AGN. NO.

MOTION BY SUPERVISORS KATHRYN BARGER April 9, 2024

IMPLEMENTING THE MENTAL HEALTH RESOURCES REPORT

The County's mental health system is a lynchpin to advancing solutions across County priorities including criminal justice reform, homelessness and access to healthcare. Given this, investing in and expanding the County's mental health continuum of care has been a top priority of the Board of Supervisors. The Board has taken many actions to bolster the mental health continuum, including increasing funding, investing in workforce, introducing innovative services, and championing state and federal legislation.

The Board has also taken specific actions to increase mental health bed capacity. In December 2019, the Board launched a two-year pilot program to procure up to 500 additional mental health beds. The Department of Mental Health (DMH) met the 500-bed goal, but many challenges of scalability still exist and the need for additional beds in our network remain.

In scaling up inpatient bed capacity, DMH and the County face structural and financial challenges to bring these beds online. The funds available to run mental health services are inadequate to meet the growing inpatient need. Due to the federal IMD exclusion, reimbursement for beds in institutes of mental disease (IMDs) is capped at 16 beds, state realignment dollars will soon be exhausted, and state Mental Health Services Act (MHSA) funding cannot used on locked facilities. Additionally, the passage of Proposition 1, while establishing an ongoing funding source for housing and behavioral health beds, creates additional uncertainty for MHSA dollars. The county needs a diverse continuum of mental health beds and facilities, acute, subacute and residential, and all three have unique and often disconnected sources of funding.

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As the demands on the County's mental health system continue to grow, it became imperative on the County to project forward the needs of its behavioral health continuum. On January 24, 2023, the Board of Supervisors (Board) approved the motion, "Establishing a Roadmap to Address the Mental Health Bed Shortage," to reinforce the County's commitment in addressing barriers to provide housing and services for individuals suffering from severe mental illness. The motion directed DMH, in consultation with the Chief Executive Office (CEO), to evaluate the current and forecasted bed capacity needs of the County and build a roadmap on how to fund and sustain these beds, and included the following directives:

1. Retain a consultant to work with the departments on the analysis and roadmap, and analyze existing data and reports;

2. Perform a gap analysis analyzing the current and future projected needs for inpatient mental health beds and facilities, consulting existing data and reports, as well as other relevant departments, service providers and labor, and report back in writing to the Board in 180 days; and

3. Develop a comprehensive roadmap to address the specific gaps in the mental health bed continuum at each bed type and level, including existing and potential funding sources, bed procurement opportunities, and legal, contracting or regulatory barriers, and include this in the report back due in 180 days.

In response to the motion, DMH commissioned Health Management Associates (HMA) to prepare the Mental Health Resources Planning Report (HMA Report) to offer an assessment of the DMH mental health service continuum including a synthesis of existing data and reports, a gap analysis, a comprehensive roadmap that offers recommendations on addressing the identified gaps, and insights from dynamic forecasting tools that can provide DMH with the ability to see capacity demands across the DMH system of care. The forecasting tools initiate new modeling capabilities within DMH to more dynamically estimate bed capacity. As is the case with any dynamic tool, the inputs will create adjusted outputs. The forecasting of bed numbers will expand or contract based on the demands to the system. The HMA report highlights a point in time estimate for the current bed projections. To develop a full picture of the continuum of care that impacts the demand for inpatient, residential, and supportive housing beds, DMH has paired the HMA Report with an assessment of regulatory, policy, financial and contracting issues that impede access to mental health beds across the DMH system of care.

The HMA report also identified systemic gaps and proposed implementation priorities to strengthen DMH's internal oversight of the mental health continuum:

1. **Gap Area: Need for Stronger Operational Approach to Manage the Full Continuum to Mental Health Resources.**

    a. Gap Observation: The current LAC DMH system is managed in separate databases with siloed oversight. As a result, LAC DMH has limited visibility into the access, availability, and resources for the full continuum of care.

    b. Recommendation:
        i. 1.1 LAC DMH needs to adopt a management and operational philosophy and approach centered on the full continuum of care.

2. **Gap Area: Siloed Oversight**

    a. Gap Observation: Structure of oversight and areas of responsibility are siloed with very few leaders who have visibility and responsibility for the total system of care.

    b. Recommendations:
        i. 2.1 To support a full continuum approach, LAC DMH needs to develop a continuum of care network governance structure comprised of LAC DMH leaders possessing visibility and oversight of the full continuum of care.

        ii. 2.2 Develop a strategic operational plan used by the leadership governance structure to set the direction and prioritize and approve system resources, including pilots and new initiatives.

        iii. 2.3 Establish a MHP Project Implementation Office and empower them to provide implementation support for the full continuum. This office will ensure that all pilots measure outcomes and will work to identify and scale best practices across the MHP system of care.

3. **Gap Area: Lack of Internal Governance Structure for the Full Continuum**

    a. Gap Observation: No single point of accountability and supporting governance/committee structure for the full continuum of LAC DMH Mental Health Plan.

    b. Recommendations:
        i. 3.1 Create a reporting structure that mirrors other Medicaid health plan structures.

        ii. 3.2 Include in the reporting structure a dyad of a Senior Administrator and a Medical Director. Ensure that all divisions associated with the MHP care and benefits report up to the dyad.

iii. 3.3 Develop a Mental Health Plan (MHP) Continuum of Care Committee with leadership team representation that analyzes financial, utilization, quality of care, and system-wide performance against key performance metrics.

4. Gap Area: Siloed Utilization Management

a. Gap Observations: Utilization analysis is siloed by division. LAC DMH needs visibility into the impacts of access (or lack of access) to resources up and down the continuum on bed utilization. Multiple systems are used to track utilization; currently there is not a single system showing the full network average length of stay (4LSO) or tracking 4LSO trends across the full continuum of care.

b. Recommendations:
   i. 4.1 Develop a data warehouse that all systems feed into to allow for analyses of the full continuum.

   ii. 4.2 Expand the data analytics team currently focused on outpatient care to encompass data analysis for the entire continuum of care.

   iii. 4.3 Develop a Utilization Management (UM) Committee with appropriate division representation that analyzes trends in utilization across levels of care and makes recommendations for system-level approaches to trends and gaps identified.

5. Gap Area: Lack of Common Definitions and Terminology for the Levels of Care Across LAC DMH Continuum.

a. Gap Observation: There is a lack of common terminology and definitions for levels of care across the continuum, which can contribute to gaps, double counting of beds, and a confounding of the ability to analyze the actual capacity of the full continuum.

b. Recommendation:
   i. 5.1 Create a commonly accepted data dictionary and language regarding levels of care. Use agreed upon terms in all reporting and dashboards.

6. Gap Area: Limited Visibility into Actual Capacity (Used, Needed, Available)

a. Gap Observation: LAC DMH needs to improve data and analytic capabilities and tools to effectively manage the full continuum.

b. Recommendations:
    i. 6.1 Develop a MHP dashboard with bed capacity by level of care, utilization trends by level of care, and metrics such as wait time by level of care.

    ii. 6.2 Build dashboards to give overall system feedback in regular intervals to monitor and respond nimbly to changing system demands and capacity requirements.

    iii. 6.3 Dedicate system analyst resources to develop, maintain, track, and trend data across the full continuum of care.

7. **Gap Area: Limited Visibility into Actual Versus Forecasted Cost of Care by Level of Care**

    a. Gap Observations: Current financial reporting is not sensitive to the specific levels of care in the system. LAC DMH is not currently reporting on budgeted versus actual spend by level of care.

    b. Recommendations:
        i. 7.1 Develop a specific role of MHP financial analyst who reconciles utilization to invoices, and tracks and trends reimbursements paid by facility and level of care.

        ii. 7.2 Report budgeted-to-actual and variance analysis for MHP care continuum to the MHP Continuum of Care Committee monthly. Committee to analyze financial, utilization, quality of care, and system-wide performance against key performance metrics.

Adoption of these changes will improve DMH's ability to effectively plan and manage the mental health safety net and more adequately respond to the growing demands on our mental health system.

I, THEREFORE, MOVE that the Board of Supervisors direct the Department of Mental Health:

1. Adopt and implement the recommendations from the February 15, 2024 "Mental Health Resources Planning Report" prepared by Health Management Associates (HMA) and report back to the Board in writing biannually with a status report on implementation; and

2. Include in the biannual report a status update on the total service units per level of care and the projected demand at that time.

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