JOINT OVERSIGHT HEARING

Asm. Accountability and Administrative Review Committee
&
Asm. Health Committee

Wednesday, August 21, 2019
10 a.m. – 12:00 p.m. State Capitol, Room 447

Mental Health Services Act (Prop 63) Funds: Oversight and Accountability

Below is the transcription of testimony from Dr. Veronica Kelley, Director, San Bernardino County Department of Behavioral Health:

"Thank you so much.

Good afternoon. I am Veronica Kelley. I'm the Behavioral Health Director of San Bernardino County and I really am here to be the local county voice, someone who has actually been on the ground and providing these services and then continuing to monitor them.

I also want to speak to our partnership with the Department of Health Care Services and the Oversight and Accountability Commission, as well as the changes that we make on a daily basis to the lives of those people that we serve.

So first starting out with our partnership. Counties consider ourselves to be active, invested partners with DHCS and the OAC. We look forward to more productive collaborations, noting challenges experienced by our partners. There is a lot of talk about the Annual Revenue Expenditure Report, the ARER, and part of that, we worked very hard with our partners at DHCS because in order to complete that form you have to complete a cost report form, they are both due the same date. So you need to have completed one following the fiscal year to complete the other.

In the last few years there have been some difficulties with the template itself, which is just a very logistical issue, but impacts everybody. And so wrong formulas on both of those forms then contributed to us not being able to meet the date requirements. But we were able to work with DHCS so that we could complete adjustments if we needed to do that. The difficulty in that is that the ARER data is pulled from the Oversight and Accountability Commission (OAC) and put on their dashboard, and that information might not be inclusive of the adjustments being made after the MHSA cost reports. But we do appreciate the recently issued guidance and programming, and the responsiveness and the ability to provide technical assistance by DHCS to counties. Our County, San Bernardino, just went through our MHSA review with DHCS and

found the reviewers to be very knowledgeable and very open. We just completed that last month.

We also, as counties, appreciate our collaborative relationship with the OAC. They have been very open in receiving feedback regarding the innovations process, and we appreciate the introduction of the consent calendar, as well as staff approval for projects that our under the $1 million threshold.

As far as implementation of the MHSA, in 2005, I was charged with the community planning process in Orange County and, at that point, we really noticed that this was a brilliant part of the legislation. To begin to engage stakeholders in a process where we actually talked out loud about mental health and mental illness really helped increase our education of our communities, of ourselves, and also helped decrease stigma. We have been doing stakeholder processes every year, some of our counties do it more often, but we, in San Bernardino, have been doing it every month for 15 years. So what that has afforded us is the ability to create long term relationships that allow us to leverage those relationships, and more importantly, funding from our partners and community. That includes our school districts. That includes our law enforcement partners, both sheriff and local. And other first responders, our hospital system of care, our faith-based organizations, and our community-based organizations.

We, as counties, really do see the MHSA like the rebar; meaning that it is beneath the bricks when you are building a structure. It has now become the actual structure itself that really only strengthens the mental health services we can provide.

And so to move on to how MHSA is working, let me just also say, that prior to in 2009, if we go back 10 years, in my county we served 38,000 unduplicated clients a year. Today we serve over 60,000 unduplicated clients a year. Certainly, that was with the advent of the Affordable Care Act, but also the MHSA and also our changing world. MHSA has allowed us to expand our public services to respond to very complex needs of a very diverse population. And I'm not just speaking to ethnicity or language about diversity, I mean counties where we have rural, urban and frontier areas. San Bernardino is the largest county in the contiguous United States with over 21,000 square miles so I am responsible for frontier areas as well as very populated urban areas. MHSA allows us to go beyond our current benefit structure on both the private and the public side which is an amazing thing. It adds flexibility for service delivery. It allows creativity and innovation. It allows us to provide services that research tells us are essential to change the trajectory of mental illness.

But preventing and intervening early, and supporting ongoing recovery, cannot happen in one individual session or by a prescription pad. The extra that the MHSA brings allows us to attend to the whole person and not just one psychiatric episode. For example, Yolo County matches their first five dollars with MHSA as needed to provide developmental screenings to children 0 to 5, and the follow up services as needed if the children don't have insurance or it is not considered "medically necessary".

In Nevada County they also leverage their MHSA with their school partners to provide therapists in the schools; Leveraging MHSA and EPSDT, which is full scope children's Medi-Cal. They draw down federal financial participation and they get the school district to ante up. That is an amazing collaborative that is not possible with our regular system of care.

Mono County, which is another small county, 13,900 folks in 3,100 square miles, they had an issue with access to services so they utilized their MHSA dollars in a county-awarded project to work with the Paiute native tribe, and they have a program called Dinner and a Movie, but it doesn't involve dinner or movies though; I just want to make sure that's clear. It really is about opening community dialogue and now the tribal elders are the ones who initiate the dialogue with both non-native people as well as their own youth. And what the county has seen is an 85% increase in treatment-seeking by this population, which is amazing.

Kern County, like many of our counties has a full-service partnership dedicated specifically to our senior population. Their program is called WISE: Wellness Independent Senior Enrichment. Our senior population continues to grow, and we continue to ignore it as a nation. This ability for them to utilize MHSA dollars to leverage Medi-Cal and Medi-Care is impacting that population in a very positive manner.

And then, of course, there is my county, San Bernardino. We built an entire crisis system of care utilizing MHSA dollars. We started in 2006, creating community crisis response teams that include clinicians for adults and children, alcohol and drug counselors, and peer navigators all funded by MHSA. They go out into the community and respond to any crisis, and I will tell you we are amazing at it, which is highly unfortunate.

We had a team and an infrastructure in place prior to our December 2nd terrorist attack. Our CCRT, crisis care response team, was who we initiated and deployed. For the first 48 hours of that event we were able to get our communities 300 clinical boots on the ground, in part because of the MHSA. We then used that knowledge to assist the Las Vegas shooting, in which our county had six people who were shot, and one person who was murdered, to provide crisis intervention to families, to our communities, many folks who attended that event. We would never have been able to do that; we would never have been able to impact the trajectory of such a crisis without the MHSA.

And then, most recently, to our Ridgecrest Trona earthquakes, the 6.9 and 7.1. Our crisis support team were the first ones out and they were out for four weeks. They were in a town that had no water, and all of our county buildings except for one were red tagged. We have the experience in dealing with all of that based on the MHSA being able to fund those services.

And we've added to our crisis system of care. We leveraged a grant from the California Health Facilities and Financing Authority via the California Treasurers Office for mental health wellness. Our county was awarded $22.2 million from that grant and we leveraged $24.5 million dollars of MHSA to build facilities; specifically, psychiatric facilities.

The most northern part of our county is the town of Needles, close to Arizona, Nevada, California Border. If you are up there having a nice summer vacation with your family and your child has a psychiatric break, or you run out of your medication and you have a psychiatric crisis, you will have to drive five hours to get to the first psych bed. Our county is that large, and we have no psychiatric hospital services from the town of Victorville on up.

So we, working with our communities and our stakeholders, built six facilities for crisis residential treatment and two crisis stabilization units. We have done those in the high desert and the low desert and in the central part of our county. Each crisis residential facility has 16 beds, and we are at 98% capacity all the time. Our CSUs, crisis stabilization units, are like an urgent care where you can go and receive care for 23 hours, up to 23 hours. We have 20 beds in each of those facilities, four designated for children and youth in each of those facilities. And in the 17 months we've been open, for one facility I can tell you we have drawn down $4 million dollars in federal participation.

We have also, as Director Ewing points out, we are really investing in telling our story, and I will be the first to say counties don't do it very well, because we are busy. That's truly the reason, but if we are looking at our crisis care response teams, or I'm sorry, at our crisis residential facilities and our crisis stabilization units, in the past year with those facilities we have reduced hospital emergency department admission and inpatient psych use by 52%. We have decreased law enforcement involvement by 33%. We have increased client participation and outpatient services after the crisis after discharge from one of our programs by 40%, and have a 98% client and family satisfaction rate.

We have leveraged prevention and early intervention (PEI) and have done so, as many counties have for years before MHSA. PEI, in particular, allows us to intervene early. PEI is specific, you cannot have a diagnosis to use PEI funds. Early intervention means you are interacting with someone who might have a diagnosis in the first five years, so we have been very flexible and creative with that.

We work with our schools, similar to Yolo County, in doing a screening assessment and referral to treatment program as well as an early identification and intensive services program for kids age 0-5. We leverage First Five local matching funds and funding from Desert Mountain, a Special Education Local Planning Area. We draw down other federal funds so we can make it all work. None of these services would be billable to Medi-Cal, nor would they be to commercial insurance.

In those services, we screen all of our kids, using the Adverse Childhood Events screening tool. What we found is that 48% of the children who are referred from our school partners have an ACE score of four, which is high. A two is high. These children are a four. And although we cannot change trauma that has already occurred, we do use the Child-Adolescent Need Survey tool to monitor. We do that in six-month intervals, and post discharge information from the program. And after our work, we saw that the resiliency scores of these children increased by 78%.

We have leveraged MHSA to assist in our homelessness issue. In our county we have a system of care that includes our sheriff's department, who do homeless policing. They do it in conjunction with our MHSA-funded staff. We ride along together into encampments, out into the middle of the Mojave Desert, underneath bridges and overpasses. We leverage all of our partners in order to attend to being able to support someone in housing. It is not enough. I am a social worker by training. It is not enough to give someone a home. Our folks need to know how to stay in that home; they need supportive services to do so.

We also fund our coordinated entry system for our homeless partners though MHSA. Like many counties, we also fund crisis intervention treatment which includes education to first responders and law enforcement on what mental illness looks like and how to intervene if they come in contact with someone that is experiencing a mental illness. It is a requirement of our sheriff's academy that anyone who goes through receive 30 hours of that, all funded by MHSA. We offer that course, again, to our fire department, to CHP, to our probation department.

We also fund strike teams to work with our sheriff in custody so they can do a warm handoff to folks experiencing a serious mental illness as they leave the jail systems so that they can then be engaged in outpatient services.

And none of these services would be possible without the MHSA. At least to the breadth and depth we are able to use them now. As well as the ability to leverage our relationships, other funding sources, our counties experience, our expertise, and our partner's relationships.

MHSA has allowed us as a system to interrupt a trajectory of a person mental illness and that is invaluable.

Thank you very much for your attention. Happy to answers any questions."