Review of Mendocino County's Administrative Service Organization (ASO) Model for the Delivery of Mental Health Services

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Mendocino County Mental Health System Review

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Mendocino County Mental Health System Review

I. Executive Summary

Kemper Consulting Group (KCG) was hired by the Mendocino County Executive to conduct an organizational review of the progress and effectiveness to date of the County Behavioral Health and Recovery Services Department /Mental Health (BHRS/MH) strategy of utilizing two contracted Administrative Services Organizations (ASO), Ortner Management Group (OMG) and Redwood Quality Management Company (RQMC), to deliver mental health services to adults and children. The review was not intended or designed to be a formal "program audit" or "fiscal audit" of either ASO or BHRS/MH, but rather, a management review of organizational effectiveness. In conducting this review, KCG consultants reviewed a wide range of written documents and programmatic and fiscal data and conducted Key Informant interviews with more than 40 individuals, including Board of Supervisors members, county staff, Health & Human Services Agency and County Executive Office officials; leadership of the Mental Health Advisory Board; justice system officials; representatives of both ASOs; and various local service providers.

During our review, we identified six major deficiencies of the ASO model as implemented by BHRS/MH. These deficiencies include:

- Fundamental Weaknesses of ASO Agreements:
    - No ASO Program Implementation Plans Required.
    - Lack of Clarity About Services Covered by the ASO Agreement.
    - Lack of Clearly Defined Data Reporting by ASOs and Subcontracting Providers.
    - Lack of Clear ASO Goals and Objectives, Deliverables, Timelines and Performance Outcomes.
- Conflicting Approaches for ASO Accountability.
- Inadequate County Decision Structure and Process.
- Delay of Electronic Health Records.
- Lack of Memorandums of Understanding.
- ASO Administration Costs Not Clearly Defined.

We further identified six areas of tension in the County Mental Health System that both affect and are affected by the ASO model and the manner with which it was implemented:

- Lack of In-County Residential Care & Crisis Residential Services.
- Lack of Defined Structure for Coordination with Health Care Providers.
- Incomplete Interface with County Justice System.
- Lack of Services for Seriously Mentally Ill in Remote Coastal Areas.
- Need for Clearer Transition of Youth to the Adult System.
- Lack of Interface with County Substance Use Disorder Treatment Services.

The ASO Contract strategy shifted responsibility for direct delivery of mental health services to children and adults from BHRS/MH to two Contractors. With this model, the role for BHRS/MH has fundamentally changed from being a "service provider" to being a monitoring and enforcement agency, a "regulator." In our opinion, BHRS/MH has not, to date, established the structure needed to be an effective regulator. Furthermore, the ASO Contract weaknesses described in this report have not provided BHRS/MH with sufficient tools to effectively carry out its new regulator role.

With respect to the ASO contractors, based upon our review we have concluded the following:

- In our opinion, the Children's System of Care established and operated by RQMC is generally effective. Notwithstanding this conclusion, we believe that the accountability mechanisms we have proposed for the ASO Contracts, including the proposed set of changes to the ASO Contract, the establishment of specified MOUs, and specified other changes, need to be implemented for both ASOs to assure parity in the treatment of each organization, including parity in reporting on ASO performance.
- In our opinion, the Adult System of Care established and operated by OMG provides Mendocino County with the foundation for adult mental health service delivery upon which further improvements can and should be made. While we believe the new Adult System is incomplete and we identified a number of important deficiencies that are described in this report, we believe BHRS/MH has the opportunity to make substantial mid-course improvements with the Adult Mental Health System if the set of recommendations we have proposed is implemented.

Overall, we recommend the best approach for assuring effective mental health service delivery, irrespective of whether services are delivered by county staff, or through contracting with a for profit company or a not-for-profit organization, is public accountability. Such accountability can be achieved through a stronger ASO Contract; clear oversight and accountability mechanisms and management by BHRS/MH; and, transparency in ASO system design and structure, financing and financial accounting, and reporting of service delivery outcomes. We offer a set of recommendations throughout this report and summarized in Table 12 in Section IX to promote this type of public accountability.

II. Background

1. Purpose of Review

Kemper Consulting Group (KCG) was hired by the Mendocino County Executive to conduct an organizational review of Mendocino County's mental health delivery system. The purpose of this review was to assess the progress and effectiveness to date of the County Behavioral Health and Recovery Services Department /Mental Health (BHRS/MH) strategy of utilizing two contracted Administrative Services Organizations (ASO), Ortner Management Group (OMG) and Redwood Quality Management Company (RQMC), to deliver mental health services to adults and children. The review was not intended or designed to be a formal "program audit" or a "fiscal audit" of either ASO or BHRS/MH. Rather, it was an overall management review of the current effectiveness of the BHRS/MH contracted service delivery approach.

As a part of this review, KCG consultants reviewed a wide range of written documents and programmatic and fiscal data. Sources included:

- Board of Supervisors agenda summaries and associated memoranda, presentations, budget documents and fiscal reports submitted to the Board.
- Programmatic and fiscal data supplied by BHRS/MH and both ASOs.
- Mental Health Advisory Board reports and committee reports.
- Mendocino County Grand Jury reports.
- EQRO Reports and a US Department of Health and Human Services Survey.
- ASO Contracts and Contract amendments and ASO proposals in response to the BHRS/MH RFP.
- Brochures and reports from service providers and press reports on ASO related issues.

In addition, KCG consultants conducted Key Informant interviews with a range of informants to solicit their views and perspectives on the effectiveness of the current mental health delivery system. Key Informants included Board of Supervisors members; county staff with BHRS/MH and Social Services; Health and Human Services Agency officials and staff; leadership of the Mental Health Advisory Board; County Executive Office and justice system officials; representatives of both ASOs; and various local service providers. More than 40 Key Informants were interviewed (see Appendix A for a listing of Key Informants).

The report that follows is the written deliverable specified for KCG's Services Agreement with the County Executive. The report presents KCG's:

- Assessment of current administrative, programmatic, and fiscal issues and dynamics affecting the delivery of mental health services for adults and children in Mendocino County.
- Recommendations for system improvement pertaining to the ASO Services Agreement (ASO Contract) and the BHRS/MH structure and process for oversight of and reporting on ASO performance.

2. Prior Reports on Mental Health

A. Mendocino County Grand Jury

The Mendocino County Grand Jury has released three recent reports that relate, in whole or in part, to the delivery of mental health services in Mendocino County. Key findings from these reports are:

- ***Cutbacks in Mental Health Services Impacting Law Enforcement (May 2013)***
  - Severe cuts to the County's mental health budget have resulted in less staff and resources, and the lack of mental health workers is costly to law enforcement and local hospitals as well as to the safety of all citizens.
  - The Mental Health administration should expand the search for a county psychiatrist for the jail; provide additional crisis workers after hours; re-examine the 5150 hospitalization and release procedures; and, make funds available to implement a discharge plan to aid the mentally ill released from jail.

- ***Privatization of Mental Health Delivery Services (June 2014)***
  - Imprecise language and provisions included in the contract for privatization results in ineffective service for clients who are diagnosed as Level 3, the most severely impaired.
  - After nine months of transition, Level 3 clients continued to receive inadequate wrap-around resources, such as housing, transportation, education, and job training.
  - A contract should be written to include ongoing structured care provisions for Level 3 clients.

- ***An Appearance of Conflict of Interest (June 2014)***
  - Ethics policies for Mendocino County should be corrected to include time limitations on when County employees must recuse themselves from decisions regarding previous employers and County employees should be trained to understand and apply these policies.
  - County senior managers and senior staff must recuse themselves from any contract activities when they have or had a financial or business relationship with the contracting party within the last three years.
  - Evaluation of the ASO proposals were scored by seven County employees, including the County Mental Health Director, who had a prior business relationship with OMG that terminated less than 18 months before the evaluation took place.
  - No apparent illegal activity was carried out by any individual; however, there were sufficient opportunities for these individuals to have used undue influence in the ASO selection process.

- An appearance of impropriety in the process of bidding and awarding the contract to OMG existed because of the previous relationship of the Mental Health Director with OMG, but there is no evidence that impropriety occurred.

B. Mental Health Advisory Board

In its 2015 Annual Report, the Mental Health Advisory Board (MHAB) stated, *"We as a group, deal mainly with perceptions. I would state as Chair that after these many months our Board sees improvement in the delivery of mental health services to our clients.*[1]*"* The report goes on to list a variety of ways in which improvements have been or are being made as well as a list of continuing barriers. The Crisis Care Ad Hoc Committee's Annual Report, which is contained within the 2015 Annual Report, further states, *"In the year and half since privatization Mendocino County has established a workable structure on which to build.*[2]*"*

In the area of continuing barriers, the MHAB identified the following:

- Lack of communication with the County Executive Office.
- Delay with implementation of AB 1421, the Assisted Outpatient Treatment Program.
- Lack of collaboration with the County Mental Health Program on review of critical and public program information and the process for receiving that information.
- Signage for the ICMS locations in Ukiah and Fort Bragg.
- Unfulfilled requests for per-person costs, diagnosis and duration of services for participants in Full Service Partnerships (FSP).
- Service delivery to the Hispanic Community.

Service Gaps Identified by the Adult Services and Crisis Care Ad Hoc Committees included:

- Lack of services for dual diagnosis clients and the lack of an affordable local detoxification facility that accepts insurance (with reference to limitations of the Ford Street Center).
- Need for Peer-to-Peer Counseling, especially for seniors, in Pt. Arena.
- Unmet service needs of Hispanic Community and Tribal Community.
- Delay of AB 1421 Implementation.
- Need for a local Crisis Residential Treatment Center.
- Need for a robust and accessible substance abuse treatment program.
- Lack of a fully operational Electronic Health Records (EHR) program.
- Consistently applied Crisis Services, 5150 Procedures, and follow through at all service locations.

The Crisis Care Ad Hoc Committee also identified the following as needed enhancements to current programming:

[1] 2015 Annual Report, Mendocino County Mental Health Advisory Board (page 1 of Board Report)
[2] 2015 Annual Report, "Crisis Care Ad Hoc Committee Annual Report," Mendocino County Mental Health Advisory Board (page 2 of Committee Report)

- Primary care health screening and the need for greater collaboration between primary care providers and mental health service providers.
- Importance of EHR and a workable reporting system that "enables the county to provide meaningful data on mental health services and their outcomes"[3]
- Easier direct access to medication for prescribers, including jail medication services at booking and release.
- Need for improved outreach services for Full Service Partnership clients.
- Need for improved billing of private insurance for non-Medi-Cal clients.

3. Medi-Cal Funded Services

In talking with Key Informants and other community stakeholders, KCG consultants found considerable passion and belief about what has taken place and what is currently occurring with the county's delivery of mental health services through its two contractors, RQMC and OMG. In light of these opinions, one of the key questions KCG consultants asked Key Informants was: *"Do you think the county's delivery of mental health services under the ASO Contracts is better, worse or the same as it had been under the county's prior structure for delivery of services?"*

There was consensus among Key Informants that services to children under the RQMC ASO Contract are *"better"* than under the prior county structure, taking into account that much of mental health service delivery for children was already contracted out to community providers prior to the ASO Contract. In general, Key Informants reported that services are better organized and coordinated among service providers under the ASO Contract. The relatively few concerns that were identified by Key Informants about RQMC's performance are presented later in this report.

There was substantial consensus, with pockets of discontent, among Key Informants that services to adults are *"better"* under the OMG ASO Contract than under the prior county staff structure. Many Informants spoke to a continuing decline in funding and limited access to adult mental health services prior to the contract with OMG. For most Informants, there was also agreement that OMG's system implementation and first year of service delivery was difficult, but that improvements have become more evident in the past year. Notwithstanding those improvements, Key Informants raised a variety of concerns and criticisms about OMG's service delivery, which will be discussed later in this report.

Perceptions can be powerful informants about the effectiveness of program operations, but to be validated, they must be placed in context with what program and fiscal data demonstrate to have occurred. For this reason, KCG consultants requested that HHSA fiscal staff conduct a data run for the mental health

[3] 2015 Annual Report, "Crisis Care Ad Hoc Committee Annual Report," Mendocino County Mental Health Advisory Board (page 4 of Committee Report)

claims paid by Medi-Cal for mental health services delivered through both ASOs and county staff for three fiscal years: FY 2012-13 (year prior to ASO contracts) and FY 2013-14 and FY 2014-15 (first two Service Years with ASOs). This data run was designed to provide reporting of Medi-Cal paid claims both immediately prior to and with the ASO contracts. Paid Medi-Cal claims data were reviewed for two reasons. First, the data is uniform and provides a basis for comparison of service delivery across provider arrangements (OMG, RQMC and county). Second, paid claims data provide hard evidence of what happened, i.e. services that were actually provided and paid.

A. Adult Mental Health Services

In summary, the data presented in Tables 1, 2 and 3 below show that the number of clients receiving approved Medi-Cal services by OMG contracted providers in the first year of the ASO Contract (FY 2013-14) was substantially below the prior fiscal year when BHRS/MH provided services. By the end of the second year of the ASO Contract, OMG approved Medi-Cal billings had increased substantially, and the number of clients receiving approved Medi-Cal services also increased substantially, roughly 35% greater than when

Table 1
Adult Mental Health Services
Approved Medi-Cal Payments (FY 2012-13)
Unduplicated Persons Served

Provider	Age 25-60	Age 61+	Total Clients
BHRS/MH	348	48	396

Table 2
Adult Mental Health Services
Approved Medi-Cal Payments(FY 2013-14)
Unduplicated Persons Served

Provider	Age 25-60	Age 61+	Total Clients
OMG	47	6	53
BHRS/MH	188	18	206
TOTAL	235	24	259

Table 3
Adult Mental Health Services
Approved Medi-Cal Payments (FY 2014-15)
Unduplicated Persons Served

Provider	Age 25-60	Age 61+	Total Clients
OMG	479	55	534
BHRS/MH	139	3	142
TOTAL	618	58	676

BHRS/MH provided services (534 OMG served clients vs. 396 BHRS/MH served clients).

With respect to the types of services for which Medi-Cal reimbursement was received, the data show that in the first contract year of the ASO Contract, Medi-Cal payments to OMG were exclusively for psychiatric hospital services and adult residential services and payments totaled $1,008,000. No other Medi-Cal qualifying services were billed or paid. As shown in Table 4, in the second year of the ASO Contract, Medi-Cal payments to OMG increased and were for a variety of services. Of a total of $3,178,324 in Medi-Cal reimbursements in FY 2014-15, psychiatric hospital services and residential services combined totaled $1,867,690, roughly 59% of Medi-Cal expenditures.

Table 4
Adult Mental Health Services
Approved Medi-Cal Payments (FY 2014-15)
Services by Service Type

Service Type	Units of Service	% of Services	Expenditures
Adult Residential	6,214	41.19%	$867,560
Case Management/Brokerage	3,596	23.83%	$440,000
Crisis Intervention	362	2.40%	$243,322
Medication Support	234	1.55%	$31,035
Mental Health Services	3,469	22.99%	$596,275
Psychiatric Health Facility (PHF)	1,213	8.04%	$1,000,130
TOTAL	**15,088**	**100.00%**	**$3,178,324**

B. Children's Mental Health Services

In summary, the data in Tables 5, 6 and 7 show that the number of clients receiving approved Medi-Cal services by RQMC providers and county staff in the first year of the ASO Contract (FY 2013-14) was roughly the same as the year prior to the ASO Contract, but the proportion of clients served by RQMC contracted providers was greater (roughly 21% greater). For year two of the ASO Contract (FY 2014-15) this trend continued. Additionally, in year two of the ASO Contract the total number of Medi-Cal clients receiving services was 5.4% higher than in the year prior to the ASO contract (1,166 versus 1,096 total clients served).

Table 5
Children's Mental Health Services
Approved Medi-Cal Payments (FY 2012-13)
Unduplicated Persons Served

Provider	Age 0-5	Age 6-14	Age 15-24	Total Clients
CONTRACTORS	77	501	270	848
BHRS/MH	12	81	155	248
TOTAL	**89**	**582**	**425**	**1,096**

Table 6 Children's Mental Health Services Approved Medi-Cal Payments (FY 2013-14) Unduplicated Persons Served				
Provider	**Age 0-5**	**Age 6-14**	**Age 15-24**	**Total Clients**
RQMC	93	627	305	1025
BHRS/MH	3	33	45	81
TOTAL	**96**	**657**	**350**	**1,106**

Table 7 Children's Mental Health Services Approved Medi-Cal Payments (FY 2014-15) Unduplicated Persons Served				
Provider	**Age 0-5**	**Age 6-14**	**Age 15-24**	**Total Clients**
RQMC	108	623	360	1,091
BHRS/MH	7	34	34	74
TOTAL	**115**	**657**	**394**	**1,166**

With respect to the types of services for which Medi-Cal reimbursement was received, the data over the first two years of the RQMC Contract show a consistent array of services for which Medi-Cal reimbursement was received. As shown in Table 8, in the second year of the ASO Contract (FY 2014-15) Medi-Cal payments were for a wide variety of services.

Table 8 Children's Mental Health Services Approved Medi-Cal Payments (FY 2014-15) Services by Service Type			
Service Type	**Units of Service**	**% of Services**	**Expenditures**
Case Management/Brokerage	3,498	8.5%	$278,244
Crisis Intervention	237	0.6%	$130,651
Day Rehabilitation - Full Day	113	0.3%	$14,830
Day Treatment Intensive- Full Day	59	0.1%	$11,943
Katie A - ICC	819	2.0%	$78,194
Katie A - IHBS	736	1.8%	$160,441
Medication Support	19	0.0%	$5,109
Mental Health Services	34,910	85.3%	$5,863,094
Psychiatric Health Facility (PHF)	11	0.0%	$9,020
Therapeutic Behavioral Services	532	1.3%	$194,614
TOTAL	**40,934**	**100.0%**	**$6,746,144**

4. Non-Medi-Cal Funded Services

The Medi-Cal paid claims represent one part of the financing equation for mental health services delivered by the two ASOs. Separate and distinct from Medi-Cal payment is financing for services by the Mental Health Services Act (MHSA) and Realignment (1991 and 2011 statutes that provide sales tax and Vehicle License Fees). KCG asked both ASOs to provide a data file on services provided with these non-Medi-Cal funds. Table 9 below provides data on Adult Mental Health Services supported with non-Medi-Cal funds.

Table 9
Adult Mental Health Services
NON-Medi-Cal Payments (FY 2014-15)
Services by Type and Fund Source

REALIGNMENT FUNDING	Units of Service	Service Unit Type	Expenditures
Inpatient			
North Valley Behavioral Health, LLC	152	Days	$ 125,400
Restpadd, Inc.	23	Days	$ 18,860
Mental Health Rehabilitation Center			
Sequoia Psychiatric Treatment Center	29	Days	$ 7,540
California Psychiatric Transition, Inc.	31	Days	$ 21,700
Crestwood Behavioral Health	1904	Days	$ 46,170
Residential			
Redwood Creek (part of Willow Glen)	50	Days	$ 5,250
Willow Glen Care Center*	8,003	Days	$ 840,315
Davis Guest Home*	689	Days	$ 58,565
Outpatient Services			
Manzanita Services, Inc.**	9,109	Minutes	$ 0
Mendocino Coast Hospitality Center**	15,609	Minutes	$ 0
MHSA FUNDING			
Senior Centers			
Redwood Coast Seniors	NA	NA	$ 31,788
Ukiah Senior Center	NA	NA	$ 24,840
South Coast Seniors	1,399	Encounters	$ 4,800
Wellness Centers			
Mendocino Coast Hospitality Center	NA	NA	$ 109,848
Manzanita Services, Inc.	NA	NA	$ 200,000
NON-BILLED* **			
Integrated Care Management Solutions	93,038	Minutes	$ 289,561
Manzanita Services Inc.	14,671	Minutes	$ 37,722
Mendocino Coast Hospitality Center	797	Minutes	$ 1,964
Mendocino County AIDs Volunteer Network	1,189	Minutes	$ 2,494
TOTAL			**$ 1,826,817**

*Non-Medi-Cal Provider
**Services provided but documented with non-billable codes
***Medication management and other outpatient services ineligible for Medi-Cal or other reimbursement due to client ineligibility, lack of Medi-Cal retroactivity, or Medicare limitations
NA = Not available

As demonstrated by Table 9, a variety of providers and adult mental health services were funded with MHSA and Realignment funding. It is important to note two things: 1) Roughly half of expenditures were for inpatient or residential care; and, 2) Most expenditures were for services that could not be reimbursed by Medi-Cal, including residential treatment services delivered by providers that do not quality under Medi-Cal facility rules, and outpatient or other services for clients that were not eligible for Medi-Cal.

As demonstrated by Table 10, a variety of providers and children's mental health services were funded with MHSA and Realignment funding. Just over 30% of expenditures were for inpatient and residential services.

Table 10
Children's Mental Health Services
NON-Medi-Cal Payments (FY 2014-15)
Services by Type and Fund Source

REALIGNMENT FUNDING*	Units of Service	Service Unit Type	Expenditures
Aurora Vista del Mar Hospital	6	Days	$ 7,500.00
Crestwood (Carmichael)	45	Days	$ 11,070.00
Crestwood (Behavioral Health)	45	Days	$ 44,604.00
Psynergy	249	Days	$ 48,729.00
Rest Padd Hospital	49	Days	$ 41,000.00
Casa Serenity	365	Days	$ 21,900.00
St. Helena Behavior Health	57	Days	$ 62,760.00
Heritage Oaks Hospital	6	Days	$ 6,650.00
Doctors Bills		Office Visits/Other	$ 722.00
California Psychiatric Transition, Inc.	40	Days	$ 30,450.00
Hilltop Recovery Services	1	Month	$ 680.00
Sierra Vista	88	Days	$ 75,050.00
MHSA FUNDING	**Units of Service**	**Service Unit Type**	**Expenditures**
Action Network	118	Session	$ 49,250.00
Anderson Valley School District	117	Days	$ 2,069.00
Mendocino County Youth Project	5408	Hours	$ 150,000.00
Redwood Community Services (Arbor Youth Resources)	924 8746	Groups, Classes Drop-In Contacts	$ 115,000.00
Redwood Community Services (TAY Wellness)	4193	Bed Nights	$ 200,000.00
Tapestry Family Services	6743	Minutes	$ 90,000.00
Redwood Community Crisis Center	26947 864	Minutes Crisis Line Calls	$ 60,000.00
Laytonville Healthy Start FRC	284	Session	$ 18,750.00
Mendocino County Youth Project (Levine House)	463	Bed Nights	$ 38,060.00
FSP Funding Pool	3	Clothing/Other	$ 1,034.00
Mendocino Community Health Center	52 104	Crisis Client Review Psychiatric Appt.	$ 25,000.00
TOTAL			**$ 1,100,278.00**

*Services funded with these dollars are for adult residential placements or inpatient psychiatric hospitalizations that are not eligible for Medi-Cal reimbursement for various reasons.

5. Prior and Current Reviews of Service Delivery Quality

Service delivery data provide evidence of what happened, but they do not speak to the quality of services delivered. To inform that question, KCG reviewed findings from the 2013-14, 2014-15 and 2015-16 External Quality Review (EQRO) evaluations and a recent review by the U.S. Department of Health and Human Services concerning Recertification of the Mendocino County Community Mental Health Center. Discussion of findings from these reviews is presented below.

A. External Quality Review Findings[4]

The Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care programs by an External Quality Review Organization (EQRO). The rules require an on-site review or a desk review of each Medi-Cal Mental Health Plan (MHP). In Mendocino County, these reviews were conducted by the firm Behavioral Health Concepts, Inc.

The 2013-14 EQRO review presented the following recommendations for improvements in program management and service delivery:

- Enhance the Quality Improvement Work Plan activities with increased measurable goals, timelines, routine data reports and timely, detailed documentation of the meeting activities.
- Routinely analyze results from identified outcome measures to assist in monitoring appropriate service utilization and consumer progress.
- Create an inter-agency line staff venue for sharing of service delivery practices to establish collaboration and eliminate access barriers.
- Establish routine reporting, analysis and subsequent improvements as warranted for medication support services.

In the 2014-15 EQRO review, the above recommendations were determined to have been substantially addressed but the following issues were identified:

- Utilize consumer and staff input on the development of a survey to assist the MHP in obtaining feedback on the strengths and challenges of the new dual Administrative Services Organization (ASO) model of care.
- Establish work groups to conduct a needs analysis to determine adequate resources to support and maintain EHR and data access requirements and practice management functions.
- Prioritize resources to complete the EHR contract and include feasibility of a rollout to organizational providers.

[4] CAEQRO Fiscal Year 2014/15 Final Report, Behavioral Health Concepts, conducted December 10, 2014; and, CAEQRO for Fiscal Year 2015/16 Final Report, Behavioral Health Concepts, conducted on September 29, 2015

Specific improvements reported in the 2014-15 EQRO review showed that the actual "time to services" for adult clients improved greatly, by 68%. "Time to services" is defined as the time from the client's initial contact to the first service and the time to the first psychiatry service. These improvements included a more timely and consistent transition from county to contracted providers, and appear to support the perspective of many Key Informants of improved adult service delivery in the second year of the OMG ASO Contract.

In the 2015-16 EQRO review the prior year recommendations were determined either fully or partially addressed except the following:

- Prioritize the implementation of an electronic EHR/Practice Management system within OMG (Avatar or other selected option) and online integration of outcome instruments, and noted:
    - The MHP continues to work in partnership with OMG, RQMC, NetSmart, Xpio, and Redwood Mednet to get all Mental Health Plan providers online with an electronic health records system, with the Adult System of Care prioritized.
    - The MHP has worked with RQMC to integrate the CANS and ANSA fully into their electronic health record system.
    - The next phase the MHP intends to focus on with the OMG will be to integrate the CANS and ANSA into the NetSmart system.

Further, the "time to service" trend showed continued improvement in the 2015-16 EQRO review:

- From initial client contact to first service the County Mental Health Plan has an overall standard of 14 days. Both ASOs met this standard. For Adult Services it reported an average of 11 days. For Children's Services it reported an average of 10 days.
- The time to first psychiatric service from client initial contact has an overall standard of 30 days. Both ASOs met this standard. For Adult Services it reported an average of 11 days. For Children's Services it reported an average of 12 days.

Other selected EQRO review findings are presented in Appendix B.

B. U.S. Department of Health and Human Services Survey

The U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services (CMS), conducted an on-site survey of clinical records for BHRS/MH on September 28, 2015, for Recertification of the Mendocino County Community Mental Health Center (CMHC). CMS issued a report of its survey on November 24, 2015.[5] The review was based on observation, interviews and record reviews of ten client

[5] U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, survey completed 9/28/2015, Summary Statement of Deficiencies

records (5 adult and 5 children) between 9/23/14 and 9/25/15. This report identified a variety of essential elements of regulatory non-compliance for BHRS/MH.

Insofar as BHRS/MH has not operated a CMHC for many years, the legal basis for this federal Survey is highly questionable. Apparently, the federal government was working from an existing, albeit long inactive, Medicare provider identification number for the County's prior CMHC. The California Department of Health Care Services (DHCS), in communications with the Interim Mental Health Director, confirmed the federal review should not have been conducted.

Notwithstanding the questionable authority of the federal government to conduct the Survey in the first place, we believe the findings merit consideration because they offer another perspective on current ASO system effectiveness that is separate from the EQRO reviews. Key findings from the CMS survey are:

- BHRS/MH failed to develop and maintain a system of communication that assures the integration of services; specifically that communications between OMG and outside health care providers did not occur.
- BHRS/MH failed to retain oversight of fiscal and administrative management for OMG contracted services.
- OMG failed to maintain an accounting of various active clientele in the Adult Services System.
- There was potential for inaccurate billing submissions to BHRS/MH by OMG.
- OMG failed to practice effective infection control procedures in certain circumstances.

In general, CMS stated that "When Mendocino County has a written agreement with another agency, individual, or organization to furnish any services, the County must retain administrative and financial management and oversight of staff and services for all arranged services. As part of retaining financial management responsibility, the County must retain all payment responsibility for services furnished under the arrangement on its behalf." Further detail concerning key Survey findings is provided in Appendix C.

In response to the CMS Survey, BHRS/MH representatives reported that BHRS/MH is investigating the findings. It conducted a site review with OMG in mid-January 2016 and corrective actions were put into place at that time. BHRS/MH will be preparing a report once its full investigation is completed and the report will be sent to OMG. In our opinion, the deficiencies identified by CMS in this Survey coincide with some of the findings of our review, which are describe in the further detail in Sections III and IV. Further, we believe it was important for BHRS/MH to conduct its own investigation in response to the federal survey and initiate necessary corrective actions with OMG.

III. Major Deficiencies of ASO Model as Implemented

In consideration of the documents we have reviewed and the Key Informant interviews we have conducted, it is KCG's assessment that the manner in which the ASO Contracts were implemented was deficient in a number of respects. Each deficiency is described in this section.

1. Fundamental Weaknesses of the ASO Agreements

In our opinion, the ASO Contract between the two ASOs and BHRS/MH is fundamentally weak in key areas. We believe these weaknesses or "gaps" in the ASO Contract are the result of three dynamics:

- The County's reported desire to contract out mental health service delivery as a means for addressing the County's long-standing shortfalls in mental health and multiple years of costly mental health financing "audit exceptions," and the former BHRS/MH Director's intention of getting the ASO Contracts in place as quickly as possible to help Mendocino County meet this objective, with the belief that any "gaps" in the Contracts, such as specific service delivery requirements, data reporting requirements, and implementation of Electronic Health Records (EHR) could be addressed after the Contracts were executed.
- The former BHRS/MH Director's expectation that documented processes for determining medical necessity for mental health services, periodic Quality Improvement reviews of ASO service delivery, annual External Quality Review Organization (EQRO) reviews, and compliance with Medi-Cal treatment and billing requirements, in combination, would assure overall mental health service needs among children and adults would be addressed.
- Insufficient attention given by other County leadership, including the HHSA Director, County Counsel, County Executive and the Board of Supervisors, to the significance of the ASO Contract "gaps," most specifically the following:
    - Lack of clearly defined ASO Contract deliverables, notably the lack of a formal "Program Implementation Plan" from each ASO to be approved by BHRS/BH.
    - Lack of specified ASO service delivery goals, objectives, timelines, and performance metrics.
    - Unclear structure for receipt of defined data and other reporting by ASOs.
    - Lack of specified fiscal, programmatic or other penalties for subpar ASO performance.

The fundamental weaknesses in the ASO Agreements we identified through our review are the following:

- *No ASO Program Implementation Plans Required.* There was no required "Program Implementation Plan" from the ASOs, subject to the approval of BHRS/MH, specified in the ASO Contract. In lieu of this, the former Director reported that he undertook a series of "Flash Team" meetings and other meetings to lay out the structure of the systems and address the transition of clients from the

County to the two ASOs. He also reported that he personally prepared the required County Mental Health Plan for submission to DHCS, but did so in the absence of receiving any formal Implementation Plan from each ASO outlining their service delivery structures and timeframes for implementation. Had the ASO Contract required the submission of ASO Implementation Plans for approval by BHRS/MH, the requirements contained in the ASO Scope of Work (Exhibit A) could have been incorporated into these plans as well as the County's Mental Health Plan, and BHRS/MH would have been in the position to review, understand, negotiate and approve the overall framework for the service delivery system proposed by each ASO. The absence of these Implementation Plans, and the lack of a Plan approval role by BHRS/MH, left the County with accepting the service delivery systems as they have been defined and established by each ASO, and with little uniform documentation of each delivery system.

- *Ambiguity About Services Covered by the ASO Agreement.* The lack of a Program Implementation Plan for each ASO also resulted in certain ambiguity about what services are specifically covered in the ASO Contract and when. This ambiguity has been a particular problem in the context of OMG's service delivery for county residents involved with the county justice system, including misdemeanants, 5150s and residents in need of public guardianship, and interactions with health care providers in the community.

- *Lack of Detail on Data Reporting by ASOs and Subcontracting Providers*. The primary requirements for data and other reporting by the ASOs are contained in the Scope of Work (Section 17 for RQMC and Section 16 for OMG). These relatively high level reporting requirements, while important and useful, do not describe in substantive detail the type of information that will be contained in each report. Further, from these data reporting requirements it is not clear what information will be provided by each ASO that describes the mental health services that are delivered through each ASO by fund source, by subcontractor, by program, by service, by client served, and by cost. For example, it is not clear what is to be included in the "Annual Program Report" or the "Annual Cost Report." In addition, while the ASOs are required to report monthly to the MHAB, the structure and form of this reporting is not described and we found the ASO reports to the MHAB lacked uniformity and were not easily comparable. Overall, it is not clear how BHRS/MH will bring the data reported by the ASOs together to present a report on each system's performance that allows comparability between the different ASOs and with county staff delivered services.

- *Lack of BHRS/MH Approval Role and Structure for Holding ASOs Accountable.* The ASO Contracts do not specify an overall set of ASO goals and objectives, deliverables, associated timelines, and performance outcomes. In large part, this deficiency is tied to the lack of a Program Implementation Plan. Further, the ASO Contracts do not establish a clear BHRS/MH approval role

for all ASO activities. The language in the Scope of Work specifies that the ASOs shall establish and manage a wide range of services and activities but does not make the manner in which those ASO duties are accomplished subject to the approval of BHRS/MH. In addition, the language does not establish a mechanism for BHRS/MH to address poor ASO performance in completion of those duties. Both of these provisions are needed for BHRS/MH to actively oversee ASO performance and hold the ASOs accountable.

Because of the weaknesses in the ASO Contract we have identified above, both ASOs have substantial authority to make decisions about mental health service delivery to children and adults in Mendocino County but their accountability to BHRS/MH, and thus to Mendocino County, for the outcomes of their performance or lack of performance is limited.

RECOMMENDED ACTION

In Appendix D we propose specific additional requirements for amendment into the ASO Contracts to strengthen BHSR/MH's ability to oversee and manage the ASO Contracts, including specified penalties for ASO non-compliance. We recommend the County Executive submit the proposed language to County Counsel for legal review and refinement. Following County Counsel review, we recommend the County Executive direct BHRS/MH to initiate amendment of the ASO Contracts to incorporate these new requirements and set a 90-day timeframe for final execution of the amendments.

In light of the passage of time, the requirements call for each ASO to develop a "System Design Structure Report" (in lieu of a Program Implementation Plan) that describes each delivery system; describes overall goals and objectives for the system; identifies and describes the role of all subcontracting providers; describes and provides a flow chart for the referral and service delivery framework; and, provides a description of the ASO system interfaces with other systems, specifically hospitals, community health centers and other health care providers in the county, and the county justice system.

2. Conflicting Approaches for ASO Accountability

From our Key Informant interviews, we learned that that were different perspectives among county staff and management about the County's role in a ASO contracting model. One view, held by the former BHRS/MH Director, focused on maximum delegation to the ASOs. A second view, held primarily by HHSA fiscal staff, focused on establishing defined parameters for ASO Contract monitoring to prevent the potential for future Medi-Cal and other audit exceptions and to hold the ASOs accountable for defined service delivery standards. Of the two approaches, the requirements set forth in the ASO Contract lean toward maximum delegation to the ASOs.

HHSA fiscal staff reported finding the framework for implementation of the ASO Contracts "fluid." In our opinion, the absence of a clear accountability framework in the ASO Contract made implementation and monitoring the first year difficult for both county staff and the ASOs. It is important to note that the ASO Contracts do require the ASOs to assume financial responsibility for any federal financial audit exceptions with their management of the care delivered, and the ASOs have in turn passed on this liability to their contracting service providers. However, the relative ability of BHRS/MH to enforce these provisions is unknown. The practical reality is that both ASOs are legally constructed entities, each with for-profit and not-for profit components. Whether or not either ASO would assume responsibility for and repay a federal financial disallowance will ultimately depend on the audit findings; each ASO's overall financial strength; the ASO's levels of applicable professional liability insurance and errors and omissions insurance; and, the ASO's willingness to make payment without legal dispute.

Under state law the County Mental Health Plan is always be responsible for the delivery of mental health services under its delivery system, irrespective of whether those services are delivered by county staff or through contractors. The recent federal audit made this clear with its finding, "When Mendocino County has a written agreement with another agency, individual, or organization to furnish any services, the County must retain administrative and financial management and oversight of staff and services for all arranged services. As part of retaining financial management responsibility, the County must retain all payment responsibility for services furnished under the arrangement on its behalf.[6]" Thus, BHRS/MH's delegation of responsibilities to both ASOs needed to be placed within a framework that assured appropriate BHRS/MH oversight of ASO activities.

In our opinion, the Board of Supervisors should not have approved the ASO Contracts in the form brought to the Board because of the lack of a clear BHRS/MH approval and oversight role and ASO accountability mechanism in the Scope of Work contained in the contracts. Further, we believe other county officials, including the former BHRS/MH Director, HHSA Director, County Counsel, and County Executive should have assured the ASO Contracts included these key provisions prior to submission to the Board for approval.

RECOMMENDED ACTION

As proposed in Section III (1) we recommend the County Executive proceed with refinement and execution of the amendments to the current ASO Contracts proposed in Appendix D.

3. Inadequate County Decision Structure and Process

During our review, we found little evidence of a documented decision process for BHRS/MH's

[6] U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, survey completed 9/28/2015, Summary Statement of Deficiencies

implementation of the ASO Contracts and addressing "gaps" in the Contracts during the ASO implementation. In addition, from Key Informant interviews with county staff and the former BHRS/MH Director, it's clear there was disagreement during the ASO implementation process concerning Contract requirements and steps necessary to facilitate implementation.

A key problem during implementation was the lack of a clearly defined county staffing structure to oversee and manage the ASO Contracts. For example, below the Mental Health Director there was no clearly identified "Contract Manager" or "Contract Implementation Manager" to oversee ASO Contract implementation. While HHSA fiscal staff had oversight responsibility for other contracts (i.e. tracking to assure deliverables are submitted on time and appropriate fiscal claiming) and the BHRS/MH Program Division was charged with overseeing clinical program requirements associated with the ASO Contracts, the fiscal staff's role with the ASO Contract management was less clearly defined. As a consequence, when these staff tried to carry out contract oversight, such as setting requirements for opening paperwork for a case, Treatment Authorizations, or data reporting, the ASOs would appeal directly to the former Director, who would then make decisions on a case-by-case basis he determined were necessary at the time to facilitate implementation of each ASO system. Ultimately, the former Director became the de-facto ASO Contract Manager, managing day-to-day contract issues that should have been managed at a lower staff level with a designated Contract Manager.

In addition, in our review and discussions with the former Director, we found little documentation of his decisions as de-facto ASO Contract Manager. County staff reported that the former Director was regularly pressured by both ASOs to overturn or relax requirements county staff had sought to impose on the ASOs, although the dynamic was reported to be more frequent with OMG.

In our opinion, the lack of BHRS/MH organizational infrastructure for ASO Contract implementation and management, and the associated role of the former Director as de-facto ASO Contract Manager – in combination with a lack of documentation of the former Director's decision process concerning ASO implementation – resulted in a lack of clarity and transparency about the ASO implementation process.

RECOMMENDED ACTION

First, we recommend the County Executive direct the HHSA Director and BHRS/MH Director to prepare a proposal in the next 90 days for creation or assignment of an ASO Contract Manager in HHSA or BHRS/MH with a set of job duties specific to administrative and financial management oversight of the ASO Contracts. Second, we recommend the ASO Contract Manager, once assigned, establish a mechanism for regular review of financial claiming and service delivery outcomes for both ASOs and work with the Program Division overseeing ASO clinical requirements to assure coordination of administrative and clinical oversight and assure that an onsite review of all ASO subcontracted facilities regularly takes place.

4. Delay of Electronic Health Records

In today's health care world, the Electronic Health Record (EHR) is considered an essential tool. From a quality of care perspective, the coordination of medical services between mental health crisis workers, case managers, contract providers, psychiatric hospitals, and emergency rooms is only truly effective when there is a consistent method for sharing real time critical health care information between these providers. For example, the simple coordination of highly potent prescription medications between primary care physicians, psychiatrists and impatient settings is significantly impeded without an EHR. Further, the claiming and documentation required for mental health service delivery is complex and paperwork-driven without a viable EHR.

Both ASOs were expected to have an EHR system as part of their administrative structures, as set forth under the Scope of Work, which called for "Management of service delivery utilizing a comprehensive Electronic Record.[7]" More than two years into ASO program operations, the implementation of EHRs is only now gaining traction.

From our Key Informant interviews, there were differences of opinion about what contributed to the delay in development of EHR. However, it's clear that the ASOs started with different levels of EHR capacity. OMG, which did not operate an EHR, reported that it understood that the County's Avatar system would be extended to both ASOs and therefore did not seek development of a separate OMG-based EHR that was not Avatar. RQMC had already invested in its own system (Exiom) that they use with their providers for clinical management and billing purposes, and was reportedly reluctant to proceed with Avatar because of expected additional costs, and uncertainty about its impacts on client service delivery, reporting and financial claiming. During the first two years of ASO operation, BHRS/MH's continued thinking about the EHR was that both ASOs had to participate in the Avatar system in order to have quality data and reporting. In the most recent External Quality Review, one finding stated that the county continues to be "disadvantaged by having legacy data collection protocols and multiple information silos to manage its System of Care. The Youth ASO uses its own EMR. The Adult ASO utilizes legacy paper methodologies. Internal providers, who are being functionally transitioned to ASO integration have no access to the MHP's EHR. The MHP's Substance Use Disorder (SUD) division utilizes a different EMR. None of these systems communicate clinical data in a way that is of broad utility to the Mental Health Plan's QI initiatives."[8]

It is anticipated that implementation of the EHR strategy will address many of the deficiencies identified in the EQRO report. Once the EHR systems are fully implemented, substantial administrative time will be

[7] Exhibit A, Scope of Work, #2, Provide a Quality Management Program, page 2

[8] CAEQRO Fiscal Year 2014/15 Final Report, conducted December 10, 2014 by Behavioral Health Concepts and again on September 29, 2015 for the CAEQRO for Fiscal Year 2015-16

saved for both ASOs and BHRS/MH staff, and the data will be more complete and reliable because data errors typically associated with manual data collection and input will be eliminated. Further, when both ASOs have a fully implemented EHR, BHRS/MH will be in a better position to assess "real time" delivery of services to clients. It must be noted, however, that the EHR will not apply to the BHRS Substance Use Disorder Treatment (SUDT) Branch, which will continue to operate as a separate, stand-alone system.

We understand work is underway for development of EHR systems with both ASOs. This past fall, the Department determined that RQMC could, in fact, use its existing EHR and create claiming files that upload to the Department's Avatar system through an Electronic Data Exchange (EDE). At the same time, OMG is expected to either join Avatar or establish its own EHR and connect through the EDE. Intended go-live for these systems is reported to be no later than July 1, 2016.

RECOMMENDED ACTION

In our opinion, the ASO Contract is clear. It specifies that each ASO shall provide "Management of service delivery utilizing a comprehensive Electronic Record." We recommend the County Executive direct BHRS/MH to hold both ASOs accountable for development and implementation of this EHR requirement by July 1, 2016 and take all necessary steps to enforce completion of this contractual obligation.

5. Lack of Memorandums of Understanding

The ASO Contracts call for development of Memorandums of Understanding (MOU) between the ASOs, BHRS/MH, and various parties. However, more than two years into the ASO arrangement, most of these MOUs have not been completed. In addition, there are various areas in the ASO Contracts where the ASOs are required to "collaborate with" specified parties. During our review, we found that key points of tension existed between OMG and other parties with whom such collaboration was required by the Contract. These areas of tension are discussed in further detail in Section IV. While the ASO Contract, as previously described, is deficient in a number of ways, the lack of more formalized agreements between the ASOs and the other parties has also resulted in a lack of clearly defined processes by which the parties carry out their work.

RECOMMENDED ACTION

We recommend the County Executive direct BHRS/MH to initiate development of MOUs in all of the following areas:

- MOU between RQMC and OMG for the transition of TAY youth from the Children's System to the Adult System.

- MOUs between BHRS/MH, BHRS/SUDT, and RQMC and OMG for the provision of county SUDT services to clients served by RQMC and OMG.
- MOU between BHRS/MH, OMG, County Jail (Sheriff), and the Courts defining roles, responsibilities and timelines for service delivery to misdemeanants.
- MOU between BHRS/MH, OMG, Public Guardian, County Jail (Sheriff) and the Court defining roles, responsibilities and timelines for service delivery to 5150s and responsibilities associated with conservatorships.
- MOUs with all three hospitals in the County with BHRS/MH, OMG and RQMC to define roles and responsibilities of each party for residents with mental health conditions who present at these facilities.
- MOUs between each community health center in Mendocino County (FQHC, Rural Health Clinic, and Tribal Health Program), BHRS/MH, OMG, and RQMC defining roles and responsibilities, processes and timelines for care transitions, and structure of communication pathways.

We further recommend these MOUs be reviewed annually and amended as needed to conform to the evolving environment of mental health service delivery in the County.

6. ASO Administration Costs Not Clearly Defined

In general, the ASO Contracts have been presented as contracts for "administrative services" pertaining to the delivery of mental health services. While it is true that the two ASO are charged with administration of mental health services for Mendocino County, by their very nature the ASO Contracts are, in practical terms, contracts for the direct delivery of mental health services, albeit services provided largely through organizations that subcontract with each ASO. Within this context, the ASO Contracts are composed of two fundamental components: services of the ASO associated with administering ASO Contract requirements and managing subcontracts with service providers; and, direct services provided by subcontracting organizations (which may include various administrative components associated with service delivery).

The Scope of Work for both Contracts outlines over 20 separate sets of duties to be carried out by each ASO. Many of these duties call for varying levels of administrative support, or what would be considered "administration." Despite the range of required duties, the Contracts do not include a written definition for what is considered an "administration cost" of the ASO. In subsequent amendments to both Agreements made effective July 7, 2015, language is included that states "payments will include the Administration/UR Component" and that these payments will be distributed quarterly beginning in July 2015. Along with this

language, each provision lists a specified dollar amount for "administration" and "Utilization Management.[9]"

Because the July 7, 2015 amendments both specify and provide payments for "administration" and the "UR component," it is clear BHRS/MH has established some methodology for determining what is considered "administration" versus the "UR component" versus other services specified in the Scope of Work. It is also clear that payment amounts to the ASOs for administration and UR differ. These differences may be entirely appropriate and result from differences in administrative structure, qualifications and training of staff, time dedicated to specific functions, or the ability of the ASO to bundle administrative activities with other existing operations. However, a definition of these terms is not provided in the ASO Contracts and the BHRS/MH methodology for determining these costs has not been presently publicly. Consequently, differences in payments to the ASOs for these activities cannot be assessed. In the absence of this information from BHRS/MH, it is not possible for the County Executive or Board of Supervisors to make a determination of the appropriateness and reasonableness of payments for these different activities.

RECOMMENDED ACTION

We recommend the County Executive direct BHRS/MH carry out the following activities within 90 days and report to the County Executive:

- Proposed definitions of the following terms for use in administering the ASO Contracts: ASO administration, direct mental health services, and Utilization Review.
- Proposed methodology for BHRS/MH to determine payments for ASO administration, Utilization Review, and direct mental health services provided by or through each ASO.
- Proposed amendments to the ASO Contracts to incorporate these definitions and a description of the methodology for determining payments for these activities.

[9] Services Agreement with Ortner Management Group, Amendment 5, effective July 7, 2015, Exhibit B, page 24; and, Services Agreement with Redwood Quality Management Company, Amendment 6, effective July 7, 2015, Exhibit B, page 23.

IV. Key Tensions in the Current Delivery System

From our Key Informant interviews, we learned about a variety of tensions in the current delivery system, most of which were reported to be present in the Adult System of Care administered by OMG. We believe each of these tensions needs to be addressed by BHRC/MH in order to move forward most effectively with the ASO Contract model.

1. Lack of In-County Residential Care & Crisis Residential Services

The need for expanded residential care and crisis residential services for severely mentally ill adults in Mendocino County is a long-standing problem that predates the current ASO arrangement. Since the closure of the Psychiatric Health Facility (PHF) in Mendocino County in 2001 the dynamic of services to severely mentally ill adults meeting 5150 criteria has relied on placement of these residents with available out-of-county inpatient hospital or residential care providers. This dynamic has resulted in the continued delivery of care that is:

- Provided far from the county, making family visitation and support difficult.
- Provided in the most restrictive setting for care delivery.
- Expensive.

Key Informants reported varying perspectives about this matter, but most agreed that the County's prior determination of 5150s was much more restrictive and difficult than it has been to date with OMG, and they viewed this as an improvement. At the same time, several Key Informants were critical in their assessment of the lack of alternatives to inpatient and residential care and found OMG's delivery of the expected "continuum of care" severely wanting. Under the Scope of Work OMG is required to deliver a range of mental health services.

Recently, the Mendocino County Sheriff, among other critical remarks he made concerning OMG, told the Mendocino County Board of Supervisors he believes that the Board "needs to build a building in this county where we can have mental health services provided in Mendocino County. We are paying a lot of money outside of this county to take care of our citizens…"[10] This sentiment was shared by many Key Informants we interviewed, who expressed concern that there are no local "upstream solutions" that address crises at an earlier time and with a less restrictive and less expensive approach. As of this writing, real alternatives to the delivery of inpatient and residential care outside of Mendocino County have not yet been identified.

[10] Anderson Valley Advertiser, *Ortner Denounced*, Malcolm McDonald, found at http://theava.com/archives/50711

RECOMMENDED ACTION

We recommend the County's leadership – County Executive, HHSA Director, new BHRS/MH Director and Board of Supervisors – renew efforts to develop community consensus about a strategy for developing expanded in-county capacity for short-term crisis services and short-term and/or longer-term residential services. Toward this end, we recommend the County Executive direct the BHRS/MH Director to begin the process of community consensus building by convening key public officials and community stakeholders in a public process to discuss ideas and options for moving forward.

2. Lack of Defined Structure for Coordination with Health Care Providers

According to the ASO Contract with OMG, adult client access to mental health services is expected to occur at multiple entry points within Mendocino County, including multiple Federally Qualified Healthcare Centers (FQHC), Rural Health Clinics, several Indian Health Clinics, three Hospital Emergency Rooms and two Access Centers. As stated in the Contract "…these locations will provide defined outpatient services and have direct access to crisis services, psychiatric emergency services, multiple 24-hour care mental health referral/placement sites, substance abuse linkages and primary care support. Qualified mental health clinicians and care managers will staff each location. Two strategic locations will operate 24 hours/day and seven days/week."[11] The language goes on to specify the following:

- Community Clinics within the system network will provide assessments, medication management, brief therapies, coordinated care management and integration with substance abuse and primary health needs.
- Hospital Emergency Rooms shall be destination points for 5150 determinations (determinations by a qualified officer or clinician to involuntarily confine persons deemed to have a mental disorder that makes them a danger to themselves and/or others and/or are gravely disabled).
- Access Centers provide urgent mental health assessments and referrals; supportive care management services; substance abuse links; integration with primary care; crisis intervention and stabilization services; emergency mental health services when there is a danger to self, others or grave disability; and emergency room response services.

Despite these contractual requirements, Key Informants reported there is a lack of consistent clinical information exchange and communication between both ASOs, notably OMG, and health care providers in the community, including community health centers that serve severely mentally ill clients. They cited a variety of examples:

[11] Administrative Services Organization Agreement with Ortner Management Group, Exhibit A, #12, page 7

- *Restricted provider access to client information.* Discharge summaries for clients leaving inpatient settings do not get released to other health care providers in the community seeing the clients. This makes it difficult for these health care providers to competently provide assessments and medical services and is especially difficult when clients show up at the provider's office, often unannounced, without supporting information about their conditions and the medications they have been prescribed.

  OMG representatives we interviewed expressed their understanding that OMG contracted service providers are limited in the information they are allowed to provide other health care providers in the community because of patient confidentiality laws. Specifically, the federal Health Insurance Portability and Accountability Act (HIPPA) does not permit their contracted providers to provide critical medical information, even when the care for the patient is shared between the two providers, unless there is a written release from the patient.

  In our opinion, this is a mistaken interpretation of the authorities and limitations of HIPAA. In our experience, HIPAA specifically allows for the sharing/disclosure of patient health information between health care providers for treatment purposes. The relevant sections are 45 CFR §164.502(a)(1)(ii) and §164.506. As an aside, the Confidentiality of Medical Information Act (CMIA), as set forth under California Civil Code §56.10, also allows for the sharing of medical information between health care providers for treatment. While we agree a "patient release of information" is a good practice and should be implemented when possible, it is not required when care is transferred from one medical practitioner to another.

- *Lack of feedback on referrals for mental health services.* Community health centers will make referrals for mental health services to the subcontracted providers, ICMS and RCS, but there is seldom feedback to the health centers on what happened to the referred clients.

- *No ability of health care providers to appeal 5150 determinations by OMG.* There is no apparent appeal mechanism with either OMG or BHRS/MH when a hospital, community health center, or other health care provider disagrees with OMG's determination of 5150 for a client with serious mental illness.

- *Lack of a clear process for transferring seriously mentally ill clients from community health centers to the ASOs.* A protocol for appropriate referral and hand-off of clients with serious mental health conditions to the ASOs has not been formalized between the ASOs and local health care providers, resulting in sporadic, time-consuming, case-by-case determinations between these health care providers and the ASOs.

- *Community hospitals outlined a range of difficulties, including:*
  - For clients pending a 5150 determination, hospitals reported difficulty getting medication lists and diagnoses from OMG, resulting in extended stays in the Emergency Department.
  - The volume of adult 5150 patients has increased and inpatient mental health options for clients are getting tighter, resulting in clients staying longer in hospital Emergency Departments pending transfer to inpatient care; the absence of a Mendocino County crisis residential setting puts the burden of this care responsibility on community hospitals.
  - Many adult clients regularly return to the hospital Emergency Department because there is no warm handoff with OMG or because clients transferred for care outside of the county return to the county without a structured "after-care" plan.
  - Hospitals don't have the ability to refer psychiatric emergencies out to community providers because there is a lack of this outpatient service capacity.
  - For children in Mendocino County it's very difficult to get a Child Psychiatrist.

While both ASOs appear to have put processes in place for interaction with hospitals concerning residents that present with serious mental health conditions, we found no evidence of formal MOUs between BHRS/MH, OMG, RQMC, hospitals and other local health care providers that define the roles, responsibilities, and the structure and process for communications between the parties. We did receive a copy of a proposed MOU between OMG and hospitals that was never executed.

RECOMMENDED ACTION

As referenced in Section III (5) we recommend the County Executive direct BHRS/MH to develop separate MOUs between BHRS/MH, OMG, RQMC and two groups of providers – Mendocino County hospitals and community health centers – to define and establish clear roles, responsibilities, and communication processes.

In furtherance of developing these MOUs, we recommend that BHRS/MH establish a short-term workgroup composed of representatives of both ASOs, County Counsel, and representatives of health care provider community, including community health centers and hospitals, to consider and resolve the following issues:

- Health care provider access to client information.
- ASO feedback on referrals for mental health services.
- Process for transferring seriously mentally ill clients from community health centers to the ASOs.

Finally, we recommend the County Executive direct BHRS/MH to establish a structured clinical review process that provides a formal mechanism for BHRS/MH review of more contentious 5150 decisions and recurring problems identified by both the health care and law enforcement communities. As a part of this

process, BHRS/MH will need to establish a mechanism by which local health care providers can bring forward their client-specific concerns.

3. Incomplete Interface with the County Justice System

The ASO Contract with OMG lays out requirements pertaining to the delivery of mental health services to misdemeanants and clients requiring involuntary detention and conservatorships. Key Informants associated with the justice system reported a variety of difficulties in the current working relationship with OMG regarding delivery of these services. These dynamics are discussed below.

A. Mental Health Services to Misdemeanants

The ASO Contract with OMG requires OMG to provide specified mental health services to clients involved with the county justice system[12]. Specifically, for the "Thursday 11 AM Court Calendar" OMG is required to:

- Provide and/or arrange for the provision of care management, medications and outpatient services to participants of the Thursday 11 AM Court Calendar.
- Collaborate and coordinate with the multi agency Thursday 11 AM Court Calendar planning group.

The "11:00 AM Mental Health Court" proceeds with referrals taken from court via the Probation Officer to OMG for assessment and services. Even with this seemingly direct route to care, Key Informants reported the system regularly bogs down with OMG's delivery of needed mental health treatment services. In particular, Key Informants reported continuing difficulties getting clients that have been stabilized on medications while in custody appropriate follow up by OMG after their release.

For the misdemeanants, Mendocino County has initiated an effective Restoration of Competency Program (operated by a contractor) for people in jail who are charged with a misdemeanor to help restore their competency in order for them to stand trial. While Key Informants report the program has worked well, they report continuing communication problems between the court, BHRS/MH, and OMG, and OMG's follow-up provision of mental health services. Further, delays in assessments and apparent role confusion or disagreement between OMG, BHRS/MH, and the county jail have resulted in extended waiting times for assessments and treatment.

While Key Informants associated with the justice system generally agreed that the ASO Contract for adult services has been an improvement over the county's prior adult mental health service efforts, these Informants also reported continued frustration with repeated attempts at coordination and the lack of

[12] Administrative Services Organization Agreement with Ortner Management Group, Exhibit A, pages 15

clarity about when justice system involved individuals meet criteria for services under the Adult System.

RECOMMENDED ACTION

In our opinion, the ASO Contract spells out specific responsibilities for OMG regarding the provision of mental health services to misdemeanants and we believe BHRS/MH should enforce those contractual requirements. Toward this end, we recommend the County Executive direct BHRS/MH to initiate development of an MOU between BHRS/MH, OMG, the County Jail (Sheriff) and the Courts outlining roles and responsibilities for the provision of mental health services to misdemeanants.

B. 5150s and LPS Conservatorships

The ASO Agreement with OMG[13] requires the following duties of OMG pertaining to the provision of mental health services for clients requiring involuntary detention and conservatorship:

- OMG will collaborate and develop a Memorandum of Understanding (MOU) with the County Public Guardian office and the County BHRS Director will review and approve the MOU.
- OMG will provide or arrange for the provision of mental health services to persons within Mendocino County pursuant to the Lanterman-Petris-Short Act and shall recommend to the County's Public Guardian Office, as necessary, the establishment of conservatorships pursuant to said provisions.
- OMG's staff is designated to secure comprehensive evaluation and intensive treatment at locked facilities designated for such purposes.
- OMG will provide or arrange for the provision of initial and annual renewal documentation for all clients conserved.

Notwithstanding the contractual requirements specified above, Key Informants associated with the justice system and the Public Guardian's Office reported there is continuing disagreement with OMG about OMG's role and responsibilities pertaining to involuntary detentions and conservatorships, and 5150 determinations by OMG.

To date, the required MOU between the Public Guardian and OMG, with sign-off by the BHRS Director, has not been executed. Further, even though the ASO Contract calls for OMG to "provide or arrange for the provision of initial and annual renewal documentation for all clients conserved," OMG is now taking responsibility only for the "renewal documentation," not the initial documentation, i.e. initial assessment. BHRS/MH has assumed responsibility for the initial assessment. We did not find any amendments to the ASO Contract with OMG that removes OMG responsibility for conducting initial assessments.

[13] Administrative Services Organization Agreement with Ortner Management Group, Exhibit A, pages 19

In most California counties, including Mendocino County, the jail has become a safety net of last resort for individuals with disruptive behavior and a history of severe mental illness. Assessing and stabilizing these individuals in this correctional setting is an essential first step toward their recovery. In Mendocino County, contracted medical staff with the California Forensic Medical Group (CFMG) start psychiatric medications when the clients are in the jail, but when clients leave the jail setting services are reported to drop off. Effective communication between the CFMG medical staff and OMG contracted staff is essential for these clients to maintain the medications that began in jail, and a regular staffing of jail clients between CFMG and OMG contracted staff is needed to promote an effective hand-off.

In general, to end the cycle of "jail, release to the street, re-offense and back to jail," care management services need to begin with clients while they are in custody and follow the clients to their next level of care. Toward this end, many California counties have established care managers or case managers who specialize and focus on high cost repeat offenders and follow clients from jail to outpatient services, a strategy that has shown success in reducing costly recidivism.

RECOMMENDED ACTION

In our opinion, the tension between the parties in this relationship stems from a lack of structure and process for OMG's relationship with parties to the justice system, as evidenced by the lack of a formal MOU between the parties; and, a lack of BHRS/MH oversight and enforcement of OMG's responsibility to carry out its contractual obligations which require OMG to "provide or arrange for the provision of mental health services" to LPS clients as required under the ASO Contract.

We recommend the County Executive direct BHRS/MH to develop the contractually required MOU between the Public Guardian and OMG, and that BHRS/MH involve the participation of the County Jail (Sheriff) and Courts in this MOU. In general, we believe OMG should begin the delivery of care management services to these clients while they are in jail, prior to discharge, and this should be described in the MOU. Further, the roles of OMG and BHRS/MH for the provision of initial and annual renewal documentation for all conserved clients needs to be described in the MOU, and any change from the current ASO Contract should be incorporated in the ASO Contract by amendment.

Finally, as referenced in Section IV (2), we recommend BHRS/MH establish a structured clinical review process to provide a formal mechanism for review of more contentious 5150 decisions and recurring problems identified by both the health care and law enforcement communities.

4. Lack of Services for Seriously Mentally Ill in Remote Coastal Areas

Key Informants on the Southern Coast of Mendocino County (Gualala, Pt. Arena) reported a variety of

shortcomings in the response from the ASOs and BHRS/MH to mental health needs in their region. They cited specific failures in getting people from the area referred for services and being frustrated by a long-standing experience of being ignored by BHRS/MH, an experience they say has not changed with the addition of the ASOs.

These Informants noted that Redwood Children's Services (RCS), the direct service provider contracting with RQMC, provides some services in the community, but that OMG and its contractors have no presence in the community. At the same time, they presented examples of difficulties they have had with both ASOs and BHRS/MH responding to local suicides and suicide attempts and other crises affecting their community. They reported that locally based providers deliver most mental health services and identified the following problems:

- General difficulty getting OMG and BHRS/MH to respond to mental health crisis situations with individuals or the community.
- Specific difficulties with the 5150 process for seriously mentally ill adult clients and frustration with 5150 denials by OMG.
- Frustration that locally available clinical staff with qualifying training and expertise have not been authorized to make 5150 determinations in the region.
- Lack of communication from the ASOs, notably OMG, following a client's discharge from a mental health facility, resulting in serious problems with medications.
- Lack of communication by OMG and follow-up for service referral by local providers.
- No Child Psychiatrist and no local mental health providers serving young children.
- No Spanish-speaking mental health providers.
- No county services to address drug and alcohol problems.
- No homeless services.

Representatives of the two ASOs offered their views on their service roles on the Mendocino Coast and in the Gualala and Pt. Arena area. A representative of RCS reported that the agency provides a wide range of youth services, from 5150 crisis assessments to psychotherapy, and that the agency has working relationships with a variety of other local agencies, most notably the schools. Their service focus is on the whole family and they have a "no wrong door," walk-in philosophy. Further, RCS has an integrated review of clinical documentation and claiming through the RQMC ASO and reports to BHRS/MH every six months.

An OMG representative stated that the process used for 5150s on the Mendocino Coast is the same as that used in Ukiah and Willits. Clinical staff with Integrated Care Management Solutions (ICMS) meet the clients at the local emergency room, where they receive necessary medical clearance, and the clinical staff provide the 5150 assessment, which is then reviewed for approval by the OMG Medical Officer to assure 5150 clinical oversight. At the North Coast ICMS office in Fort Bragg two staff are certified to provide 5150

assessments, one MFT and one Mental Health Rehabilitation Specialist (MHRS). There are no local on-call services after business hours, so the requests go through police dispatch or the Ukiah 1-800 number. If there is a need for a response from Ukiah to Fort Bragg, the response time standard is two hours. ICMS' goal is to have a small pool of on-call staff that can respond to 5150 situations on the Coast, but to date this service structure has not been implemented because of a limited supply of available clinicians.

In the Gualala area, residents have a unique asset with Redwood Coast Medical Services (RCMS), which currently provides medication support, mental health treatment services for "mild to moderate" conditions, and intervenes with the community members that exhibit severe mental illness. According to RCMS representatives, the provider currently supports 600 individuals with psychiatric medications. However, these representatives reported that neither ASO nor BHRS/MH has engaged the provider in the delivery of expanded mental health services in the South Coast area.

In our opinion, the opportunity exists in the Gualala area for both ASOs, BHRS/MH, and RCMS to enter into a "pilot project" MOU that provides RCMS the authority to conduct the 5150 process under delegation by the County and the ASOs. While appropriate legal terms, conditions and mechanisms for accountability would need to be established, we see no legal or policy reason this delegation of authority cannot be made to RCMS. This authority would enhance continuity of care for county residents in the region, particularly when they return to RCMS for care post hospitalization. As a pilot project, this MOU could serve as the basis for developing this type of delegated 5150 authority in other areas of the county where the professional expertise exists.

In addition, we understand that BHRS/MH received Intergovernmental Transfer Funding (IGT) through Partnership HealthPlan for development of a 2-year pilot project to provide "mobile crisis services" in the county. Funding is reported to be available through FY 2016-17 and supports two county staff, a BHRS/MH clinician and a Sheriff's Department community service worker. In our opinion, the staff delivering this new service need to reach out to the more remote areas of the county, including Gualala and Pt. Arena, and establish working relationships with health care and community service providers.

Finally, it should be noted that a new opportunity for expanded substance use disorder treatment (SUDT) services in Mendocino County will become available as these services are expanded through the new Drug Medi-Cal Waiver Program. This opportunity will be available across the county, but is particularly relevant for remote coastal and inland areas that have had little historical access to these types of services.

RECOMMENDED ACTION

We recommend the County Executive direct MHRS/MH to carry out the following tasks:

- Work with both ASOs to further define and describe the mental services that will be provided to

remote coastal and inland areas and the structure and reporting on such service delivery.

- As referenced in Section IV (2), develop MOUs between both ASOs, BHRS/MH, and coastal hospitals and other health care providers to define the roles, responsibilities, and the structure and process for communications between these parties.
- Develop and implement a "pilot project" MOU with both ASOs, BHRS/MH and RCMS that provides RCMS the authority to conduct the 5150 process under delegation by the BHRS/MH and the ASOs, subject to BHRS/MH development of appropriate legal terms, conditions and mechanisms for accountability.

Further, we recommend the County Executive direct MHRS/SUDT to prepare a plan for establishing a stronger service delivery presence in remote coastal and inland areas, including Gualala and Pt. Arena, and present this plan to the County Executive for consideration within 90 days.

5. Need for Clearer Transition of Youth to the Adult System

Originally, OMG was responsible for delivery of mental health services to adults beginning with young adults at age 21. In the first year, responsibility for young adults ages 21-24 was transitioned from OMG to RQMC to enable more robust service delivery for the population. Since the transition of TAY services from OMG to RQMC, Key Informants reported that the transition of these youth to the Adult System has been uneven. There have been times where the transition worked seamlessly and other times where it fell off.

In general, youth and families in the Children's System are provided intensive services that wrap around the client, including school-based services, crisis response, provider team meetings, and group, individual and family psychotherapy. When the Adult System assumes service responsibility, it can be difficult for the TAY client because the Adult System assumes more adult independence and decision-making and offers a less supported level of services. As these new "adults" begin to utilize adult programs, the services are seen as voluntary. Parents that had previously been involved in the care plan can suddenly be excluded at the young adult's choice. Psychotherapy is often less frequent; medication support must be pursued by the young adult client; and, drop-in centers are often crowded with older seriously mental ill adults. These youth can become lost or simply drop out of care.

RECOMMENDED ACTION

We recommend the County Executive direct BHRS/MH to take the following actions:

- Work with both ASOs to define the framework for a "crossover" care strategy under which both ASOs provide transitional services while the youth is still in the Children's System. As a part of this, parents of youth making the transition to adult care should be educated as what they can expect with the transition to the Adult System.

- Develop and execute an MOU between BHRS/MH and both ASOs that clearly defines the roles and responsibilities of each party, including scheduled staffing meetings to discuss youth that will be transferring to the Adult System.

6. Lack of Interface with County Substance Use Disorder Treatment Services

While the focus of our review was on the mental health system, we believe it is important to comment on the continued separation of the mental health and SUDT systems in Mendocino County. We note that while the Department name is "Behavioral Health and Recovery Services" we found little evidence of a meaningful integration of the services that the name suggests. Rather, the services for mental health are provided under a Mental Health Branch, primarily with contracted providers, and SUDT services are delivered by a separate SUDT Branch composed of county employees. Both branches utilize their own separate EHR systems.

Numerous Key Informants stated that County SUDT services are very limited across the county and virtually non-existent in remote coastal areas of the county. To make the most of available resources between the mental health and SUDT systems, strong service delivery linkages are essential. Currently, there is no formal MOU between the two BHRS branches and the ASOs regarding the service linkage between SUDT services and mental health services. This gap in service linkage undermines effective service delivery for dually diagnosed Mendocino residents and creates the potential for severely mentally ill clients to be hospitalized in order to avoid risks associated with combined SUDT and mental health conditions.

Most other California counties have either integrated mental health and SUDT services or begun efforts to do so. Beyond this integration, many California counties are also seeking integration and/or linkage of mental health and SUDT services with the broader health care delivery system. In Mendocino County, we believe the opportunity exists to focus on greater linkage and integration within BHRS, and with community health centers (FQHC, RHC and Tribal Health Programs) for residents with SUD conditions, residents who suffer mild to moderate mental health problems, and residents that are served by the two ASOs. In particular, we believe coming opportunities for expanded SUDT under the State's Drug Medi-Cal Waiver provide an opportunity for the County to work toward this type of linkage and system integration.

RECOMMENDED ACTION

We recommend the County Executive direct BHRS to take the following actions:

- Develop and execute an MOU between the between the Mental Health and SUDT Branches and the ASOs that defines and describes service linkages and responsibilities between SUDT services and mental health services.

- Convene key stakeholders, including representatives of the two BHRS branches, the ASOs, and community health care providers, to begin discussions about opportunities under the State's Drug Medi-Cal Waiver to achieve:
    - Expanded SUDT services for Mendocino County residents.
    - Expanded SUDT services for dually diagnosed residents, including those with serious mental illness and those with "mild to moderate" mental health conditions.

V. Perceptions of Conflict of Interest

From several Key Informants we interviewed, we heard two different narratives about perceived conflicts of interest. One perceived conflict focused on the former BHRS/MH Director. This narrative argued that the former Director was biased in favor of OMG because he had previously worked as a Consultant for the firm. The second perceived conflict focused on OMG. This narrative argued that OMG, as an organization, has a conflict of interest in its administration of adult mental health services in Mendocino County because OMG, as ASO, approves the placement of 5150 clients needing inpatient or residential psychiatric care in OMG affiliated facilities outside of Mendocino County.

KCG consultants are not attorneys and do not have legal expertise to offer an opinion on whether legal conflicts have been or are present. Therefore, we offer no such opinion. However, we do offer information in the following section to put these community perceptions into a larger context.

1. Former BHRS/MH Director

With regard to the alleged conflict of interest of the former BHRS/MH Director, it is important to note that the Mendocino County Grand Jury considered the former Director's role in serving on the ASO selection panel that chose OMG. In its June 2014 report, the Grand Jury found that no legal impropriety occurred although the perception of impropriety was present (see Section II (2) for further information). In our Key Informant interview with the former Director, he stated that he has had no type of financial relationship with OMG since leaving his role with the firm in 2011. From the information we have reviewed and the Key Informant interviews we have conducted, we are comfortable deferring to the Grand Jury's findings. At the same time, we believe a set of dynamics contributed to the community's perception of a conflict of interest for the former Director. These dynamics were:

- *Participation on ASO Selection Panel.* As stated, the former Director served on the review panel selecting the ASOs to serve Mendocino County. While his background and knowledge of OMG could potentially be considered an asset, it could also be a potential detriment because of the appearance of bias based on the Director's prior working relationship with OMG. In our opinion, the Director should never have served on the selection panel and the HHSA Director, County Executive, and County Counsel erred in permitting his involvement, specifically because of the importance of avoiding the appearance of any conflict. One or more other county mental health experts from outside of Mendocino County should have been contracted to assist with the ASO selection process.

- *Insufficient BHRS/MH ASO Contract Management Structure.* As outlined in Section III (3), the lack of

county organizational infrastructure for ASO Contract management and the former Director's assumed role as de-facto ASO Contract Manager – in combination with a lack of documentation of the former Director's decision process concerning ASO implementation – resulted in a lack of transparency about the BHRS/MH decision process that left the former Director open to the charge of playing favorites and being biased in favor of OMG.

- *Unclear Communications.* Several Key Informants reported that the former Director lacked the ability to clearly and effectively communicate his reasoning and decision-making to county staff, other county officials, including the courts, and the larger community on various matters pertaining to the ASO arrangement and specifically with regard to his decisions associated with OMG. As a consequence, the former Director's communications were widely viewed by community members as vague, lacking transparency, and biased in favor of OMG.

- *Director's Prior Role in Mental Health Staff Reductions.* Several Key Informants reported that the advent of the ASO concept, which called for contracting out the delivery of mental health services, brought a certain degree of animosity to the former Director from some county staff and community members because of his prior role in laying-off county mental health staff. This residual animosity may have played into an argument that the former Director had underlying intentions regarding OMG, his former employer, and their selection as the ASO for the adult system.

2. Inpatient and Residential Placements

An argument has been made that OMG has a conflict of interest because, as ASO, it "self-refers" Mendocino County clients to facilities with which it has business affiliations. For it's part, OMG representatives stated that they view the inpatient and residential care capacity provided by OMG affiliated providers as a "complimentary component" for adult program service delivery. In this context, we believe three questions should be considered.

First, in the absence of OMG serving as the ASO for the Adult System, would BHRS/MH be utilizing OMG affiliated facilities (inpatient and residential care) for service to Mendocino County residents? In discussions with the HHSA Director and former BHRS/MH Director, we were advised that BHRS/MH had utilized and would, by necessity, continue to utilize OMG affiliated facilities outside of Mendocino County because of a lack of local crisis, inpatient and residential treatment alternatives.

Second, what mechanisms does BHRS/MH have in place, or need to put in place, to monitor inpatient and residential placements and provide public reporting on these placements? We received a copy of a "Point of Authorization Policy and Procedure" adopted by BHRS/MH which defines the process for County review

of inpatient hospitalizations, among other services. This Policy and Procedure[14] specifies the following:

- "Crisis Services," defined as emergency and urgent care, do not require pre-authorization.
- Crisis Services, the placement of crisis clients, and acute/emergency hospital stays will be managed by OMG and RQMC.
- OMG and RQMC will manage and review charts daily and authorize as appropriate.
- Hospital Charts and Hospital Chart Audit Sheets will be sent to the MC-POA[15] Office for 100% review and signature prior to payment.
- OMG and RQMC in collaboration with MC-POA Office will approve or deny all Inpatient TARs within fourteen (14) calendar days (9 days for OMG/RQMC and five (5) days for MC-POA) of the receipt of the TAR and in accordance with all Title 9 regulations (unless a qualified exception occurs).
- All TARs are approved or denied by licensed mental health or waivered/registered professionals, employed by the MHP.
- OMG and RQMC will submit a monthly Hospitalization log to MC-POA by the 10th of each subsequent month.

Based upon this Policy and Procedure, it is clear that BHRS/MH is involved in the review and approval of inpatient hospitalizations and residential placements and maintains data on these placements, although BHRS/MH reported that it does not review and approve specific placement locations. In light of the data available, BHRS/MH is in a position to report publicly on these placements on a periodic basis.

Third, what do the placement dynamics look like for Mendocino County residents since OMG has assumed ASO responsibility for adult services? We asked OMG for statistics on all placements of Mendocino County residents in inpatient and other residential care. Table 11, on the following page, presents information for FY 2013-14 and FY 2014-15 and part of FY 2015-16. From the data, there is no appearance of increased utilization of facilities with which OMG has a business affiliation (either through partial ownership by an OMG principal or executive management of the other programs). The data show that placements in these facilities are equal to or less than levels in prior years and that a wide variety of other providers have been utilized.

[14] Point of Authorization Policy and Procedure, P/P No. 111 C-23, Mendocino County Health and Human Services Agency, Mental Health Branch, Revised 7/15

[15] MC-POA is defined as Mendocino County Point of Authorization

Table 11 Adult Mental Health Services Inpatient Hospital and Residential Placements – Comparison of Fiscal Years Unduplicated Persons Served			
Inpatient Hospital Provider	**FY 13-14***	**FY 14-15**	**FY 15-16**
Alta Bates Hospital - Oakland		2	1
Asante Three Rivers Hospital – Grants Pass, OR		1	
Aurora Behavioral Health - Santa Rosa	19	52	19
College Hospital Costa Mesa – Costa Mesa, CA	2		
College Medical Center – Long Beach, CA			1
David Grant Hospital – Travis AFB, CA		4	
Doctors Behavioral Health – Modesto, CA	2		1
Fremont Hospital – Fremont, CA			3
Good Samaritan Hospital – Bakersfield, CA		1	
Heritage Oaks Hospital – Sacramento, CA	7	9	3
John Muir Medical Center – Walnut Creek, CA			2
Loma Linda University Medical – Redlands, CA			1
Marin General – Greenbrae, CA	7	19	7
Monterey Peninsula - Monterey, CA		1	
North Valley Behavioral Health – Yuba City, CA**	103	96	31
Pacific Medical Center – San Francisco, CA		1	
Palo Alto VA – Palo Alto, CA		1	
Restpadd Psychiatric Health Facility – Redding, CA	8	30	14
Sempervirens Psychiatric Hospital – Eureka, CA			2
Sierra Vista Hospital – Sacramento, CA	1		
St. Frances Hospital – San Francisco, CA	6	4	
St. Helena Hospital – St. Helena, CA	14	21	4
St. Helena Hospital – Vallejo, CA		17	10
Stanford Health Care – Stanford, CA	1	1	
Napa State Hospital – Napa, CA	1		
Woodland Memorial Hospital – Woodland, CA		1	
SUBTOTAL	**171**	**261**	**99**
Residential Care Provider			
Crestwood Eureka B&C – Eureka, CA	1		
Davis Guest Home – Modesto, CA	4		
Redwood Creek Care Center – Willits, CA***	25	11	6
Rosewood Care Center – Yuba City, CA	13	7	7
Willow Glen Care Center – Yuba City, CA***	17	17	7
SUBTOTAL	**60**	**35**	**20**
Rehabilitation Centers			
CA Psychiatric Transition – Delhi, CA	3		
Creekside, CA	1		
Crestwood (Various)	9		1
Sequoia Treatment Center – Yuba City, CA***	26	10	9
SUBTOTAL	**39**	**10**	**10**
TOTAL	**270**	**306**	**129**

* Admissions for 2013/14 transferred into the OMG System of Care from BHRS/MH
**50% ownership by Tom Ortner (not OMG)
***Operate under Willow Glen Care Center, a non-profit provider, for which Tom Ortner is Executive Director

In general, finding an appropriate inpatient or residential treatment provider for seriously mentally ill clients is a complex undertaking. The process requires finding a match of the client's needs with a qualified provider that has an available "open" bed; a clinical treatment program appropriate for the patient's needs; a payment rate that is within an acceptable range; and, acceptable professional reliability (i.e. the provider carries out services and communications effectively). At any given point in time, Mendocino County's two ASOs will compete with Mental Health Departments in counties across Northern California for available inpatient and residential beds. There is less inpatient supply than demand.

Inpatient and residential facilities come at a high cost to the County and its ASOs. In practical terms, since there is only so much money available for overall mental health service delivery for adults and children, to the extent that resources must support expensive inpatient and residential care those resources are not available to support other outpatient care options. Regardless of who owns the facility, the ASOs and the County need to carefully monitor inpatient and residential stays to avoid unnecessary costs, and continued efforts need to be made to establish community based alternatives to this care for adult clients.

RECOMMENDED ACTION

On the question of a conflict of interest for the former BHRS/MH Director, we defer to the Mendocino County Grand Jury findings.

With respect to the question of inpatient and residential facility placements by OMG, from the data we do not see any obvious trends that indicate a reliance on facilities with which OMG has business affiliations. We recommend the County Executive direct BHRS/MH to provide continued oversight of all placements and periodically report publicly on them.

VI. Community Engagement

1. Role of Mental Health Advisory Board

California Welfare and Institutions Code Section 5604 mandates that all counties that provide public mental health services have a Mental Health Advisory Board composed of mental health consumers, family members, and members of the general public. Key duties of the Mental Health Advisory Board are to:

- Review and evaluate the community's mental health needs, services, facilities and special problems.
- Review any county agreements entered into pursuant to Section 5650.
- Advise the Board of Supervisors and the Mental Health Director as to any aspect of the local mental health program.
- Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.
- Submit an annual report to the Board of Supervisors on the needs and performance of the county's mental health system.
- Review and make recommendations on applicants for appointment as the local Mental Health Director; the Board shall be included in the selection process prior to the vote of the Board of Supervisors.
- Review and comment on the County's performance outcome data and communicate its findings to the State.

In our Key Informant interview with MHAB Board leadership, we were advised of difficulties the Board has had getting concrete information from BHRS/MH about client service delivery under the ASO model, including basic data on the services that are being provided to clients and the amount expended. In general, MHAB leadership expressed concern that the transition to the ASO model by BHRS/MH was not carried out in a manner that offered openness and transparency, which has resulted in MHAB and public confusion and suspicion. Going forward, the MHAB seeks more open communication between BHRS/MH, the County Executive, and the MHAB about mental health needs and services in the County.

In our view, it is clear that the MHAB seeks to play a constructive role in advising the BHRS/MH Director and other county officials regarding the MHAB's concerns and recommendations about mental health service delivery for children and adults in Mendocino County. The MHAB 2014-15 Annual Report, summarized in Section II (2), presents a set of concerns and recommendations that mirror many of the concerns we heard from Key Informants interviewed for this review.

RECOMMENDED ACTION

We recommend the County Executive, HHSA Director and BHRS/MH Director reach out to the MHAB and establish a renewed spirit of openness and transparency with the MHAB through frank discussion of key issues and successes of the county's mental health delivery system, identification of strategies for improvement, and that BHRS/MH provide regular data reporting to the MHAB on the performance and costs of the two ASOs and county staff for mental health services delivery.

2. County's Broader Community Mental Health Role

As described previously, through the ASO Contracts and the manner in which they have been implemented to date, Mendocino County has delegated substantial responsibility to the contracted ASOs for mental health service delivery to adults and children. Within this context we raise two inter-related concerns. First, we have been unable to identify a process for individuals and communities affected by the new system to provide input on their experience with the system, other than through the MHAB. Second, beyond contracting with the two ASOs, we do not see that BHRS/MH has defined a role for itself in promoting mental health improvement among it various communities.

The MHAB plays an important role in presenting the concerns and perspectives of consumers and providers about Mendocino County's delivery of mental health services. At the same time, in order for BHRS/MH to promote improvements in community mental health, it needs to provide a mechanism separate from the ASOs and the MHAB for BHRS/MH to solicit and hear from residents and communities about their mental health needs and how the Department's service delivery strategy is or is not addressing those needs. BHRS/MH must be in the position to hear from its different communities, including distinct ethnic communities and remote coastal and inland areas, to understand their needs and their ability to interact with and be served by the service delivery system the County has established.

RECOMMENDED ACTION

We understand that BHRS/MH recently established a part-time County Ombudsman/ Patient Advocate position. We recommend the County Executive direct BHRS/MH to assess the current duties for this position and develop a recommendation to the County Executive on how the position could be further developed to provide a more robust presence for BHRS/MH to reach out to and receive feedback from individuals and communities about their experience with the County's mental health delivery system.

VII. County Financing, Budgeting and Financial Accounting for Mental Health Services

KCG's review of the Mendocino County Mental Health System focused primarily on programmatic and delivery system matters. As a result, we did not conduct a substantive review of the County's budgeting process and allocations for the ASO contractors and county-delivered services, or associated cost accounting by BHRS/MH. However, in our overall review of financial documents associated with the ASO model, we generally found an absence of easily understandable information about how the ASO system is budgeted by fund source (i.e. Med-Cal, MHSA, Realignment and County General Fund) and how this budgeting fits within the County's larger framework for revenues and expenditures for BHRS/MH. Furthermore, we heard from a number of Key Informants that there is a lack of understanding about how the ASO model has been constructed and financed and how it is placed in the overall financing structure for mental health services in the County. Specifically:

- *Financing.* The larger financial picture associated with the delivery of mental health services through the two ASOs and county staff is unclear, specifically how the overall system is financed, what the various revenues can be used for, and how the blend of these revenues supports delivery of services across the Adult System and Children's System and by county staff in BHRS/MH.

- *Budgeting.* With budget allocations for ASO operations and county staff delivered services, it is difficult to understand each system component and make relative comparisons in terms of overall budgeting. Finding the right balance of financing for adult services and children's services – prioritizing the use of available, limited resources – would be made more productive if decision-makers and the public had easy to understand, comparable, and timely financial and programmatic information about both ASOs and the county staff delivered services. For county delivered services, this also means documentation of filled and unfilled full-time equivalent (FTE) staff and how staffing levels have changed over time.

- *Financial Accounting for Services.* BHRS/MH has various accounting mechanisms in place to track expenditures. For example, Medi-Cal claims data is incorporated through the County's claiming system to Medi-Cal, and there are separate spreadsheets submitted by each ASO for Medi-Cal and non-Medi-Cal billable services and non-billable services. However, the public reporting of this information by BHRS/MH has been limited, which has left county decision-makers and the public with unanswered questions. Further, it is unclear whether and when BHRS/MH intends to require that an outside financial audit be conducted of each ASO contractor.

RECOMMENDED ACTION

We recommend the County Executive direct BHRS/MH to prepare and present quarterly "Financial Summary Reports" that provide summary financing, budgeting, expenditure, and service delivery information on all aspects of the Mental Health Delivery System – both ASOs and county delivered services. In the first of these reports, BHRS/MH should provide a description and outline of the overall structure of financing and budgeting for ASO delivered services and county-staff delivered services.

Further, we recommend the County Executive direct BHRS/MH to make a recommendation on when an independent financial audit of both ASOs will be conducted and for which time periods.

VIII. Summary Assessment of ASO Performance

1. Children's System of Care: Redwood Quality Management Company

There was broad agreement among the Key Informants we interviewed that the Children's System of Care operated by RQMC, with subcontracted services through RCS and other subcontracted providers, provides a high level of children's mental health services. The subcontracted providers provide all services for severely emotionally disturbed children under the Mendocino County Mental Health Plan and many mental health services for children in the Child Welfare Services (CWS) system. In this latter regard, County CWS leadership reported that the structure works well to assure delivery of needed mental health services to CWS children and families. Coordination with residential and other resources by RCS is managed through ongoing treatment team meetings with County CWS that keep track of clients and calibrate therapeutic interventions to match the needs of the children who are presented.

With respect to 5150 determinations, as they do for adults, local hospital emergency room clinicians provide a medical clearance before youth can be admitted to a psychiatric facility. Key Informants reported that RCS staff give clients ample time and the transition from residential care to outpatient care generally works well. RCS has appointed staff that work on discharge while the client is still participating in residential or inpatient treatment and have established effective processes for bringing children from high cost residential placements back to the community.

As the first year of contracted ASO services began TAY youth were a part of the Adult System administered by OMG. By agreement of BHRS/MH, RQMC and OMG, these youth were transferred to RQMC for care under the Children's System to provide the population the higher level of support generally available to children. Notably, RQMC accepted responsibility for the TAY population without additional funding in deference to the need to effectively serve these youth and with anticipation that a future discussion with BHRS/MH about funding would take place. RQMC reported that it continues to wait for that conversation to occur. Key Informants agreed that the TAY population, which often confronts multiple problems, has been better served following the move to RQMC. However, as noted in this report, to date there has been no formal MOU between BHRS/MH and OMG and RQMC regarding the transition of the TAY population from the Children's System to the Adult System.

One area Key Informants identified as needing improvement is the care of children and families in Mendocino County with "mild to moderate" mental health conditions. It is important to note that responsibility for these services rests with the Medi-Cal Managed Care Plan serving Mendocino County, Partnership HealthPlan of California, and its contracted service provider, Beacon Health Options. It is also important to note that limited service authorization for mild to moderate mental health conditions by

Medi-Cal managed care plans is a problem across California and is not unique to the County or RQMC. While we believe the solution lies largely with Partnership and its subcontractor, Beacon, we also believe BHRS/MH and the two ASOs should seek improvements in this care through a coordinated strategy to engage Partnership and Beacon in expanded delivery of necessary care.

CONCLUSION: In our opinion, the Children's System of Care established and operated by RQMC is generally effective. Notwithstanding this conclusion, we believe that the accountability mechanisms we have proposed for the ASO Contracts, including the proposed set of changes to the ASO Contract, the establishment of specified MOUs, and specified other changes, need to be implemented for both ASOs to assure parity in the treatment of each organization, including parity in reporting on ASO performance.

2. Adult System of Care: Ortner Management Group

Key Informants widely agreed that OMG was charged with building the Adult System of Care from the remnants of the county's adult system, which had long suffered from Mendocino County's lack of funding priority for adult mental health services and an associated lack of community-based adult services providers. Within this context, most Informants said the Adult System today with OMG is an improvement over the County's prior system. The Medi-Cal paid claims data provide evidence of improvement in the level of mental health services provided to adults with OMG's ASO role. At the same time, most Key Informants were critical of OMG for what they saw as a slow and incomplete process of establishing a continuum of mental health services for adults, with particular concern about crisis care, case management, and counseling services.

Prior to its role as ASO for the Adult System, OMG affiliated mental health treatment facilities had contractual agreements with BHRS/MH for the delivery of inpatient and residential care services in various locations outside of Mendocino County. With few existing adult mental health service providers in Mendocino County providing outpatient services to adults, we believe OMG has had a comparatively "heavy lift" to build the continuum of care called for in the ASO Contract.

In our opinion, the transition from BHRS/MH to OMG for the Adult System – and the development of the adult continuum of care – has been longer and more difficult than anticipated for a variety of reasons:

- OMG committed to using local service providers wherever possible, of which there were relatively few, and those that existed were not Medi-Cal certified and needed to be trained to provide appropriate and allowable services; document the services in accordance with Medi-Cal rules; and, submit billings to OMG for submission to the County for billing. There was a learning curve for these contracted providers, which was actively supported through continued OMG training.

- There was no real "warm handoff" from BHRS/MH to OMG. BHRS/MH provided little client contact information and often incomplete original paperwork, which made it very difficult for OMG and its subcontracting service providers to document Medi-Cal billable diagnoses and treatment plans.
    - OMG representatives reported that 386 clients were initially identified by BHRS/MH for transfer to OMG, of which roughly 200 clients were further identified as bona-fide active clients (i.e. open and active cases, not just a case that was never closed). However, BHRS/MH provided few complete records for these 200 clients to OMG, which meant that OMG started with little base-line information on the existing adult client population. With insufficient records, OMG had to "play catch-up" and build out client records before it could begin to conduct client service delivery. This added unanticipated time and duties at the front-end of OMG's system development. County officials acknowledged their shortcomings in the hand-off of clients and client records to OMG.
    - The poor hand-off by BHRS/MH contributed to a recurring OMG problem, reported by county fiscal staff, of incomplete front-end paperwork on cases by OMG and repeated follow up by fiscal staff requesting additional, required information.
- Subcontracting providers reported that OMG, at the outset, lacked clear service delivery procedures and protocols for service delivery, i.e. the specific pathways for patient services to be provided by subcontracting organizations, including requirements for taking a referral, opening paperwork on a case, assessments, and associated components.
- OMG initially contracted with RQMC to create a Crisis Service, but subsequently determined RQMC was not prepared to take on this task due to the organization's limited experience with the adult population. Responsibility for the Crisis Service was returned to OMG, but the back and forth dynamic resulted in delayed development of this service capacity. This delay contributed to the experience of many Key Informants that Crisis Services seemed to be nonexistent during the initial year of the contract.
- BHRS/MH's highly paper-based process and lack of an EHR contributed to an unreliable client referral and documentation process with OMG. The County's billing system was a mix of paper and electronic components, and this required OMG (and RQMC) to upload paper documents to the county for billing and county staff would then key-enter the data into the county billing system. As OMG developed its systems and adapted to the county's requirements, OMG regularly submitted late billings (i.e. later than 60 days) and regularly submitted "billing adjustments" for services that were unaccounted for and had not previously been billed. OMG's billing process build-out was complicated, in part, by OMG's receipt of incomplete records for clients transferred by BHRS/MH to OMG for services.
- Under Medi-Cal rules, the county can only receive funding from Medi-Cal via the Certified Public Expenditure (CPE) claiming structure. In order to draw down these funds, the expenditures must be made first and matching funds are provided after these expenditures are claimed by the county.

In its initial ASO Agreement with OMG, BHRS/MH allocated money to OMG and provided the rules for Medi-Cal CPE claiming, but the structure of the allocation with OMG didn't tie to the claiming structure. Specifically, to assist OMG with start-up the County provided 1/12 of the annual allocation each month, but the structure for claiming Medi-Cal reimbursement by OMG was not developed. Thus, expenditures by necessity were made without reference to specific Medi-Cal covered services, which thereby undermined the opportunity for Medi-Cal matching funds. In a subsequent amendment to the OMG Contract, the allocation structure was revised to better align with Medi-Cal claiming the structure, and OMG substantially improved its documentation for adult clients receiving services as a result of training OMG provided subcontracting providers on Medi-Cal documentation and claiming requirements.

CONCLUSION: In our opinion, the Adult System of Care established and operated by OMG provides Mendocino County with the foundation for adult mental health service delivery upon which further improvements can and should be made. While the new Adult System is incomplete and there are a number of important deficiencies that we have described in this report, we believe the structure now in place offers BHRS/MH the opportunity to make substantial mid-course improvements. Implementation of the recommendations made throughout this report, and summarized in the next section, will facilitate achievement of these improvements.

IX. Summary of Key Recommendations

The ASO Contract strategy for the delivery of mental health services to children and adults shifted responsibility for direct delivery of services from BHRS/MH to two contractors, which in turn subcontract with a variety of other direct service organizations. With its ASO contracting model, the role for BHRS/MH has fundamentally changed from being a "service provider" to being a monitoring and enforcement agency, a "regulator." To date, BHRS/MH has not established the structure needed to be an effective regulator. Furthermore, the ASO Contract weaknesses described in this report have not provided BHRS/MH with sufficient tools to effectively carry out its new regulator role. As stated by the Center for Medicaid and Medicare Services, "When Mendocino County has a written agreement with another agency, individual, or organization to furnish any services, the County must retain administrative and financial management and oversight of staff and services for all arranged services." To date, the BHRS/MH has not fully discharged this responsibility.

In our opinion, the best approach for assuring effective service delivery, irrespective of whether services are delivered by county staff, a for profit company, or a not-for-profit organization, is public accountability. Such accountability is achieved through a strong Services Contract with clear oversight and accountability mechanisms and transparency in system design and structure, financing and financial accounting, and reporting of service delivery outcomes. To date, many of these critical aspects of the ASO model adopted by BHRS/MH have been absent, but they can be addressed going forward.

Contained in this report, and summarized in Table 12 below, are specific recommendations for improving the effectiveness of the ASO Contract strategy. Key among these recommendations are the following:

1. The two ASO Agreements should be amended as proposed in Appendix D.
2. Both ASOs should be required to develop and submit a "System Design Structure Report" that describes each delivery system, identifies and describes the role of all subcontracting providers, describes and provides a flow chart for the referral and service delivery framework, and provides a description of the ASO system interfaces with other systems, specifically hospitals, community health centers and other health care providers in the county, and the county justice system.
3. A variety of MOUs should be negotiated, finalized and executed between various parties, notably including BHRS/MH, OMG and RQMC.
4. BHRS/MH should clearly define and require specific programmatic and financial data reporting for the ASOs and these data reporting requirements should be included in the ASO Contracts by amendment.
5. BHRS/MH should establish a structure of quarterly public reporting of the following:
   A. Service delivery data for both ASOs and county staff delivered services. Maximum efforts should be made to ensure the structure of this data reporting is uniform so that relative comparisons of service delivery by each responsible entity can be made.

B. Financial reporting for both ASOs and county staff delivered services that show services and expenditures by type of service (e.g. inpatient, case management, counseling, etc.), revenue source (i.e. Medi-Cal, MHSA, Realignment, etc.) and number of utilizers.

6. BHRS/MH's administrative staffing should be reconfigured to establish a dedicated ASO Contract Manager who is supported by other analytical and administrative staff. The ASO Contract Manager should be charged with monitoring compliance of all ASO administrative requirements, including preparation of ASO reporting on delivery system design, financial claiming and reporting, and program data reporting. The Contract Manager should work in collaboration with the BHRS/MH Clinical Program Director that currently has responsibility for overseeing clinical performance of the ASOs and the subcontractors providing direct services.
7. The recently appointed BHRS/MH Director, along with other key county officials, should bring an attitude of openness and transparency and a "partnering approach" with the County's mental health stakeholders in order to frankly and fully identify successes, problems and potential solutions associated with mental health service delivery under the two ASOs and by county BHRS/MH staff.

Table 12 Summary of Recommendations		
Section	**Topic**	**Recommendations**
III (1) **III (2)**	**Fundamental Weaknesses of ASO Agreements** **Conflicting Approaches for ASO Accountability**	• Adopt specific changes to the ASO Contracts proposed in Appendix D. • As set forth in Appendix D, require each ASO to develop a "System Design Structure Report" that fully describes each delivery system.

III (3)	**Inadequate County Decision Structure and Process**	• County Executive direct BHRS/MH Director to prepare a proposal in next 90 days for creation or assignment of ASO Contract Manager for administrative and financial oversight of ASO Contracts.
		• ASO Contract Manager would, among other duties:
		  ○ Establish a mechanism for regular review of financial claiming and service delivery outcomes for both ASOs.
		  ○ Work with clinical Program Division to assure coordination of administrative and clinical oversight and onsite reviews of all ASO subcontracted facilities.

III (4)	**Delay of Electronic Health Records**	County Executive direct BHRS/MH to hold both ASOs accountable for development and implementation of the EHR requirement by July 1, 2016 and take all necessary steps to enforce completion of this contractual obligation.
III (5)	**Lack of Memorandums of Understanding**	County Executive direct BHRS/MH to initiate development of MOUs in all of the following areas: • MOU for the transition of TAY youth from the Children's System to the Adult System. • MOUs for the provision of county SUDT services to clients served by both ASOs. • MOU with OMG, BHRS/MH and justice system defining roles, responsibilities and timelines for service delivery to misdemeanants. • MOU with OMG, BHRS/MH, Public Guardian and justice system defining roles, responsibilities and timelines for service delivery to 5150s and responsibilities associated with conservatorships. • MOUs with both ASOs and hospitals defining roles and responsibilities of each party for residents with mental health conditions who present at these facilities. • MOUs with both ASOs and community health centers defining roles and responsibilities, processes and timelines for care transitions, and structure of communication pathways.
III (6)	**ASO Administration Costs Not Clearly Defined**	County Executive direct BHRS/MH to propose the following in the next 90 days: • Proposed definitions for ASO administration, direct mental health services, and Utilization Review and proposed methodology for determining payments for these activities. • Proposed amendments to the ASO Contracts to incorporate these definitions and the methodology for determining payments.

Table 12 Summary of Recommendations (cont.)		
Section	**Topic**	**Recommendations**
IV (1)	**Lack of In-County Residential Care & Crisis Residential Services**	County Executive, HHSA Director, new BHRS/MH Director and Board of Supervisors renew efforts to develop community consensus about developing in-county short-term crisis services and residential services. • County Executive direct the BHRS/MH Director to begin process of community consensus building by convening key public officials and community stakeholders in a public process to discuss ideas and options for moving forward.
IV (2)	**Lack of Defined Structure for Coordination with Health Care Providers**	County Executive direct BHRS/MH to: • Initiate MOUs with both ASOs and hospitals and community health centers to define and establish clear roles, responsibilities, and communication processes. • Establish a clinical review process for review of more contentious 5150 decisions and recurring problems identified by health care and law enforcement communities, and establish a mechanism for local health care providers to bring forward client-specific concerns.
IV (3)	**Ill-Defined Interfaces with the County Justice System**	County Executive direct BHRS/MH to: • Enforce ASO contract requirements regarding ASO services to misdemeanants and initiate/execute MOU with ASOs and justice system for provision of mental health services to misdemeanants. • Enforce ASO contract requirements regarding ASO services to LPS clients and initiate MOU with ASOs and justice system for the provision of mental health services to LPS clients. • Initiate required MOU with Public Guardian, OMG, and BHRS/MH and involve justice system partners regarding services for conserved clients; and, clarify initial/annual renewal documentation for conserved clients. • Establish a clinical review process for review of more contentious 5150 decisions and recurring problems identified by health care and law enforcement communities.
IV (4)	**Lack of Services for Seriously Mentally Ill in Remote Coastal Areas**	• County Executive direct BHRS/MH to: ○ Work with both ASOs to define and describe mental services that will be provided to remote coastal and inland areas and the structure and reporting on such service delivery. ○ Initiate MOUs with both ASOs and hospitals and community health centers regarding roles, responsibilities, and communication process. ○ Develop and implement a “pilot project” MOU with both ASOs, BHRS/MH and RCMS that provides RCMS the authority to conduct the 5150 process under delegation by the BHRS/MH and the ASOs. • County Executive direct the BHRS SUDT Branch to prepare a plan for establishing a stronger service delivery presence in remote coastal and inland areas, including Gualala and Pt. Arena, and present this plan to the County Executive for consideration within 90 days.

Table 12 Summary of Recommendations (cont.)		
Section	**Topic**	**Recommendations**
IV (5)	**Need for Clearer Transition of Youth to the Adult System**	County Executive direct BHRS/MH to: • Work with both ASOs to define the framework for a "crossover" care strategy of transitional services while the youth is still in the Children's System. • Develop MOU between BHRS/MH and both ASOs defining roles and responsibilities of each party.
IV (6)	**Lack of Interface with County Substance Use Disorder Services**	County Executive direct BHRS to: • Develop an MOU between the Mental Health and SUDT Branches and the ASOs that defines and describes service linkages and responsibilities between SUDT services and mental health services. • Convene key stakeholders, including representatives of the two BHRS branches, the ASOs, and community health care providers, to begin discussions about opportunities under the State's Drug Medi-Cal Waiver to achieve expanded SUDT treatment in the County.
V	**Perceptions of Conflict of Interest**	• Defer to the Mendocino County Grand Jury on the question of a conflict of interest for the former BHRS/MH Director. • County Executive direct BHRS/MH to provide continued oversight of OMG authorized placements and periodically report publicly on them.
VI	**Community Engagement**	• County Executive, HHSA Director and new BHRS/MH Director establish a renewed spirit of openness and transparency with the MHAB through frank discussion of key issues and successes of the county's mental health delivery system. • BHRS/MH provide regular data reporting to the MHAB on the costs and performance of the ASOs and county staff delivered services. • County Executive direct BHRS/MH to assess the current duties for the County Ombudsman/Patient Advocate position and develop a recommendation on how the position could be further developed for BHRS/MH to reach out to and receive feedback from individuals and communities.
VII	**County Financing, Budgeting and Financial Accounting for Mental Health Services**	County Executive direct BHRS/MH to: • Present quarterly "Financial Summary Reports" that provide information on financing, budgeting, expenditure, and service delivery information on ASOs and county staff-delivered services; and, include a description and outline of the overall structure of financing and budgeting for ASO delivered services and county-staff delivered services. • Make a recommendation on when an independent financial audit of both ASOs will be conducted and for which time periods.

X. Appendix

A. Key Informants Interviewed
B. External Quality Review Organization (EQRO) Findings
C. U.S. Department of Health and Human Services Survey Findings
D. Proposed Revisions to ASO Services Agreement

APPENDIX A Key Informant Interviews		
Organization	**Informant**	**Title**
Action Network	Janet Kukulinsky	Executive Director
	Javier Chavez	Family Advocate
Auditor/Controller, Mendocino County	Lloyd Weer	Auditor/Controller
Behavioral Health & Rehabilitation Services, Mental Health, Mendocino County	Jenine Miller	Deputy Director
	Tom Pinizotto	Director (former)
Board of Supervisors, Mendocino County	Dan Gjerde	Supervisor, 4th District
	John McCowen	Supervisor, 2nd District
	Tom Woodhouse	Supervisor, 3rd District
Coastal Life Support District	David Caley, BSN	District Administrator
Consultant	Dr. Jay Holden	Clinical Psychologist
County Executive, Mendocino County	Carmel Angelo	County Executive
	Alan Florio	Assistant County Executive
Health & Human Services Agency, Mendocino County	Stacey Cryer	Director
	Doug Gherkin	Chief Fiscal Officer
	Venus Hoaglen	Staff Service Administrator
	Todd Storti	Administrative Services Manager II
	Andrea Turchin	Department Analyst II
	Mary Alice Willeford	Administrative Services Manager I
Manzanita Services Inc.	Susan Wynd-Novotny	Executive Director
Mendocino Coast Clinics	Paula Cohen	Executive Director & ARCH Chair
	Kianna Zielesch	Clinical Director, Behavioral Health
	Lucrecia Renteria	Director of Administrative Services
Mendocino Coast Hospitality Center	Anna Shaw	Executive Director
Ortner Management Group	Connie Drago, RN	Compliance Officer
	Todd Harris, PhD, MFT	Clinical Director
	Melissa Lance	Chief Financial Officer
	Mark Montgomery	Vice President of Operations
	Tom Ortner	CEO and Principal
	John Riley, MD	Chief Medical Officer
Mental Health Advisory Board	John Wetzler	President
	Nancy Sutherland	Member
Pacific Redwood Medical Group	Charles Evans, MD	Chief Executive Officer
Physician	Marvin Trotter, MD	Community Physician
Probation Department, Mendocino County	Buck Ganter	Chief
	Jean Glentzer	Adult Division Manager
Redwood Children's Services	Dan Anderson	Clinical Director
Redwood Coast Medical Services	Diane Agee	Chief Executive Officer
	Jefferson Nerney, PhD	Licensed Psychologist
Redwood Quality Management Company	Chandra Gonsales	Program Manager, Crisis Services
	Camille Schraeder	Systems Officer
	Tim Schraeder	Chief Executive Officer
County Sheriff, Mendocino County	Captain Timothy Pearce	Jail Commander
Social Services Department, Mendocino County	Bryan Lowry	HHSA Assistant Director, Human Services
	Jena Conner	Deputy Director, Family & Children's Services
Sonoma County Indian Health Project (Satellite Clinic: Manchester, Pt. Arena)	Lorelei Hammond	Licensed Clinical Social Worker
Superior Court, Mendocino County	Ann Moorman	Judge
	Jeanine Nadel	Judge

APPENDIX B External Quality Review Organization (EQRO) Review – Selected Findings Comparison of Fiscal Years	
EQRO Review (FY 2014-15)	**EQRO Review (FY 2015-16)**
Mental Health Plan (MHP) access to care measured by overall penetration rate is less than both small county and statewide averages (*penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count).*	The MHP's overall penetration rate has declined each year between CY12 and CY14 similar to the trend experienced overall statewide and across small MHPs. Its penetration rate has been lower than that statewide during the same period.
MHP 7-day and 30-day outpatient follow-up rates after psychiatric inpatient discharge is below the statewide averages.	The MHP's 7 and 30-day outpatient follow-up rates after discharge from psychiatric inpatient was significantly higher in CY14 compared to its CY13 rates and higher than statewide rates in CY14.
MHP 7-day inpatient recidivism rate is comparable to the statewide average and the 30-day recidivism rate is below the statewide average.	The MHP's 7-day psychiatric re-hospitalization rate was lower in CY14 compared to its corresponding rate in CY13. The MHP's 30 day psychiatric re-hospitalization rate was higher in CY14 compared to its corresponding rate in CY13 and lower than the statewide rate for the same timeframes.
MHP percentage of high-cost beneficiaries is greater than the statewide average and the corresponding percentage of total approved claims is less than the statewide average.	The MHP's percentage of CY14 high-cost beneficiaries increased from its CY13 percentage and higher than the statewide percentage. Its total HCB claims dollars and total number served increased from CY14 but remains lower than the average approved claims statewide.
Foster care approved claims per beneficiary are greater than both small MHP and statewide averages.	The MHP's foster care penetration rate is slightly higher than the small MHP average and comparable to statewide. There has been a small downward trend in foster care rate statewide and for the MHP.
The MHP had higher rates of anxiety and disruptive disorders and lower rates of depressive, psychosis, bipolar and adjustment disorders.	The MHP had a significantly higher percentage of beneficiaries with a primary diagnosis of Anxiety Disorders and those with Deferred Diagnoses, and a slightly higher percentage with a diagnosis of Disruptive Disorders. The MHP had a lower percentage with a primary diagnosis of Bipolar Disorders, Depression, Psychosis and Adjustment Disorders than statewide figures.
The MHP has approximately four times the percentage of individuals with a deferred diagnosis compared to the statewide average.	The MHP appears to use Deferred Diagnoses for a slightly higher percentage of its beneficiaries compared to statewide.

APPENDIX C U.S. Department of Health and Human Services Survey – Key Findings	
Finding Summary	**Finding Details**
BHRS failed to organize, manage and administer its resources.	• Failed to provide an outpatient Partial Hospitalization Program (PHP) service, i.e. a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care other than in an individual's home or in an Inpatient or residential setting; • Failed to maintain an accurate accounting of the center's active clientele; • Failed to provide documentation of inspection of a fire extinguisher; and, Failed to practice effective infection control measures.
BHRS failed to develop and maintain a system of communication that assures the integration of services.	• Communication between contracted adult mental health services (OMG) and the client's outside healthcare providers did not occur. • In review of record #10, the failure resulted in: o Lack of coordination of care between OMG and the outside primary care provider and/or lack of evidence of coordination with outside healthcare provider that prescribed psychiatric medications. • Failure by OMG to meet the required clinical contacts prescribed in the care plan (60 minutes 1 time per week for 6 months for each intervention), and absence of evidence in clinical record or concurrent review of client's sign-in at wellness/drop-in centers between 12/29/14 and 3/2/15; the care plan Closing Summary stated that the agency was notified on 3/2/15 that the client was discovered in his apartment having passed away.
BHRS not retain oversight or fiscal and administrative management for OMG contracted services.	The County must retain administrative and financial management and oversight of staff and services for all arranged services. Arranged services must be supported by a written agreement which requires that all services be as follows: • Authorized by the Mental Health Department; • Furnished in a safe and effective manner; and, • Delivered in accordance with established professional standards, the policies of the CMHC, and the client's active treatment plan.
OMG failed to maintain an accounting of its active clientele.	• There was a name listed on two sections of the provided active client lists; • Another client was listed on the active client list and was not an actual client of Mental Health Services; and, • Client #10 was listed on the active client list; however he was found deceased on 3/2/2015;
OMG billings had potential for inaccuracies.	The review of 5 client adult records found the potential for inaccurate billing by OMG when submitting documents to the county.
OMG adult access/crisis service failed to practice effective infection controls	• Supplied sharps containers located in the Med Room did not have the manufacturer's lid closure completely sealed, or at all; and, • Sharp's container had numerous medication tablets and capsules mixed in and were not disposed of timely, or kept in a manner according to the provider's Policy and Procedure.

Appendix D

Proposed Additional Requirements for ASO Agreements
For Exhibit A – Scope of Work

1. Proposed System Design Structure Report

System Design Structure Report. In a manner and form to be determined by BHRS, CONTRACTOR shall prepare a System Design Structure Report that describes the CONTRACTOR's mental health delivery system, including all of the following:

- Proposed goals and objectives for the delivery system;
- Written description and/or outline of how the requirements specified in each section of the Scope of Work (Exhibit A) have been met; and, for those requirements pending completion, a timeline for completion and the manner in which the requirements will be met;
- Identification and description of the roles of all subcontracting providers and other organizations providing services on behalf of or to CONTRACTOR;
- Written description and flow chart for the referral and service delivery framework involving ASO and subcontracted providers delivering mental health and any other services specified in the Scope of Work; and,
- Written description of the CONTRACTOR'S mental health system interfaces, including services delivered to and by other systems, including community hospitals, community health centers and other health care providers in the county, and the county jail and justice system.

The System Design Structure Report shall be due in final form from CONTRACTOR no later than ninety (90) days from formal notification by BHRS of the required structure and format for this report. BHRS, in its sole discretion, shall have the right to review and approve CONTRACTOR'S System Design Structure Report and require modification of such report. Following BHRS approval of CONTRACTOR'S System Design Structure Report, BHRS shall provide written notice of approval to CONTRACTOR. BHRS shall treat CONTRACTOR's noncompliance with the requirements of this section in the same manner as set forth under the CONTRACTOR Global ASO Compliance Requirement.

2. Proposed Global ASO Contractor Compliance Requirement

In carrying out the Scope of Work contained in this Exhibit A, CONTRATOR shall comply with all requirements to the satisfaction of BHRS, in the sole discretion of BHRS. For any finding of CONTRACTOR's non-compliance with the requirements contained in this Exhibit A, BHRS may notify CONTRACTOR of the

requirement to submit a Corrective Action Plan to correct the area of non-compliance and shall define the timeframe for such Corrective Action Plan. Following such notification by BHRS, should CONTRACTOR'S Corrective Action Plan and/or CONTRACTOR'S performance of such Plan fail to satisfy BHRS that CONTRACTOR has complied with the requirements of this Exhibit A, BHRS may withhold monthly payments for Administration/UR pending determination by BHRS that CONTRACTOR'S Corrective Action Plan and/or performance meets BHRS requirements. Should BHRS determine that CONTRACTOR'S non-compliance has not been addressed to the satisfaction of BHRS for a period of 60 days or more from the date of notice by BHRS of the required Corrective Action Plan by CONTRACTOR, BHRS may impose a penalty of five percent (5%) of the monthly amount otherwise payable to CONTRACTOR for Administration/UR for each month following the 60-day time period that CONTRACTOR'S non-compliance continues.