criteria:

DIAGNOSES

Must have one of the following DSM IV-TR diagnoses, which will be the focus of any treatment intervention which is provided:

Included Diagnoses:

- Pervasive Developmental Disorders, except Autistic Disorders which are excluded
- Attention Deficit and Disruptive Behavioral Disorders
- Elimination Disorders
- Schizophrenia and other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorders
- Eating Disorders
- Impulse-Control Disorders, Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorder, excluding Antisocial Personality Disorders
- Medication-Induced Movement Disorders

Excluded Diagnoses:

- Mental Retardation
- Learning Disorders
- Communication Disorders
- Autistic Disorders
- Tic Disorders
- Delirium, Dementia, Amnestic and Other Cognitive Disorders
- Mental Disorders due to a general medical condition
- Substance-Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorders

A beneficiary may receive services for an included diagnosis even when an excluded diagnosis is

also present.

IMPAIRMENT CRITERIA

Must have one of the following as a result of a mental disorder(s) identified in the diagnostic criteria and must have one of 1, 2, or 3 below

1. A significant impairment in an important area of life functioning, or
2. A probability of significant deterioration in an important area of life functioning or
3. Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder that can be corrected or ameliorated.

INTERVENTION RELATED CRITERIA

Must have **all** 1, 2, and 3 below:

1. The focus of the proposed intervention must address the condition identified as part of the impairment criteria above and
2. It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and
3. The condition would not be responsive to physical based health care treatment.

DEPARTMENT OF BEHAVIORAL HEALTH

TRANSITION PLAN FOR CLIENTS BASED ON TARGET POPULATIONS POLICY

Presented to Mental Health Board 6/27/07

POPULATION	TARGET POPULATION	CRISIS SERVICES	NEW CLIENTS	CURRENT NUMBER AFFECTED	TIME FRAME TO TRANSITION OUT OF COUNTY OUTPATIENT SYSTEM
NON MEDI-CAL ELIGIBLE & NON-SERIOUSLY MENTALLY ILL (SMI)	NO	CONTINUES	NOT ACCEPTED AFTER POLICY APPROVAL	650	CLIENTS CURRENTLY RECEIVING SERVICES WILL CONTINUE TO RECEIVE SERVICES UNTIL THEY ARE STABILIZED ON MEDICATIONS AND/OR FROM RECEIVING COUNSELING SERVICES – UP TO 12 MONTHS MAXIMUM. TRANSFER TO COMMUNITY PROVIDER IF NEEDED.
MEDI-CAL ELIGIBLE & NON- SERIOUSLY MENTALLY ILL (SMI)	YES IF MEET STATE MEDICAL NECESSITY CRITERIA	CONTINUES	ACCEPTED IF CLIENT MEETS STATE MEDICAL NECESSITY CRITERIA	1379	STABLE CLIENTS CURRENTLY RECEIVING SERVICES WILL BE TRANSFERRING TO A COMMUNITY-BASED AGENCY OR PRIMARY HEALTH CARE PROVIDER ++
MEDI-CAL ELGIBILE & NEEDING SPECIALITY MENTAL HEALTH SERVICES	YES	CONTINUES	WILL BE ACCEPTED	3418 SMI MEDI-CAL	NO TRANSITION OUT. THIS REMAINS MEDI-CAL ELIGIBLE POPULATION
SERIOUSLY MENTALLY ILL (SMI) REGARDLESS OF PAYOR SOURCE	YES	CONTINUES	WILL BE ACCEPTED	3418 MEDI-CAL 1234 NON MEDI-CAL 4652 TOTAL	NO TRANSITION OUT. THIS REMAINS THE TARGET POPULATION

++ See attached Community Resource List

DEPARTMENT OF BEHAVIORAL HEALTH
TRANSITION PLAN FOR CLIENTS BASED ON TARGET POPULATIONS POLICY

This transition plan would be applicable for clients who are:

- **Non-severely and non-persistently mentally ill**
  AND
- **Are not medi-cal eligible**

BACKGROUND

The Department of Behavioral Health is proposing to develop policies and procedures in order to comply with existing state law regarding the expenditure of mental health realignment funds for services rendered to those individuals who meet the state defined target populations. The Department of Behavioral Health is proposing the following plan to transition individual who are not Medi-Cal eligible and who do not suffer from a severe and persistent mental health disorder (SMI) out of the existing outpatient mental health system.

This policy is imperative if the Department is going to redesign its current delivery system and to focus it's financial and human resources on serving the target populations identified in existing state law. All county residents, regardless of payer source, who are in crisis, will continue to be seen by the Crisis Response Service (CRS).

NEW CLIENTS

New clients who do not have a diagnosis of major depression, schizophrenia or other psychotic disorders or mood disorder (bi-polar) and who are not Medi-Cal beneficiaries, (thus do not meet the State's target population definition) would not be eligible to receive outpatient services from the Department of Behavioral Health.

TRANSITION PLAN FOR EXISTING CLIENTS

Clients currently receiving services who are not Medi-Cal beneficiaries and who do not meet the State' target population definition, would continue to receive service for up to 12 months. Since of the majority of clients are episodic users of service and typically stop coming for services after a few months, it is anticipated that a significant number of clients will discontinue outpatient services on their own accord. An analysis of the non-severely mentally ill clients seen in outpatient services during the first 11 months of FY 06-07, 56% have already completed their treatment and are no longer in care. Of the 650 clients seen, 70% of them received 6 visits or less.

At any point, if non-target population clients become stabilized on medications and/or from receiving counseling services, they will be assisted in transferring to a community agencies or primary health care providers. At the end of the 12 month period, a multi-disciplinary utilization review team will be established to review and authorize services for those clients who are considered in need of additional services.

TIME FRAME

- New admission of clients to crisis and inpatient would continue.
- New admission of non Medi-cal, non SMI clients to outpatient services would cease when the Board of Supervisors approved this policy.
- For existing non-target population clients currently receiving outpatient services will be transferred during the FY 07-08 fiscal year. At the end of FY 07-08, if any non-target population clients (who were not Medi-Cal beneficiaries) who remain in care will have their cases reviewed on an individual basis before a decision would be made regarding disposition.

FISCAL IMPACT

In FY 05-06, the Department spent approximately 2.4 million dollars providing outpatient services to clients who were not Medi-Cal beneficiaries and who were not severely and persistently mentally ill.

In the first 10 months of this fiscal year 2006-07, clients who were not severely and persistently mentally (both Medi-Cal eligible or non-Medi-eligibles) accounted for only 8.23% of all cost of acute inpatient services. The severely and persistently mentally ill, on the other hand, accounted for 91.77% of all acute inpatient costs during this same time period. Providing a higher level of service to clients with severely and persistent mental illness will reduce the use of acute inpatient services and the number of clients who are subsequently placed on conservatorship and transferred in long term institutional care.

EXHIBIT B: COMPREHENSIVE CONTINUOUS INTEGRATED SYSTEM OF CARE (CCISC) MODEL

By Kenneth Minkoff, MD

The Four Basic Characteristics of the Comprehensive, Continuous, Integrated System of Care Model

The Comprehensive, Continuous, Integrated System of Care (CCISC) model for organizing services for individuals with co-occurring psychiatric and substance disorders (ICOPSD) is designed to improve treatment capacity for these individuals in systems of any size and complexity, ranging from entire states, to regions or counties, networks of agencies, individual complex agencies, or even programs within agencies. The model has the following four basic characteristics:

System Level Change: The CCISC model is designed for implementation throughout an entire system of care, not just for implementation of individual program or training initiatives. All programs are designed to become dual diagnosis capable (or enhanced) programs, generally within the context of existing resources, with a specific assignment to provide services to a particular cohort of individuals with co-occurring disorders. Implementation of the model integrates the use of system change technology with clinical practice technology at the system level, program level, clinical practice level, and clinician competency level to create comprehensive system change.

Efficient Use of Existing Resources: The CCISC model is designed for implementation within the context of current service resources, however scarce, and emphasizes strategies to improve services to ICOPSD within the context of each funding stream, program contract, or service code, rather than *requiring* blending or braiding of funding streams or duplication of services. It provides a template for planning how to obtain and utilize additional resources should they become available, but does not require additional resources, other than resources for planning, technical assistance, and training.

Incorporation of Best Practices: The CCISC model is recognized by SAMHSA as a best practice for systems implementation for treatment of ICOPSD. An important aspect of CCISC implementation is the incorporation of evidence based and clinical consensus based best practices for the treatment of all types of ICOPSD throughout the service system.

Integrated Treatment Philosophy: The CCISC model is based on implementation of principles of successful treatment intervention that are derived from available research and incorporated into an integrated treatment philosophy that utilizes a common language that makes sense from the perspective of both mental health and substance disorder providers. This model can be used to develop a protocol for individualized treatment matching, that in turn permits matching of particular cohorts of individuals to the comprehensive array of dual diagnosis capable services within the system.

The Eight Principles of Treatment for the CCISC

The eight research-derived and consensus-derived principles that guide the implementation of the CCISC are as follows:

Dual diagnosis is an expectation, not an exception: Epidemiologic data defining the high prevalence of co-morbidity, along with clinical outcome data associating ICOPSD with poor outcomes and high costs in multiple systems, imply that the whole system, at every level, must be designed to use all of its resources in accordance with this expectation. This implies the need for an integrated system planning process, in which each funding stream, each program, all clinical practices, and all clinician competencies are designed proactively to address the individuals with co-occurring disorders who present in each component of the system already.

All ICOPSD are not the same; the national consensus four quadrant model for categorizing co-occurring disorders *(NASMHPD, 1998) can be used as a guide for service planning on the system level.* In this model, ICOPSD can be divided according to high and low severity for each disorder, into high-high (Quadrant IV), low MH – high CD (Quadrant III), high MH – low CD (Quadrant II), and low-low (Quadrant I). High MH individuals usually have SPMI and require continuing integrated care in the MH system. High CD individuals are appropriate for receiving episodes of addiction treatment in the CD system, with varying degrees of integration of mental health capability.

Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting; provision of continuous integrated treatment relationships is an evidence based best practice for individuals with the most severe combinations of psychiatric and substance difficulties. The system needs to prioritize a) the development of clear guidelines for how clinicians in any service setting can provide integrated treatment in the context of an appropriate scope of practice, and b) access to continuous integrated treatment of appropriate intensity and capability for individuals with the most complex difficulties.

Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting. Each individual client may require a different balance (based on level of functioning, available supports, external contingencies, etc.); and in a comprehensive service system, different programs are designed to provide this balance in different ways. Individuals who require high degrees of support or supervision can utilize contingency based learning strategies involving a variety of community-based reinforcers to make incremental progress within the context of continuing treatment.

When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended. The system needs to develop a variety of administrative, financial, and clinical structures to reinforce this clinical principle, and to develop specific practice guidelines emphasizing how to integrate diagnosis-specific best practice treatments for multiple disorders for clinically appropriate clients within each service setting

Both mental illness and addiction can be treated within the philosophical framework of a "disease and recovery model" (Minkoff, 1989) with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery), in which interventions are not only diagnosis-specific, but also specific

to phase of recovery and stage of change. Literature in both the addiction field and the mental health field has emphasized the concept of stages of change or stages of treatment, and demonstrated the value of stage-wise treatment (Drake et al, 2001.)

There is no single correct intervention for ICOPSD; for each individual interventions must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and (in a managed care system) multidimensional assessment of level of care requirements. This principle forms the basis for developing clinical practice guidelines for assessment and treatment matching. It also forms the basis for designing the template of the CCISC, in which each program is a dual diagnosis program, but all programs are not the same. Each program in the system is assigned a "job": to work with a particular cohort of ICOPSD, providing continuity or episode interventions, at a particular level of care. Consequently, all programs become mobilized to develop cohort specific dual diagnosis services, thereby mobilizing treatment resources throughout the entire system.

Clinical outcomes for ICOPSD must also be individualized, based on similar parameters for individualizing treatment interventions. Abstinence and full mental illness recovery are usually long term goals, but short term clinical outcomes must be individualized, and may include reduction in symptoms or use of substances, increases in level of functioning, increases in disease management skills, movement through stages of change, reduction in "harm" (internal or external), reduction in service utilization, or movement to a lower level of care. Systems need to develop clinical practice parameters for treatment planning and outcome tracking that legitimize this variety of outcome measures to reinforce incremental treatment progress and promote the experience of treatment success.

Twelve Steps for CCISC Implementation

Integrated system planning process: Implementation of the CCISC requires a system wide integrated strategic planning process that can address the need to create change at every level of the system, ranging from system philosophy, regulations, and funding, to program standards and design, to clinical practice and treatment interventions, to clinician competencies and training. The integrated system planning process must be empowered within the structure of the system, include all key funders, providers, and consumer/family stakeholders, have the authority to oversee continuing implementation of the other elements of the CCISC, utilize a structured process of system change (e.g., continuous quality improvement), and define measurable system outcomes for the CCISC in accordance with the elements listed herein. It is necessary to include consumer and family driven outcomes that measure satisfaction with the ability of the system to be welcoming, accessible and culturally competent, as well as integrated, continuous, and comprehensive, from the perspective of ICOPSD and their families.

Formal consensus on CCISC model: The system must develop a clear mechanism for articulating the CCISC model, including the principles of treatment and the goals of implementation, developing a formal process for obtaining consensus from all stakeholders, identifying barriers to implementation and an implementation plan, and disseminating this consensus to all providers and consumers within the system.

Formal consensus on funding the CCISC model: CCISC implementation involves a formal commitment that each funder will promote integrated treatment within the full range of services provided through its own funding stream, whether by contract or by billable service code, in accordance with the principles described in the model, and in accordance with the

specific tools and standards described below. Blending or braiding funding streams to create innovative programs or interventions may also occur as a consequence of integrated systems planning, but this alone does not constitute fidelity to the model.

Identification of priority populations, and locus of responsibility for each: Using the national consensus four quadrant model, the system must develop a written plan for identifying priority populations within each quadrant, and locus of responsibility within the service system for welcoming access, assessment, stabilization, and integrated continuing care. Commonly, individuals in quadrant I are seen in outpatient and primary care settings, individuals in quadrant II and some in quadrant IV are followed within the mental health service system, individuals in quadrant III are engaged in both systems but served primarily in the substance system. Each system will usually have priority populations (commonly in quadrant IV) with no system or provider clearly responsible for engagement and/or treatment; the integrated system planning process needs to create a plan for how to address the needs of these populations, even though that plan may not be able to be immediately implemented.

Development and implementation of program standards: A crucial element of the CCISC model is the expectation that all programs in the service system must meet basic standards for Dual Diagnosis Capability, whether in the mental health system (DDC-MH) or the addiction system (DDC-CD). In addition, within each system of care, for each program category or level of care, there need to written standards for Dual Diagnosis Enhanced programs (DDE). There needs to be consensus that these standards will be developed, and that, over time, they will be built into funding and licensing expectations (see items 2 and 3 above), as well as a plan for stage-wise implementation. Program competency assessment tools (e.g., COMPASS (Minkoff & Cline, 2001)) can be helpful in both development and implementation of DDC standards.

Structures for intersystem and interprogram care coordination: CCISC implementation involves creating routine structures and mechanisms for addiction programs and providers and mental health programs and providers, as well as representatives from other systems that may participate in this initiative (e.g., corrections) to participate in shared clinical planning for complex cases whose needs cross traditional system boundaries. Ideally, these meetings should have both administrative and clinical leadership, and should be designed not just to solve particular clinical problems, but also to foster a larger sense of shared clinical responsibility throughout the service system. A corollary of this process may include the development of specific policies and procedures formally defining the mechanisms by which mental health and addiction providers support one another and participate in collaborative treatment planning.

Development and implementation of practice guidelines: CCISC implementation requires system wide transformation of clinical practice in accordance with the principles of the model. This can be realized through dissemination of clinical consensus best practice service planning guidelines that address assessment, treatment intervention, rehabilitation, program matching, psychopharmacology, and outcome. Obtaining input from, and building consensus with clinicians prior to final dissemination is highly recommended. Existing documents (Minkoff, 1998; State of Arizona, 2001) are available to facilitate this process. Practice guideline implementation must be supported by regulatory changes (both to promote adherence to the guidelines and to eliminate regulatory barriers) and by clinical auditing procedures to monitor compliance. Specific guidelines to facilitate access and identification and to promote integrated continuous treatment are a particular priority for implementation,

(See items 8 and 9).

Facilitation of identification, welcoming, and accessibility: This requires several specific steps: 1. modification of MIS capability to facilitate and incentivize identification, reporting, and tracking of ICOPSD. 2. development of "no wrong door" policies and procedures that mandate a welcoming approach to ICOPSD in all system programs, eliminate arbitrary barriers to initial evaluation and engagement, and specify mechanisms for helping each client (regardless of presentation and motivation) to get connected to a suitable program as quickly as possible. 3. Establishing policies and procedures for universal screening for co-occurring disorders at initial contact throughout the system.

Implementation of continuous integrated treatment: Integrated treatment relationships are a vital component of the CCISC. Implementation requires developing the expectation that primary clinicians in every treatment setting are responsible for developing and implementing an integrated treatment plan in which the client is assisted to follow diagnosis specific and stage specific recommendations for each disorder simultaneously. This expectation must be supported by clear definition of the expected "scope of practice" for singly licensed clinicians regarding co-occurring disorder, and incorporated into standards of practice for reimbursable clinical interventions – in both mental health and substance settings – for individuals who have co-occurring disorders.

Development of basic dual diagnosis capable competencies for all clinicians: Creating the expectation of universal competency, including attitudes and values, as well as knowledge and skill, is a significant characteristic of the CCISC model. Available competency lists for co-occurring disorders can be used as a reference for beginning a process of consensus building regarding the competencies. Mechanisms must be developed to establish the competencies in existing human resource policies and job descriptions, to incorporate them into personnel evaluation, credentialing, and licensure, and to measure or monitor clinician attainment of competency. Competency assessment tools (e.g., CODECAT, Minkoff & Cline, 2001) can be utilized to facilitate this process.

Implementation of a system wide training plan: In the CCISC model, training must be ongoing, and tied to expectable competencies in the context of actual job performance. This requires an organized training plan to bring training and supervision to clinicians on site. The most common components of such training plans involve curriculum development and dissemination, mechanism for training and deploying trainers, career ladders for advanced certification, and opportunities for experiential learning. Train-the-trainer curricula have been developed, or are being developed, in a variety of states, including Connecticut, New York, New Mexico, and Arizona.

Development of a plan for a comprehensive program array: The CCISC model requires development of a plan in which each existing program is assigned a specific role or area of competency with regard to provision of Dual Diagnosis Capable or Dual Diagnosis Enhanced service for people with co-occurring disorders, primarily within the context of available resources. This plan should also identify system gaps that require longer range planning and/or additional resources to address, and identify strategies for filling those gaps. Four important areas that must be addressed in each CCISC are:

a. **Evidence based best practice:** There needs to be a specific plan for initiating at least one Continuous Treatment Team (or similar service) for the most seriously impaired individuals with serious and persistent mental illness (SPMI)**-** and substance disorder. This can occur by building dual diagnosis enhancement into an existing intensive case management team.

b. **Peer dual recovery supports:** The system must identify at least one dual recovery self-help program (e.g., Dual Recovery Anonymous (Hamilton & Samples, 1995), Double Trouble in Recovery (Vogel, 1999)) and establish a plan to facilitate the creation of these groups throughout the system.

c. **Residential supports and services:** The system should begin to plan for a comprehensive range of programs that addresses a variety of residential needs, building initially upon the availability of existing resources through redesigning those services to be more explicitly focused on ICOPSD. This range of programs should include:

1. DDC/DDE addiction residential treatment (e.g., modified therapeutic community programs).

2. Abstinence-mandated (dry) supported housing for individuals with psychiatric disabilities.

3. Abstinence-encouraged (damp) supported housing for individuals with psychiatric disabilities

4. Consumer – choice (wet) supported housing for individuals with psychiatric disabilities at risk of homelessness

d. **Continuum of levels of care:** All categories of service for ICOPSD should be available in a range of levels of care, including outpatient services of various levels of intensity; intensive outpatient or day treatment, residential treatment, and hospitalization.

CCISC implementation requires a plan that includes attention to each of these areas in a comprehensive service array.

EXHIBIT C: CRISIS INTERVENTION REDESIGN BBR

Agenda Date: _____

Board Briefing Report

DATE: November 24, 2008

TO: Board of Supervisors

FROM: Giang T. Nguyen, Director, Department of Behavioral Health

SUBJECT: Proposal for Behavioral Health Services Redesign and Integration of Funding and Services

EXECUTIVE SUMMARY:

This Board Briefing Report provides information regarding a proposed redesign of the current mental health crisis intervention delivery system within Fresno County. The purpose of the proposed redesign is two fold: First, the Department wants to proactively address the realities of the anticipated revenue shortfall in state realignment funds which consist of both sales tax revenues and revenues from vehicle licensing fees (VLF). It is anticipated that in FY 2009-10, the current economic downturn will have a significant negative impact on the funding level for local mental health programs. Secondly, the Department wants to initiate a planning process, in collaboration with all community stakeholders, to identify how service could be redesigned in order to continue to meet the needs of consumers without negatively impacting other community organizations such as local hospitals and law enforcement agencies. The financial goal of the proposed redesign would be to reduce overall costs, increase Med-Cal revenues and to have less reliance on declining Mental Health Realignment funds in order to achieve a balanced budget for FY 2009-10 without any increased net County costs.

The methodology to accomplish the goal of the proposal involves phasing out the current crisis intervention services and implementing newly redesigned services/ programs to appropriately leverage other available funding and services such as Federal Medicaid reimbursement, Substance Abuse Services and Mental Health Services Act funds. The Department will continue to follow its guiding principles to first and foremost maintain mental health services for consumers and families by finding ways to provide the most cost effective services and maximize available funding. It is also important to the Department to minimize job displacement of its employees as much as possible.

The Report delineates a proposed plan of action including an estimated timeline and anticipated process for Board's review and approval in public meetings prior to the end of this current FY 2008-09.

HISTORY/STATUS:

The Department of Behavioral Health has been in reduction mode beginning 2004 which has resulted in services and/or programs being eliminated. In four consecutive years, beginning in FY 2005-06, the Department's adult mental health budget appropriation has had a reduction of 30% (reduction from $56.9M to $40.2M) of the budget and a staff reduction of 48% (from 467 to 238 FTE). In preparation for the FY 2009-10 budget and taking into account the projected increase in cost and reduction in revenue due to the downturn in the economy, the Department of Behavioral Health's adult mental health budget is projecting an estimated $2 million shortfall for FY 2009-10, starting July 1, 2009.

With the passing of Proposition 63, known as the Mental Health Services Act (MHSA), in 2004 numerous new opportunities have developed with the funding allocation being approved for Fresno County. However, with this new funding source, there are many rules and regulations that are imposed on local counties for the use of these funds. A key rule includes prohibition regarding non-supplantation of MHSA funds. Local Mental Health Directors must certify compliance with the State's non-supplantation policy on each application to the State for MHSA funding. Counties must maintain the required Maintenance of Effort (MOE) level. Counties can not use MHSA funds for an existing service using the same delivery method or for replacement of mental heath programs that were in existence when the Act passed in FY 2004-05.

PROPOSED PLAN:

While the Department has faced many challenges with program reductions in the previous years, the Department has established clear strategic planning and goals for FY 2009-10. Part of the strategic plan is to work with stakeholders including internal and external customers to redesign crisis intervention services. The current annual operational cost for the Department's crisis intervention services is approximately $5.9 million (75% to offset the salaries and benefit costs for 42.5 FTE positions and 25% to offset services and supplies costs). Approximately 75% of the operational costs are funded utilizing the Mental Health Realignment funds. In anticipation of increased operational cost and revenue reduction due to the economic downturn in FY 2009-10, it will be imperative to reduce reliance on the Mental Health Realignment funds and increase leveraging of other funding sources. The Department has identified the need to phase out the current crisis intervention model and implement a comprehensive five-pronged service delivery approach as follows:

1. Develop an Emergency Room Response Team (ERRT) to be funded by Federal Medicaid reimbursement and MHSA funds
    A. Program Hours: Available 24/7
    B. Service Description: Mobile crisis intervention services by having mental health staff available on site to promptly respond to local hospital emergency rooms for patients who are deemed by law enforcement or qualified mental health professional staff as danger to self/danger to others/gravely disabled due to a mental health disorder.
    C. Operated By: Competitive request for proposal (RFP) to provide equal opportunity for all providers including labor unions and contract providers to bid on this type of services for after hours (evening and night shifts), weekends and holidays. The RFP would have language for the Department to consider bidders who are willing to hire any displaced Department's employee.

2. Acute Inpatient Psychiatric Services to be funded by Federal Medicaid reimbursement, Managed Care/State General Funds and Mental Health Realignment Funds
   A. Program Hours: Available 24/7
   B. Service Description: Increase local inpatient acute psychiatric beds to avoid sending patients out of town. Reduce wait times for consumers in hospital emergency departments who need prompt access to inpatient care. May have State "waiver" to provide inpatient services to adolescents.
   C. Operated By: Competitive request for proposal (RFP) to allow equal opportunity for all providers including labor unions and contract providers to bid on this type of services. The RFP would have language for the Department to consider bidders who are willing to hire any displaced Department's employee.

3. Community Wellness Services (Wellness Connection) to be funded by MHSA and Federal Medicaid reimbursement
   A. Program Hours: Six days per week, Monday – Saturday 9 AM – 6 PM
   B. Target Population: Provides variety "levels of services" for up to 90 days to consumers who are newly discharged from psychiatric hospitals, released from jail, brand new consumers who need to be assessed for the next level of service, or for current consumers who have urgent needs but are not in crisis (i.e. run out medications or need to talk to someone).
   C. Service Description: A "step down"/fast-track/same day outpatient service including medications and linkage program for consumers. Current overloaded mental health outpatient system to include triage, assess and engage clients into appropriate services, which may include, but not be limited to MHSA full services partnerships services.
   D. Operated By: Department's employees

4. Co-Occurring Detox and Assessment Center to provide services to co-occurring clients (seriously mentally ill adults and having substance abuse/addiction problems). The services are to be funded by Federal Medicaid reimbursement, substance abuse funds and MHSA funds
   A. Program Hours: Available 24/7
   B. Target Population: Integrated welcoming access and services for clients, who have co-occurring disorders (consumers who are under intoxication/influence of alcohol and/or drugs and are deemed by law enforcement as danger to self/danger to other/gravely disabled due to a mental disorder).
   C. Service Description: Detox, mental health and substance abuse assessments and linkage into the outpatient or residential treatment programs.
   D. Operated By: Competitive request for proposal (RFP) to allow equal opportunity for all providers, including labor unions and contract providers to bid on this type of services. The RFP would have language for the Department to consider bidders who are willing to hire any displaced Department's employee.

5. Community Integration to be funded by MHSA and Federal Medicaid reimbursement
   A. Program Hours: Available 24/7 including housing and wrap-around intensive case management services.
   B. Target Population: Clients who might suffer from both substance abuse addiction and serious mental disabilities and those that are currently in an institution/custodial level of care setting.

C. Service Description: Expand current contracts with providers for this type of service.
D. Operated By: Full Service Partnership services.

Attached with this Report are several Exhibits as follows:

- Exhibit A: Fresno County Mental Health Current Crisis Intervention Services Flow Chart
- Exhibit B: Fresno County Crisis Intervention Services Utilization Data and Output
- Exhibit C: Business Analysis of the Current Crisis Intervention Services
- Exhibit D: Business Proposal to Redesign Acute and Crisis Intervention Services
- Exhibit E: Summary of Anticipated Benefits from the Redesign Plan

ANTICIPATED PROCESS AND TIMELINE FOR PROPOSAL IMPLEMENTATION:

1. November 17, 2008: Presented the proposal to the CAO's Office.
2. November 17, 2008: With the Mental Health Advisory Board's concurrence, posted the draft MHSA Plan Update for FY 08-09 funding request to the State in the third week of November 2008. The Plan includes the five-pronged service approach listed above excluding the Acute Inpatient Psychiatric Services.
3. December 2008 (first week): Release a Board Briefing Report on the proposal.
4. December 2008 (first week): Discuss the proposal and solicit input from the Department's employees.
5. December 2008 (throughout): Discuss the proposal and solicit input from stakeholders in the community including the Hospital Council, local hospital emergency departments, Emergency Medical Services, and law enforcement via a series of discussions.
6. December 17, 2008: Discuss the proposal and solicit input from the Mental Health Advisory Board.
7. January 2009: The Department will come before your Board to request your approval to release a Request for Proposal (RFP) regarding some of the services listed above. Upon your Boards approval of this request, the Department will work collaboratively with County Purchasing and Personnel Office on the release of the RFP no later than the first week of February 2008. Anyone can bid on this RFP and the RFP would include language for the Department to consider bidders who are willing to hire any displaced Department's employee from budget cuts.
8. March 2009: Upon receipt and completion of evaluation of the bids, the Department will return to your Board for approval of service implementation.

FISCAL IMPLICATIONS:

In anticipation of increased operational cost and revenue reduction due to the economic downturn, the Department has projected an estimated $2 million shortfall for FY 2009-10. To mitigate the projected shortfall due to these uncontrollable factors, the Department is working with community stakeholders and staff on the proposed strategies described in this Report.

CONTACT PERSON:

Giang Nguyen, Director, Department of Behavioral Health – 452-3463

cc: John Navarrette, Interim County Administrative Officer

EXHIBIT A

FRESNO COUNTY
CURRENT CRISIS INTERVENTION SERVICES FLOW CHART

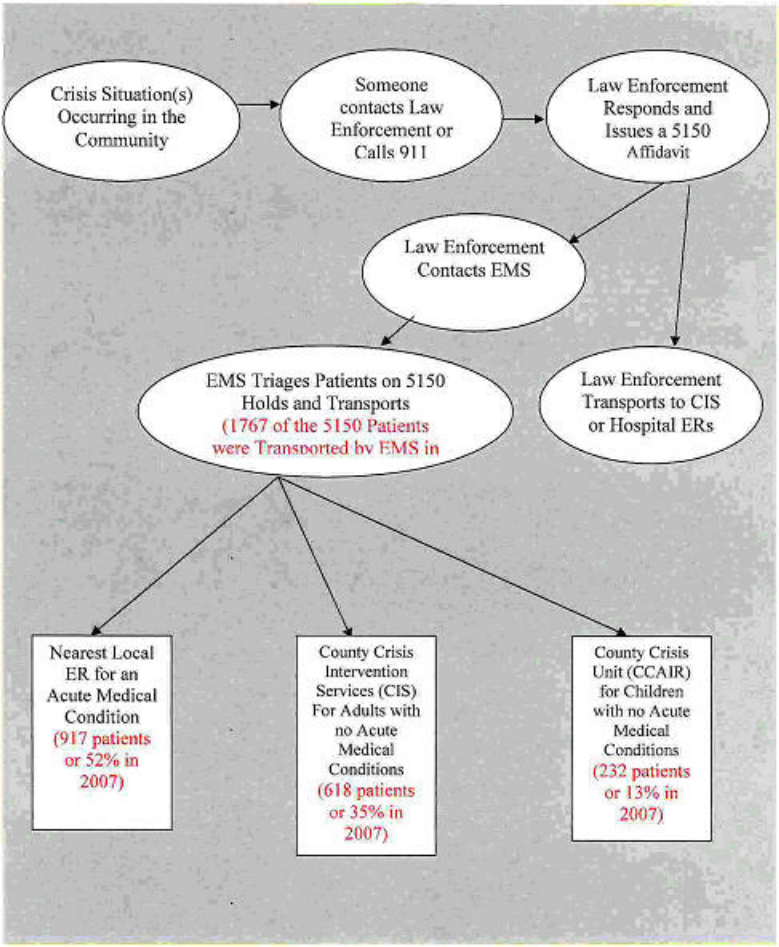
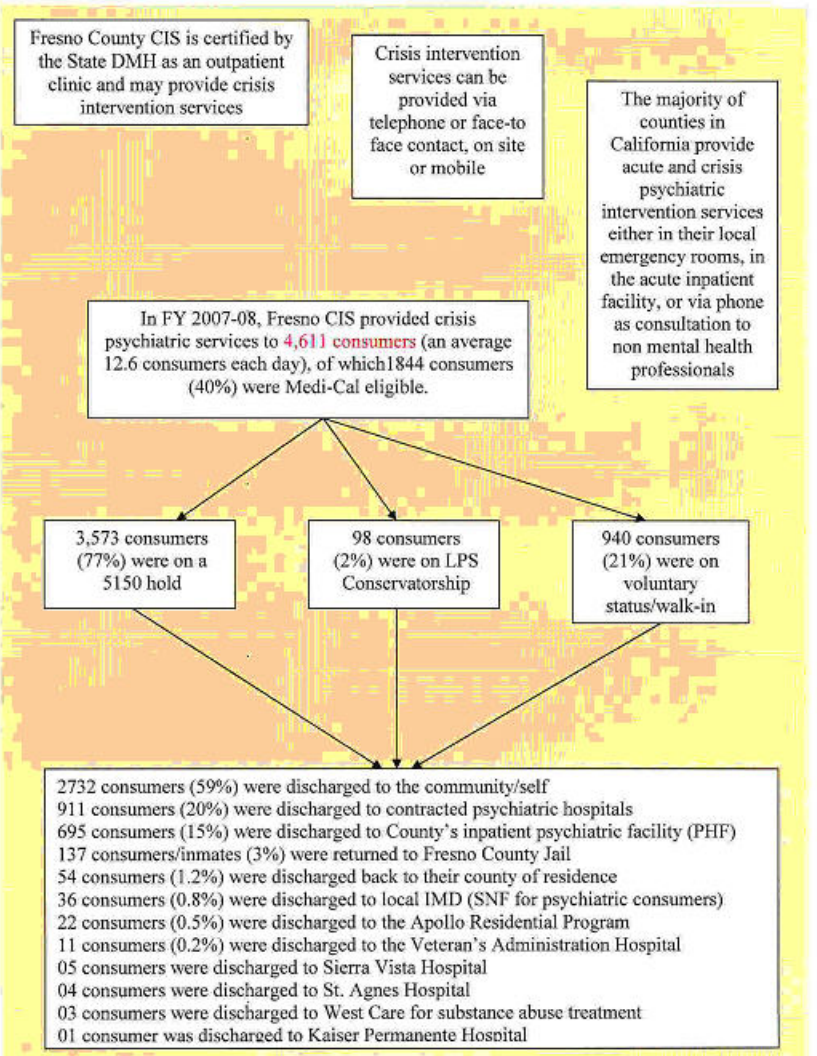


EXHIBIT B

FRESNO COUNTY
CRISIS INTERVENTION SERVICES UTILIZATION DATA AND SERVICES OUTPUT



952-4691 Exhibit C

BUSINESS ANALYSIS OF CURRENT CRISIS INTERVENTION SERVICES

Advantages:

✓ PACT/CIS is known to the community.
✓ PACT/CIS is a one centralized 24/7 "front door" and if in doubt, send them to PACT/CIS.
✓ PACT is a one-size fits all program as anyone may walk-in or be brought in by anyone including law enforcement, ambulance, taxi driver, family members.
✓ The neighboring counties do not have a PACT/CIS. Therefore, PACT/CIS is the place for any consumer from any where if he or she is in crisis or needs some "time out" for sobering or short stabilization.

Disadvantages:

✓ CIS has high-volume and high-risk consumers mixed in with low risk consumers (walk-in, brought in by EMS, law enforcement, involuntary hold, voluntary hold, etc.) which does not allow CIS to triage, prioritize and expedite crisis psychiatric services. In addition, the length of stay for less acutely ill consumers is longer because staff needs to focus on and treat the more acutely ill consumers.

✓ CIS has consumers who are also under the influence of substances and spend time in the unit to detox/"sleep it off."

✓ The neighboring counties and privately insured company (HMO) with the exception of Kaiser Permanente do not have a CIS so it is not unusual for Fresno County CIS to provide psychiatric crisis services for out-of County residents or privately insured consumers. CIS is known by others as the place for consumers if they are in crisis or need some "time out" for sobering or short stabilization.

✓ CIS is unable to provide psychiatric consultation to local ERs due to staff shortage and high volume/high acuity in CIS

✓ Delay in transferring 5150 patients from ERs to CIS due to:
- Limited acute inpatient psychiatric beds
- Some inpatient psychiatric hospitals are selective on who and when to accept consumers from CIS
- ER high volume/high risk patients which may delay medical clearance
- Trust/communication between CIS and ER (unable to eyeball the 5150 patient)

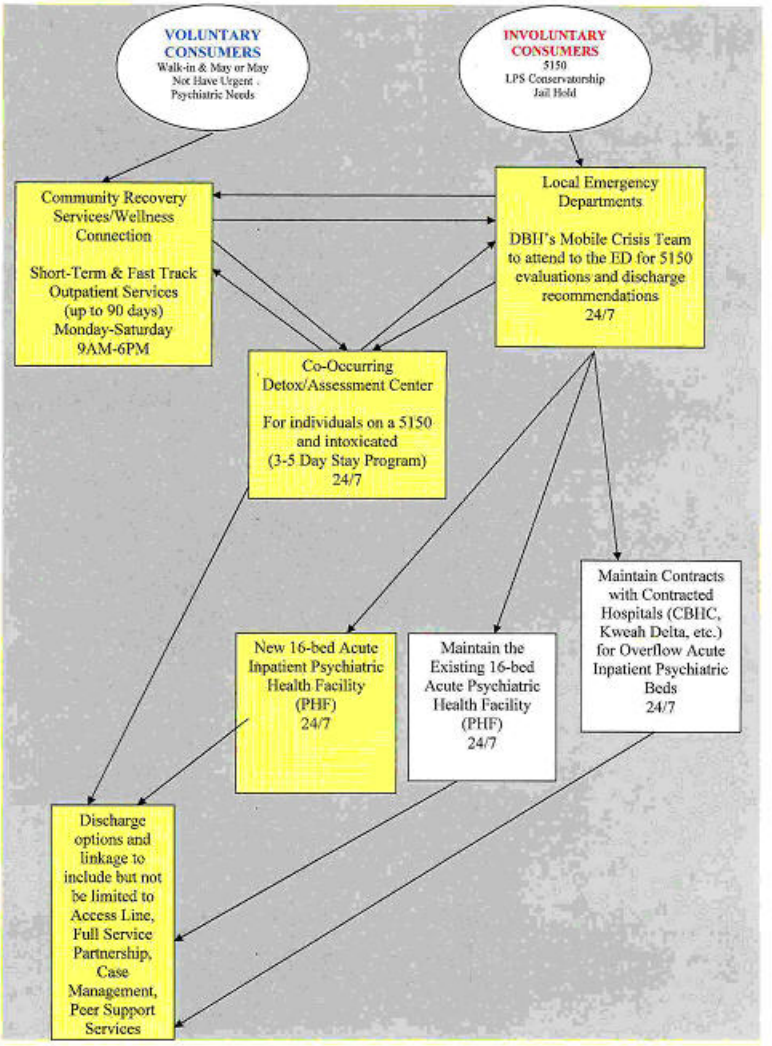
BOTTOM LINE:

One-size-trying-to-fit-all approach does not work for CIS. The current system provides limited access or options for appropriate assessment and treatment of consumers who may or may not be an acute/crisis psychiatric condition. CIS has become the place for all and it has created delay in access and services for consumers in acute and crisis psychiatric conditions and customer dissatisfaction from both internal and external customers.

EXHIBIT D

FRESNO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH

BUSINESS PROPOSAL TO REDESIGN
ACUTE AND CRISIS INTERVENTION SERVICES
(FOR CO-OCCURRING ADULT AND OLDER ADULT CONSUMERS
WITH MENTAL ILLNESS AND SUBSTANCE ABUSE PROBLEMS)



952-4691 Exhibit C

EXHIBIT E

FRESNO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH
SUMMARY OF THE RECOMMENDED REDESIGN OF ACUTE AND CRISIS PSYCHIATRIC SERVICES TO INTEGRATE INTO A COMPREHENSIVE WELLNESS AND RECOVERY SYSTEM-OF-CARE APPROACH

(THE FIVE-PRONGED APPROACH VERSUS THE ONE-SIZE FITS ALL APPROACH)

1. **Expansion of an additional 16 acute inpatient psychiatric beds in Fresno County (24/7)**

   Benefits:
   a. Reduce wait time for consumers in emergency department who need prompt access and treatment for acute inpatient psychiatric hospitalization.
   b. Increase the capacity for local inpatient psychiatric beds and avoid placing consumers out of town.
   c. Provide appropriate safety and well-being for consumers in need of the services and for the public
   d. Cost effectiveness

2. **Expansion of outpatient services for short-term assessment and treatment (Monday through Saturday 9 AM to 6 PM and up to 90-day outpatient treatment program)**

   Benefits:
   a. Increase capacity and reduce wait time for consumers who might benefit from short-term and fast track outpatient mental health services for up to 90 days. The target populations are adults and older adults who are at risk of homelessness, incarceration, have utilized multiple emergency room admissions, or have utilized intensive/crisis mental health services or had a recent psychiatric hospitalization.
   b. This program will be a model/best-practice program for wellness and recovery practice along with co-occurring disorder approach and to benchmark with other programs/services in the Department. Peer support services will be provided in this program.
   c. Address the gap in wait time for services between discharge time from a psychiatric hospital, or released from County Jail, or for a new consumers to be seen for assessment and services. These consumers would be seen with treatment/linkage recommendation from a mental health professional within the same day of referrals or within the same day when the consumer walks in.
   d. At least biannually and no later than January 2011, this program will be evaluated for program effectiveness and efficiency and funding sustainability. Thus, program outcome measures will be built-in for the regular evaluations.

3. **Expansion of co-occurring detox/assessment center for consumers who have serious mental illness (SMI) and substance abuse/addiction (24/7 and up to 3-5 day length of stay)**

   Benefits:
   a. Include a front-line triage, assessment, stabilization and engagement opportunity within a structured and integrated mental health and substance abuse services. The services include detoxification from substances, co-occurring assessments done by a trained professional in both psychosocial and substance abuse assessment, appropriate referrals/linkages to outpatient mental health services and/or substance abuse services which could include residential and housing services.

b. Provide early screening and referral to MHSA Full Services Partnership as appropriate
c. Address the repeatedly identified gap in Fresno County communities in providing co-occurring services as an expectation and not an exception.
d. Provide the mobile crisis intervention team and local emergency departments with an expanded option for co-occurring disordered consumers to receive prompt and appropriate evaluation and linkages.
e. Provide a system-of-care approach for consumers as they will have the opportunity to be engaged in options in which they and the staff deem necessary for their recovery and wellness.

4. **Expansion of MHSA Full Services Partnership for consumers who have serious mental illness (SMI) and substance abuse problems as well as those that are currently in custodial/institutional care setting**

Benefits:

a. Increase capacity for permanent and supported housing as well as "whatever it takes" behavioral health services for co-occurring disorder adult and older adult consumers.
b. Increase capacity for permanent and supported housing as well as "whatever it takes" behavioral health services for those consumers that will be integrated into community based level of care services with a wellness and recovery focus.
c. Address the target population's needs which were identified by stakeholders during the community planning process for MHSA Community Services and Supports Component. The FSP is focused on consumers who have been unsuccessful in engaging and linking to recommended services. These specialty FSP services will be designed to enroll consumers post crisis services in which referral to outpatient substance abuse services has been completed as well to engage those in preparation for integration into their Fresno County community of choice.
d. Expected outcome measures include to reduce homelessness, incarceration, crisis/ emergency services as well as hospitalization for co-occurring disordered consumers.

5. **Expansion of Emergency Room Response Team (EERT) to reduce stigmatization and barriers for consumers in receiving prompt access to and appropriate crisis evaluation and post crisis linkages to co-occurring disorder services**

Benefits:

a. To achieve the overall goal in assisting consumers in crisis to reduce further exposure to stigma and involuntary treatment in emergency departments. Thus, the consumers are afforded the opportunity to continue moving forward on their journey for wellness and recovery.
b. To assist consumers with a wellness plan post crisis interventions and return to the community as soon as possible.
c. To work site by site with local emergency department staff to provide psychiatric consultation and evaluation of 5150 consumers and to assist with discharge planning for the consumers and families.
d. To reduce wait time for consumers in local emergency departments; thus reduce ED overcrowding situations and assist consumer discharged from the ED sooner to reduce trauma and stigmatization for consumers and their family.
e. To enhance trust, rapport, and thus ongoing and open communication with other partners in health care for the consumers. This expansion embraces some of the guiding principles of the MHSA which is to integrate services for consumers in any setting and to reduce stigma and discrimination for consumers and their family.

EXHIBIT D: FRESNO COUNTY MENTAL HEALTH PLAN GRIEVANCES

Fresno County Mental Health Plan (MHP) provides beneficiaries with a grievance and appeal process and an expedited appeal process to resolve grievances and disputes at the earliest and the lowest possible level.

Title 9 of the California Code of Regulations requires that the MHP and its fee-for-service providers give verbal and written information to Medi-Cal beneficiaries regarding the following:

- How to access specialty mental health services
- How to file a grievance about services
- How to file for a State Fair Hearing

The MHP has developed a Consumer Guide, a beneficiary rights poster, a grievance form, an appeal form, and Request for Change of Provider Form. All of these beneficiary materials must be posted in prominent locations where Medi-Cal beneficiaries receive outpatient specialty mental health services, including the waiting rooms of providers' offices of service.

Please note that all fee-for-service providers and contract agencies are required to give their consumers copies of all current beneficiary information annually at the time their treatment plans are updated and at intake.

Beneficiaries have the right to use the grievance and/or appeal process without any penalty, change in mental health services, or any form of retaliation. All Medi-Cal beneficiaries can file an appeal or state hearing.

Grievances and appeals forms and self addressed envelopes must be available for beneficiaries to pick up at all provider sites without having to make a verbal or written request. Forms can be sent to the following address:

Fresno County Mental Health Plan
P.O. Box 45003
Fresno, CA 93718-9886
(800) 654-3937 (for more information)
(559) 488-3055 (TTY)

Provider Problem Resolution and Appeals Process

The MHP uses a simple, informal procedure in identifying and resolving provider concerns and problems regarding payment authorization issues, other complaints and concerns.

Informal provider problem resolution process – the provider may first speak to a Provider Relations Specialist (PRS) regarding his or her complaint or concern.

The PRS will attempt to settle the complaint or concern with the provider. If the attempt is unsuccessful and the provider chooses to forego the informal grievance process, the provider will be advised to file a written complaint to the MHP address (listed above).

Formal provider appeal process – the provider has the right to access the provider appeal process at any time before, during, or after the provider problem resolution process has begun, when the complaint concerns a denied or modified request for MHP payment authorization, or the process or payment of a provider's claim to the MHP.

Payment authorization issues – the provider may appeal a denied or modified request for payment authorization or a dispute with the MHP regarding the processing or payment of a provider's claim to the MHP. The written appeal must be submitted to the MHP within 90 calendar days of the date of the receipt of the non-approval of payment.

The MHP shall have 60 calendar days from its receipt of the appeal to inform the provider in writing of the decision, including a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.

If the appeal concerns a denial or modification of payment authorization request, the MHP utilizes a Managed Care staff who was not involved in the initial denial or modification decision to determine the appeal decision.

If the Managed Care staff reverses the appealed decision, the provider will be asked to submit a revised request for payment within 30 calendar days of receipt of the decision

Other complaints – if there are other issues or complaints, which are not related to payment authorization issues, providers are encouraged to send a letter of complaint to the MHP. The provider will receive a written response from the MHP within 60 calendar days of receipt of the complaint. The decision rendered buy the MHP is final.

EXHIBIT E: EXHIBIT 6 QUARTERLY PROGRESS GOALS AND REPORT

EXHIBIT 6: QUARTERLY PROGRESS GOALS AND REPORT

Estimated/Actual Population Served

County: Fresno
Program Work Plan #:
Program Work Plan Name: Co-Occurring Full Service Partnership
Fiscal Year: FY 2009-2010 *(please complete one per fiscal year)*

	Full Service Partnerships		**Qtr 1 – 07/01/09-09/30/09**		**Qtr 2 10/01/09-12/31/09**		**Qtr 3 01/01/10 – 03/31/10**		**Qtr 4 04/01/10 – 06/30/10**		**Total**	
	Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
	Adults/Older Adults - Age 18 and up	Adult consumers with active co-occurring disorders and symptoms. Outreach to African American and Latino populations will be emphasized. Services include integrated co-occurring capable, "whatever it takes" approach for services (housing, vocational, Peer Support and Recovery Services).	10	0	30	0	60		60		60	

	Outreach and Engagement		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
	Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
		N/A										

EXHIBIT F: FULL SERVICE PARTNERSHIP DEFINED

FULL SERVICE PARTNERSHIP SERVICE DELIVERY MODEL

On August 1, 2005 the Department of Mental Health approved a *Three-Year Program and Expenditure Plan Requirements* document for fiscal years 2005/06, 2006/06 and 2007/08. This document outlines requirements for Full Service Partnership collaborations and can be found in its entirety at http://www.dmh.ca.gov/MHSA/docs/CSSfinal_8.1.05.pdf.

Full Service Partnerships (FSP) are designed as a partnership between enrollees and the service provider. The FSP service delivery ethic incorporates recovery and cultural competence into the services and supports offered to consumers. In this partnership, the service provider commits to do "whatever it takes" and to “meet the client where they are” in order to assist the enrollee achieve their personal recovery/resiliency and wellness goals.

1. The Target Population is consistent with the population identified in the Fresno County MHSA Community Planning Process

The target population must meet requirements for SMI/SED diagnosis; and must address reduction of specific ethnic disparities, as indicated in the MHSA Community Services and Supports proposal on which the RFP is based.

The target population will include individuals who are not currently served

and meet one or more of the following criteria:

- Homeless
- At risk of homelessness – such as youth aging out of foster care or
- persons coming out of jail
- Involved in the criminal justice system (including adults with child
- protection issues)
- Frequent users of hospital and emergency room services

or are so underserved that they are at risk of:

- Homelessness – such as persons living in institutions or nursing homes
- Criminal justice involvement
- Institutionalization

Diagnoses that serve as criteria for inclusion in the target population will be based on definitions found in 5600.3 California Welfare and Institutions code defining severe mental disorder. The operational definition of “diagnosis” for programs serving the chronically homeless may also include: co-occurring disorders, personality disorders, general

anxiety/mood disorders, and Post Traumatic Stress Disorder).

2. FSP Program Components:

All MHSA FSP Programs must include the following in their program descriptions

Providers who are part of the multidisciplinary, community based "treatment" teams serve as an ally to the consumer's recovery process. The partnership allows clients and family members opportunities for informed choice

The team description must demonstrate commitment and capacity to do "whatever it takes" to assist the enrolled member, specifically:

- Low staff to client ratio (approximately 1:12; or the ratio that has been specified in the RFP's statement of work)

- 24/7 availability of the multidisciplinary team;

- Team culture is created where each member of the team knows each client and the clients are familiar with each member of the team.

- Members of the team speak the client's language, are familiar with community resources that reflect the healing beliefs of the client's culture, and are positioned to assist the client make meaningful connection with those resources.

- Crisis response comes from a person known to the client.

- Staff is given the administrative flexibility and flex-funding to connect consumers with non-mental health services and same day needs. Examples include: Housing; Primary Care; Dual Disorder Services, Education Services and Supports; Vocational services and supports; Payee services/benefits advocacy; Community recreational activities (YMCA classes, libraries, movie theaters); Social Services, Food, Transportation, and Clothing.

- Availability of Integrated Dual Diagnosis Treatment or other dual recovery intervention that will provide effective treatment for the target population.

- **Outreach and engagement.** The team's outreach and engagement strategy must be voluntary and driven by the values of client culture. This means that consumers will be engaged "where they are" in terms of their community location, their need for clinical and non-clinical services/supports and their phase of recovery. Outreach workers will have culturally competent language skills and will function as an ally to the consumer's decision to receive services. Peer Support will be included in the outreach and engagement of new clients.

- **Procedures for enrollment and dis-enrollment will be easily understood, clearly communicated and non-coercive**. Enrollment is voluntary. A condition of enrollment is that the client indicates that they want services from the assertive-community treatment model team.

- **Each adult, older adult, and transition age youth enrollee must have a Personal Service Coordinator (PSC).** The PSC is an ally to the enrollee and acts as a "single point of responsibility" within the multidisciplinary team for coordinating services and supports. *"Personal Service Coordinators (PSCs) for adults – case managers for children and youth – must have a caseload that is low enough so that: (1) their availability to the individual and family is appropriate to their service needs, (2) they are able to provide intensive services and supports when needed, and (3) they can give the individual served and/or family member considerable personal attention… PSCs/case managers must be culturally competent, and know the community resources of the client's racial ethnic community."* (Source: DMH Planning Requirements, Section III Identifying Populations for Full Service Partnerships, Aug 2005)

- **Each enrollee must have an Integrated Services and Supports Plan that is developed with their Personal Services Coordinator**. This ISSP is a planning tool that builds on the consumer's strengths. It includes goals and provides a map of the steps that the enrollee identifies as necessary to move along his/her recovery path. "*Integrated Services and Supports Plans must operationalize the five fundamental concepts* (identified listed in section three of this Exhibit*) and should reflect community collaboration, be culturally competent, be client/family driven with a wellness/recovery/resiliency focus and they must provide an integrated service experience for the client/family. In addition, the ISSP will be person/child-centered, and give individuals and their families' sufficient information to allow them to make informed choices about the services in which they participate. Services should also include linkage to, or provision of, all needed services or benefits as defined by the client and or family in consultation with the PSC/case manager. This includes the capability of increasing or decreasing service intensity as needed."* (Source: DMH Planning Requirements, Section III Identifying Populations for Full Service Partnerships, Aug 2005)

- **Peer support services will be made available to the client.** At least two staff (a minimum of 1 FTE) who act in peer support roles will be employed in each MHSA program.

- The enrollee is given significant access to peer recovery and self-help services. Tools such as Advanced Directives are made available to adult and older adult clients, and Wellness Recovery Action Plans (WRAP) are made available to adult, transition age youth and older adult clients.

- Peer Counselors are included as equal partners in the multidisciplinary team, and play a critical role in developing the recovery culture and client orientation of the team.

3. The Five (5) Core MHSA Concepts are embedded in each program

Concept 1: Recovery/resiliency orientation:

FSPs will embody the values of recovery and resiliency (i.e., hope, personal responsibility, self-advocacy, choice, respect) and the program principles of recovery and resiliency, including:

- Client-driven goal setting and Individualized Services and Supports Plans
- Providers are allies to the client's recovery process.
- A harm-reduction approach to substance abuse that encourages recovery and abstinence but does not penalize consumers or withdraw help from them if they are using.
- A built in understanding and expectation of setbacks as part of recovery.
- Links to a range of services that are part of the consumers "pathway to wellness" (i.e., employment, health care, peer support, housing, medications, food and clothing)

  FSPs will collaborate with the MHSA Family Education Center which makes support services available to family members and the MHSA Wellness Recovery Resource Hub which makes wellness recovery training and technical assistance available to FSP staff.

Concept 2: Cultural Competence Orientation: The program's structure, staffing and service delivery values will reflect the cultural values and orientation of the program's target populations.

The FSP program will embody principals of cultural competence including:

- Diverse staff, representative of the primary ethnic groups to be reached through the program
- Staff trained regarding common access barriers for racial and ethnic groups targeted (including the impact of housing discrimination)
- Links to community-based organizations that share the healing beliefs and practices of ethnic communities served by the FSP.

The FSP program must also be able to deal with gender and sexual orientation diversity. Training in sensitivity to gender and sexuality issues is a key component for staff on the Team.

Concept 3: Community Collaboration: FSP Collaborations ensure that community resources are made available to enrollees. These collaborations include subcontracts between the vendor and other agencies, memoranda of understanding with community non-profits and businesses regarding providing services to clients, and informal relationships built between FSP staff and community stakeholders that result in improved access and decreased discrimination.

Concept 4: Client/Family Driven program: In FSPs, the Integrated Services and Supports Plan (ISSP) is used by adult clients and families of children and youth to identify their needs and preferences which lead to the services and supports that will be most effective for them. Providers work in full partnership with clients to develop these ISSPs. Their needs and preferences drive the policy and financing decisions that affect them.

Concept 5: Integrated Service Experience: FSP programs were incorporated into the MHSA to ensure that these dollars funded "integrated service experiences." This means that services are "seamless" to clients and that clients do not have to negotiate multiple agencies and funding sources to get critical needs met and to move towards recovery and develop resiliency. Services are delivered, or at a minimum, coordinated through a single agency or a system of care. The integrated service experience centers on the individual/family, uses a strength-based approach, and includes multi-agency programs and joint planning to best address the individual/family's needs using the full range of community-based treatment, case management, and interagency system components required by children/transition age youth/adults/older adults.