DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

JONATHAN E. SHERIN, M.D., Ph.D.
Director

Gregory C. Polk, M.P.A.
Chief Deputy Director

Curley L. Bonds, M.D.
Chief Medical Officer

Lisa H. Wong, Psy.D.
Senior Deputy Director

October 6, 2021

TO: Supervisor Hilda L. Solis, Chair
Supervisor Holly J. Mitchell
Supervisor Sheila Kuehl
Supervisor Janice Hahn
Supervisor Kathryn Barger

FROM: Jonathan E. Sherin, M.D., Ph.D.
Director

SUBJECT: **EXPANDING ALTERNATIVE CRISIS RESPONSE IN LA COUNTY (ITEM 6 , AGENDA OF JUNE 8, 2021)**

On June 8, 2021, your Board approved the motion "Expanding Alternative Crisis Response in LA County," which directed the Department of Mental Health (DMH) and the Chief Executive Officer (CEO) to provide a plan to expand Los Angeles County's alternative crisis response system using the increased federal match available beginning in early 2022, including a recommended plan to increase the operation hours of the Psychiatric Mobile Response Teams (PMRT) program to a 24/7, an analysis of the new federal funding available and a plan to utilize these funds to expand the PMRT program in areas of the County served by the Los Angeles County Fire Department (LACoFD), and a plan to reach out to incorporated cities in the County to explore partnership with DMH that would allow the cities to access federal funding to implement and/or expand their own alternative crisis response systems.

The following provides the response to this directive.

Background

The Board has recognized the need to expand Alternative Crisis Response (ACR) services throughout the County, including to achieve faster response times and 24/7/365 coverage for non-law enforcement mobile crisis response teams. Doing so is critical in order to build a truly robust and reliable alternative to law enforcement response for individuals in crisis. Moreover, it further establishes that behavioral health crises are

health emergencies that are just as potentially harmful and even lethal as other emergency medical needs. They can occur anytime day or night, so they require an urgent, professional response that is available around the clock, just like any other health emergency.

The following outlines plans to expand capacity and establish 24/7/365 coverage for DMH's PMRT program for civilian, non-law enforcement mobile crisis response, adding community-based organization (CBO) contracted providers and focusing on unincorporated areas and contract cities served by the LACoFD, as well as to partner with incorporated cities who manage their own emergency health services to help them develop their own PMRT programs.

Expanding the DMH PMRT Program

Recommendations Summary

To address the DMH PMRT program's need for expanded capacity as well as additional coverage to provide 24/7/365 service, we recommend the following actions:

1. DMH will add full-time peer community health worker staff to the baseline DMH-operated PMRT program sufficient to create teams of one (1) clinician and one (1) peer instead of the current two (2) clinician model. This would roughly double the number of teams available in the existing program;

2. DMH will develop a competitive solicitation for one or more CBOs to provide contracted PMRT services. This will add needed PMRT program capacity as well as provide additional coverage needed to reach 24/7/365 response availability; and

3. DMH will establish the same program requirements and service enhancements for both the DMH-operated portion of the PMRT program and the CBO PMRT expansions, including the utilization of peer staff on teams, vehicles and procedures for direct client transport, and alignment with the federal Substance Abuse and Mental Health Services Administration (SAMHSA)'s guidelines for mobile crisis response.

Estimated Costs

To achieve the recommended program model, approximately 60 full-time equivalent peer community health worker positions, ideally who will become Medi-Cal Certified Peer Support Specialists, will be required in order to add peer staff to the existing DMH-operated PMRT program, at a cost of approximately $86,000 per peer community health worker annually and approximately $20,000 of operating cost per peer community

health worker. Certain enhancements to the existing program, such as the addition of vehicles capable of client transport, will also require one-time expenses.

For the CBO PMRT services, the estimate for each CBO PMRT team, utilizing a one (1) peer and one (1) clinician team model and including costs for infrastructure (including vehicles capable of client transport, information technology to operate the teams, and other overhead), is not known at this time. Upon completion of the solicitation, an estimate will be available.

Funding Analysis

For PMRT services to most Medi-Cal beneficiaries, DMH is responsible for approximately 50% of the cost of these services (the non-federal share of the cost), while the other 50% comes from federal Medicaid reimbursement, implying a typical federal medical assistance percentage (FMAP) of 50%. Section 9813 of the American Rescue Plan Act increases this FMAP to 85% for a temporary three (3) year period, and we anticipate this increased FMAP to begin sometime in 2022 (though we are still awaiting confirmation of the exact start date from the State).

With an 85% FMAP, DMH will only be responsible for 15% of the cost of PMRT services to Medi-Cal beneficiaries, though we must continue to maintain our existing level of funding as new federal revenues from the increased FMAP cannot supplant existing DMH funds for PMRT, but must rather be reinvested in an expanded PMRT program.

By maintaining DMH's funding for the non-federal share of PMRT costs at existing levels, but accounting for our reduced responsibility for the total costs of Medi-Cal PMRT services (down to 15%), we estimate that the 85% FMAP could *theoretically* support our PMRT program at a size 3.25 times its current cost, during the 3 year period, assuming we see a commensurate increase in the number of Medi-Cal clients we serve.

However, our PMRT program, by design, sees everyone in need of its services regardless of insurance status. With program expansion, we would expect to see a commensurate increase in the number of non-Medi-Cal clients we serve as well, for whom we generally pay the full cost (the 85% FMAP does not affect these clients). Thus, our actual PMRT program expansion will be limited by our ability to find funding to support an anticipated increase in the number of non-Medi-Cal clients served.

We continue to evaluate and apply for possible funding to support this anticipated increase in PMRT costs from serving more non-Medi-Cal beneficiaries, adding peer community health workers to existing PMRT teams, and expanding capacity with the CBOs. Notably, we are excited that the Board approved the CEO's proposed spending plan for LA County's phase I allocation of American Rescue Plan Act (ARPA) funds, which includes $18.5 million for Alternative Crisis Response.

Additional details on the 85% FMAP are pending the release of further guidance from the federal Centers for Medicaid and Medicare Services (CMS) as well as the California Department of Health Care Services (DHCS).

Target Areas for Service

The DMH PMRT expansion will be focused primarily on areas of the County, including all unincorporated areas and nearly 60 contract cities, where the LACoFD has responsibility for providing emergency health services.

Furthermore, expansion efforts will prioritize those areas with the worst health inequities and highest needs. DMH will work with the Chief Executive Office's Anti-Racism, Diversity, and Inclusion (CEO-ARDI) Initiative on program planning accordingly, in line with Board requirements for ARPA funded programs to prioritize areas of the County most inequitably impacted by the COVID-19 pandemic.

DMH will also work with partner departments who have likewise developed programs targeting high need areas to align and coordinate PMRT expansion with those programs. Examples include the Chief Executive Office's Alternatives to Incarceration (CEO-ATI) Initiative Pre-File Diversion program, as well as the Department of Public Health – Office of Violence Prevention (DPH-OVP)'s Trauma Prevention Initiative (TPI) and Crisis Response and Violence Intervention Program (CRVIP), all of which include a focus on high need areas with significant health inequities in unincorporated and contract city communities.

Program Requirements and General Operations

We plan to establish the same program requirements across the entire expanded DMH PMRT program, including the DMH-operated portion as well as the CBO teams. These program requirements will likely include:

- **SAMHSA's Guidelines Alignment:** Alignment with the federal SAMHSA's guidelines for behavioral health crisis care, particularly for mobile crisis response (pages 18-21) and including the utilization of peer staff with lived experience on PMRT teams.

- **Client Transport:** Utilization of vehicles capable of client transport, when transport to follow-up care is clinically indicated.

- **Public Safety Radios:** Utilization of public safety radios capable of rapid communication with the DMH Help Line, our 24/7 call center which includes PMRT

dispatch operations as well as for mutual aid from law enforcement and/or fire department partners when needed.

- **Emergency Medical Services and Law Enforcement Coordination:** Clear and reasonable protocols for escalation to fire department emergency medical services (EMS) and/or law enforcement support, including co-response teams such as the LA County Sheriff's Department's Mental Evaluation Teams (MET), when needed, including tele-consult support.

- **Insurance Status:** Teams will respond to all individuals who meet clinical criteria for PMRT response regardless of insurance status or ability to pay, similar to other emergency health services.

- **Medi-Cal Claiming:** Programs must be Medi-Cal certified and capable of claiming for Medi-Cal mobile crisis response services.

- **Private Health Plan Claiming:** Programs must utilize service designs and workflows which maximize the likelihood of reimbursement from private health plans for clients served who have commercial health insurance.

- **Youth and School-Focused Services:** Teams will serve all ages but include specialized training, care services, and follow-up procedures for schools and youth clients in crisis.

- **Lanternman-Petris-Short (LPS) Act Certification:** Program staff must be certified to be capable of writing applications for 5150 and 5585 involuntary psychiatric holds.

- **Average Response Time:** Teams will be dynamically scheduled and located in accordance with historical service demand patterns in order to minimize average and median response times, with the goal of expanding the PMRT program sufficiently to achieve a target average response time of 30 minutes or less.

- **Shared Triage and Follow-up Standards:** Programs will utilize shared standards for triage and assessment of client needs for PMRT response as well as needs for follow-up transportation and/or care, including as needed to coordinate with 9-1-1 and 9-8-8 to provide PMRT response to callers in crisis.

- **Crisis Information Exchange:** Programs must connect to and exchange client information with designated health information exchange (HIE) solutions to allow review of historical client care information relevant to their crisis.

Furthermore, we plan to dispatch the entire expanded DMH PMRT program and teams (DMH-operated and CBO) from DMH's 24/7 Help Line call center, to streamline dispatch operations for the areas served by the DMH PMRT program, and to align with pilot efforts to coordinate 9-1-1 and 9-8-8 behavioral health crisis calls in need of PMRT response.

To that end, we also plan to lean into the national implementation of the 9-8-8 number for behavioral health crisis and suicide-related response by marketing and leveraging 9-8-8 as a central receiving number for behavioral health emergency/crisis needs, including needs for PMRT response (and consistent with previous direction from the Board to ensure robust coordination between 9-8-8 and PMRT). As this is an expansion to our current suicide prevention call center services, we plan to develop a competitive solicitation for 9-8-8 call center services which will include enhanced assessment and triage of mental health and substance use-related crisis needs plus coordination with our DMH Help Line call center to deploy PMRT resources to meet those needs when indicated.

Outreach to Incorporated Cities to Expand City-Based PMRT Programs

Recommendations Summary

1. DMH will develop and disseminate clear guidance to incorporated cities who operate their own emergency health services outlining the procedure by which they can partner with DMH, as the LA County Mental Health Plan (MHP), to help them fund and operate their own city-based PMRT programs.

2. DMH will clarify in this guidance the funding available to support city-based teams, including the enhanced FMAP for Medi-Cal mobile crisis services to begin in 2022 and other grant funds received, along with the portion of program costs that tax-based municipal or other non-federal funds would be expected to cover.

3. DMH will strive to establish the same general program requirements for city-based PMRT programs as for the DMH PMRT program, including shared standards for client assessment and coordination with 9-1-1 and 9-8-8 to provide response to callers in crisis from city jurisdictions, although city-based programs should handle their own mobile crisis team dispatch operations and coordination with local fire department/EMS and law enforcement agencies as needed.

Funding

Because cities in LA County do not currently operate programs which claim for Medi-Cal mobile crisis response services, city-based PMRT programs could potentially take full advantage of the 85% enhanced FMAP for these services once it begins sometime in the year 2022, as anticipated. As per the above funding analysis for DMH's PMRT program,

the exact details of how this FMAP will be administered are still pending CMS and DHCS guidance.

Further, DMH funds received via ARPA for Alternative Crisis Response, and any other relevant new funds acquired, will be made available to support city-based PMRT partnerships as applicable and as available funds allow.

Governance

City-based PMRT program providers will have to contract with DMH and be Medi-Cal certified in order to claim for Medi-Cal mobile crisis services and receive federal reimbursement (including the 85% federal match). Furthermore, cities will need to establish an agreement with DMH whereby DMH can bill cities for their non-federal portion of the cost of these services to Medi-Cal beneficiaries.

Operations

Cities should handle their own dispatch operations for their PMRT programs, ensuring they have the ability to dispatch teams 24/7/365 as well as to coordinate with 9-1-1 and 9-8-8 call centers to respond to callers in need of PMRT response in city jurisdictions.

Next Steps

DMH will continue to report on the status of expanding ACR in LA County in our quarterly ACR updates to your Board.

If you have additional questions, please contact me or staff may contact Dr. Amanda Ruiz, Interim Deputy Director, at (213) 943-8745 or amaruiz@dmh.lacounty.gov.

JES:GP:jfs

c: Executive Office, Board of Supervisors
Chief Executive Office
Department of Health Services
County Counsel