

## **Recommendations for State Guidelines for the Integrated Plan preliminary draft of CCCMHA Comments 7-29-08**

The draft paper prepared by state DMH which was distributed on July 23<sup>rd</sup> and has the heading of **INTEGRATED PLAN AND PLANNING PROCESS** and the document entitled Draft for Discussion – Version #1 - **Providing Direction for the Mental Health Services Act (MHSA) 3 Year Integrated Plan and Annual Update** distributed by CMHDA on July 25<sup>th</sup> provide a useful framework for development of state guidelines and reflect the need to move expeditiously to an integrated plan with simplified requirements.

CCCMHA staff (with limited review by members) supports that direction and provides these recommendations to focus the integrated plan and CSS update on a number of specific requirements that should be included in the guidance to counties which will mostly replace the plan content and reporting requirements from the initial CSS plans.

### **General Observations**

The integrated plan is not only bringing together the different elements of the MHSA but is also the primary vehicle for the second three year plan for community services and supports. Similarly, the integration of MHSA and other county programs is primarily the relationship between MHSA CSS programs and other funding sources for those programs. Moreover, in this second three years, CSS funding increases from 50% of MHSA to 70% but costs for capital facilities, technology, workforce education, and training beyond the initial statewide WET allocation, will have to be funded from future CSS plans.

CSS updates will also be modified to reflect the impact of prevention and early intervention. Guidelines must require counties to incorporate into their CSS plans allocations that reserve capacity for early treatment of psychosis identified through prevention and early intervention programs as well as be able to treat people within underserved communities who may have had a long term, severe mental illness who had not previously sought care. (This will likely become a primary means of reducing disparities and access to CSS services.)

## **Full Service Partnerships (FSPs)**

In the first CSS plans the development of FSPs was the highest priority in services to adults. Now that many have been served for a year or more, an equally important priority is to differentiate between the different levels of need of the people getting FSPs as well as others being served who meet the FSP criteria but are not currently enrolled in an FSP level of care. CMHDA's Adult System of Care committee has established four different levels of need, all of which represent full service partnerships for people who require different levels of services at different points in their recovery.

In the initial CSS plans nearly all FSPs for children were established for those who did not have any other funding. However, it seems that virtually every child who meets the target population criteria of a disabling mental illness or serious emotional disturbance should qualify for special education and AB 3632, which brings in other state funding. Many of those children are already in Medi-Cal; (EPSDT) or Healthy Families which bring in Federal funds. While these funding programs provide a broad array of services they may not provide everything that a child and family would receive in a full service partnership. Given that children who are in special education are most likely to need more mental health services than those who do not qualify for special education, it should be a priority to identify which of these children may need a true full service partnership that goes beyond the specific limitations of those funding sources and use MHSA CSS funds as a patch to provide those services. There would be relatively few children who do not qualify for special education but whose needs are so great that it would be a priority to have a complete, free standing, full service partnership established.

## **Plan Contents and Reporting Requirements**

The original CSS guidelines did not speak to outcomes but had extensive reporting requirements to document every dollar spent. It is clear now that we should be focusing in reverse - more on the results of the care with a focus on the numbers of people served and clinical/functional outcomes in relation to the dollars made available. Similarly, evaluation of the stakeholder process should focus on the qualitative and substantive role that stakeholders had in shaping the ultimate product, rather than focusing on the numbers of people and the numbers of meetings that a county held.

Achievement of the goals of the integrated plan requires virtually no change to the CSS guidelines regarding qualifying services, nor the steps the county needs to take to develop the plan, but a complete rewriting of the plan contents and reporting requirements.

1. The plan in quantifying the full service partnerships for transition age youth, adults, and older adults should be required to list the numbers of people at each of the four levels of need and estimated net expenditures (MHSA funds) per person in each level of need in each program. The plan must indicate how much of the costs are expected to be for MediCal match services and how much for other services in each

program and demonstrate how these amounts are adequate to provide all of the services necessary to meet the system of care requirements for a full service partnership. For privately operated programs counties must allow flexibility for providers to switch funds between MediCal and other services within the overall per person county funding for each program.

2. Outcomes for full service partnerships of children, transition age youth, adults and older adults should be measured separately. The outcomes reporting must be immediate (real time) and specific enough to allow meaningful comparisons between each program/provider's costs and results in serving each full service partnership.
3. Plans must also specify which services are to be county operated and which are to be done by private providers and why. The same requirements to specify county operated versus private provider must also apply for planning and reporting on workforce education and training funds as well as capital facilities and technology
4. The plan would also have to document how the decisions are made as to allocations of resources or placements at each level of need.
5. For transition age youth, adults, and older adults not in full service partnerships (and served with system development funds), the plan needs to document how many are served in each such program, what services all of these individuals will receive and what services they generally won't receive. For each system development programs the plan should also state how much the estimated cost per person is in each of the programs. The plan should state to what extent these are services added for people already being served with other funds or are people only being served by MHSA funds.
6. The plan should establish the county policy with regard to the criteria under which some of these individuals are transitioned into full service partnerships when they demonstrate a need for one or more of the services that are not included in their limited system development program.
7. The plan contents and reporting should include several categories (with policy direction developed per age group and reflecting the ethnic composition of those expected to be served in each category and measuring each county's progress in each age group and type of program in reducing the disparities in services for underserved communities).
8. For children the plan should list the number of children in full service partnerships and the net cost of MHSA funds for each.
9. The plan should separate those that are completely free standing full service partnerships and identify the criteria for determining how a child is deemed to meet the need for a full service partnership and not qualify for special education EPSDT or healthy families.

10. The plan should establish the criteria for selecting children that are being served by EPSDT and AB 3632 who should have additional services for themselves and their families, the process for such selections and the likely additional services and the cost per child and family and the number expected to be served.
11. For each of these full service partnership categories there also should be an identification of how many slots need to be set aside for an anticipated number of people that will be identified as needing CSS level of care that are identified through prevention and early intervention programs.
12. There also needs to be reporting on how many slots are reserved for mental health courts and other criminal justice system programs such as follow up to MIOCR programs that are being closed or people being discharged from jail.
13. In integrating MHSA funds with other remaining county programs, it is anticipated that the growth and revenues from realignment and other sources will not be keeping pace with the cost of hospitalizations and other mandatory non MHSA eligible services. The plan should document the estimated revenues for each of the three years of the plan and the costs that will be required for those programs and the cuts that would be necessary in community programs (some of which may be full service partnerships and some of which would be more limited services most likely serving target population individuals and eligible for system development funding).
14. The plan should estimate the amount of funding required and a strategy for transforming the effective programs subject to being cut into an MHSA eligible program. The plan should document for each year how many people will be served by these programs and with what services for those in something less than a full service partnership.
15. The plan should include a strategy for how any of these individuals might become eligible for full service partnerships when their needs go beyond the limited services that they are presently receiving.
16. For those counties which have full service partnership type programs which are funded from realignment or other sources other than MHSA those numbers and costs in each of the categories needs to be documented as well.
17. While the overall eventual need for services can not be determined counties should be able to identify and report on the numbers of people in the target population that are not in system development or full service partnerships who are hospitalized, incarcerated, or estimated to be homeless and those expected to emancipate from foster care that meet target population criteria. The multiyear plan should also identify the county's long term strategy for eventually providing all children, transition age youth, adults, and older adults who meet the target population with a full service

partnership. The plan should note that this is likely to take many years and likely requiring resources well beyond that currently available.

### **Eliminate Existing Reporting and Plan Content Requirements**

These plan content requirements would largely replace the existing requirements and all of the details that are being requested that are going into much detail on exactly how dollars are going to be spent. Nearly all of those requirements that currently exist should be eliminated. The reporting requirements on outcomes should focus almost exclusively on those which are already in statute for the children's and adult's system of care and only for people in full service partnerships with minimal reporting required for expenditures in CSS other than that and with the prevention and early intervention outcome reporting being developed in accordance with those plans (which for the most part are still being developed).

Regarding stakeholder participation the plan needs to describe the outreach efforts but rather than detailing the number of meetings and participants it should describe the process for ensuring that the plan reflects the views of stakeholders, and the means used to resolve differences between the county staff and stakeholders and among the stakeholders.

The final adopted plan must identify those differences which were not resolved and the county's reasons for choosing one course of action over the alternative presented. This must also include responses to comments on the plan which may be submitted anonymously (as may be necessary for some groups seeking county funds who may believe they would be adversely treated if they identified themselves)

### **Workforce Education and Training/Capital Facilities and Technology**

The updated CSS plan should identify workforce needs and the extent to which counties' available WET funding is likely to be able to meet those needs. If there are additional workforce needs what categories of employment are they are in. The plan may reserve some of its CSS funds to assist in meeting those needs including adding funds for state administered programs.

Similarly the plan should identify Capital Facilities and Technology needs and the extent to which the funding made available meets them and the plan may reserve some CSS funds for those needs not met by the funds already made available.

### **Future Year Expenditure Levels**

While the plan goes for three years, the funding for the second and third years is unknown. Rather than just planning for the same or a specific level of growth in those years the plan should indicate how the county would spend each additional increment of funding up to 200% of the dollars being made available for the first year.

As this planning is taking place the initial prevention and early intervention programs would be just getting under way, so there would not be extensive changes for that plan. However, the amount of available funding will likely be greater than what is in the existing PEI plan so a county must identify how it would spend any estimated 2009-10 increased funds and for future years how it would spend an amount equal to 200% of the funding included in the 2009-10 expenditure plan.