



MENTAL HEALTH SERVICES ACT

INN Project 3 – Behavioral Health Crisis Services Collaborative

April 10, 2018 - Approved by Sacramento County Board of Supervisors

May 24, 2018 - Approved by Mental Health Services Oversight and
Accountability Commission (MHSOAC)

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INNOVATION WORK PLAN
Description of Community Program Planning and Local Review Processes

County Name: Sacramento
 Work Plan Name: Behavioral Health Crisis Services Collaborative

Instructions: Utilizing the following format please provide a brief description of the Community Program Planning and Local Review Processes that were conducted as part of this Annual Update.

1. Briefly describe the Community Program Planning Process for development of the Innovation Work Plan. It shall include the methods for obtaining stakeholder input. (suggested length – one-half page)

Throughout all of Sacramento County's Mental Health Services Act (MHSA) Community Planning Processes (CPP), crisis services and help in a crisis has been a recurring community concern. Since the inception of Sacramento County's MHSA CPP, stakeholders and community members have provided input and participated in CPP and discussions related to the need for building a continuum of crisis prevention and intervention services.

In 2010, through CPP activities, stakeholders and community members participated in planning meetings to develop a Prevention and Early Intervention (PEI) component Suicide Prevention Project. This comprehensive project included suicide prevention strategies and programs such as a consumer warm line, suicide prevention/crisis line, training related to suicide prevention awareness and ethnic specific programs for depression and suicide prevention. It also laid the groundwork for future planning of crisis services programs such as the Community Support Team and mobile crisis teams.

The CPP for Sacramento County's Innovation Project 1 in February 2016 resulted in the development and implementation of respite programs for many unserved and underserved communities. These respite programs provide individuals experiencing crisis with services that aim to reduce stress and ameliorate crisis.

The Investment in Mental Health and Wellness Act of 2013 / Senate Bill 82 provided Sacramento County several opportunities to develop and implement alternative strategies and services that address crisis. With the support of the MHSA Steering Committee and the community, the County responded to SB82 request for applications and was awarded funding for a Triage and Peer Navigator Program, Mobile Crisis Support Teams (MCST), and Crisis Residential Programs (CRP). These applications were presented and reviewed with stakeholders and community members at MHSA Steering Committee meetings. Members of the Steering Committee offered strong support in favor of the County's submission of these applications. Furthermore, they supported and recommended MHSA funding for several MCST staff positions and for services for a new CRP.

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The MHSA Steering Committee and community members were also involved in the development and shaping of Sacramento County's second Innovation Project, Mental Health Crisis/Urgent Care Clinic through a robust CPP in 2015. This project offers immediate outpatient mental health crisis services to individuals of any age that are experiencing a mental health crisis.

During the 30-day posting of Sacramento County's MHSA FY 2016-17 Annual Update, a variety of stakeholders, including consumers, community members, family members, system partners and others expressed support for continued progress towards implementation of the new Mental Health Crisis/Urgent Care Clinic which created an alternative to unnecessary/inappropriate emergency department visits and resulting psychiatric hospitalizations. Stakeholders also encouraged Sacramento County Division of Behavioral Health Services (DBHS) to look for opportunities to build off of this program and explore additional opportunities to partner with health systems in innovative ways to help address the needs of Sacramento County consumers and families experiencing a mental health crisis.

The CPP for the third Innovation Project builds off of these previous CPP processes. Dignity Health approached DBHS with the concept of a partnership with Sacramento and Placer Counties to explore innovative mental health services that could be sited on a hospital campus to address crisis. In alignment with the recommendation from stakeholders and the Division's commitment to explore new opportunities to improve the crisis services sector, this proposed project concept, which would establish adult crisis stabilization services on a hospital campus serving both Sacramento and Placer County residents, was introduced and discussed at the May 18, 2017, Mental Health Services Act (MHSA) Steering Committee meeting. At this meeting, an overview of the Innovation component, including component requirements, planning and implementation process was provided and the current crisis services delivery system was reviewed, including the discontinuity that can occur when individuals in crisis seek help and the need for crisis services. The Steering Committee voted in full support of DBHS moving this proposed third Innovation Project forward through the formation and convening of a Workgroup that would bring a recommendation to the Steering Committee prior to finalization.

Consistent with DBHS practice and the support of the MHSA Steering Committee, the Division designed and conducted a CPP to inform the development this proposed Innovation Project #3. This process included the formation of an Innovation Project #3 Workgroup and community input.

DBHS facilitated the Innovation Project #3 Workgroup and Community Input Session on July 20, 2017. At this meeting, workgroup and community members reviewed the Innovation component guidelines and the proposed project's purpose, learning and services. Panelists representing consumer, family members, psychiatry, and emergency physician stakeholders shared their thoughts on the benefit and value of the proposed project. In small groups, workgroup and community members discussed the importance of the project services, the benefits to co-locating crisis services at a hospital campus, strategies that can be embedded into services, and how principles of wellness and recovery and cultural competence could be incorporated into services. Workgroup and

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community members engaged in robust discussion and reported out on their input and feedback for this proposed project.

On August 17, 2017, the Workgroup presented their recommendation to the MHSA Steering Committee. The Committee reviewed and discussed Workgroup and community members input and feedback and fully supported moving this proposed project forward for inclusion in the MHSA Three-Year Plan for submission to the Sacramento County Board of Supervisors and the Mental Health Services Oversight and Accountability Commission.

2. Identify the stakeholder entities involved in the Community Program Planning Process.

A seventeen (17) member Workgroup representing a wide array of stakeholders was established. Workgroup members attended the Innovation Project #3 Workgroup/Community Input Session to provide input and ideas related to the proposed project. Additionally, twenty-eight (28) community members attended the input session. Collectively, there was representation from the following stakeholder groups:

- Consumers
- Family members
- Crisis service providers
- Mental health service providers
- Early psychosis program service providers
- Ethnic service providers
- Community psychiatry
- Emergency physician
- Local law enforcement
- First responders
- Local hospitals
- Health systems/providers
- Faith-based service providers
- Veterans
- MHSA Steering Committee
- Cultural Competence Committee
- Mental Health Board
- Sacramento County Board of Supervisors

3. List the dates of the 30-day stakeholder review and public hearing. Attach substantive comments received during the stakeholder review and public hearing and responses to those comments. Indicate if none received.

The Innovation Project #3 Plan was posted as an attachment to the MHSA Fiscal Year 2017-18, 2018-19, 2019-20 Three-Year Program and Expenditure Plan from February 5 through March 7, 2018. The Public Hearing was conducted by the Mental Health Board on March 7, 2018.

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During the 30-day posting period, there were many comments received expressing support for the Project. The MHSA Steering Committee, Cultural Competence Committee, Public Health Advisory Board, and Mental Health Board were supportive of moving the Project forward for approval as part of the MHSA Fiscal Year 2017-18, 2018-19, 2019-20 Three-Year Program and Expenditure Plan. On April 10, 2018, the Sacramento County Board of Supervisors approved the MHSA Fiscal Year 2017-18, 2018-19, 2019-20 Three-Year Program and Expenditure Plan which included the Innovation Project #3 Plan. Support for this proposed Innovation Project was community-wide as evidenced by the attached letters of support and the public comment received during the posting period.

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Innovation Work Plan Narrative

MHSOAC Presentation Date: May 24, 2018

County: Sacramento

Work Plan #: 3

Work Plan Name: Behavioral Health Crisis Services Collaborative

Purpose of Proposed Innovation Project (check all that apply)

- INCREASE ACCESS TO UNDERSERVED GROUPS
- INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
- PROMOTE INTERAGENCY COLLABORATION
- INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

Sacramento County's proposed innovation project, the Behavioral Health Crisis Services Collaborative, will establish adult crisis stabilization and intensive mental health support services on a hospital campus (Mercy San Juan Medical Center) located in the underserved and high need northeastern section of Sacramento County.

This innovative emergency care integration initiative advances the standard for existing crisis services in several distinctive ways:

- It is a unique public/private collaboration between Sacramento County, Placer County and Dignity Health, and engages multiple Plan and community-based partners to serve residents of both Counties.
- It represents a commitment from a large hospital system, Dignity Health, to provide quality and integrated medical and behavioral health services under the hospital's license and make a financial investment that includes:
 - Dedicated hospital campus space and construction of facilities, designed to meet crisis stabilization services specifications
 - Ongoing facility operations and maintenance
 - Client transportation
 - Funding for a hospital navigator position
- Project services will:
 - Be sited in the northern region of Sacramento which lacks sufficient crisis service programs across two counties with growing populations
 - Serve adults, 18 years and older, who:
 - Present in the emergency department (ED), are medically treated and stabilized, and would benefit from multi-disciplinary mental health evaluation and crisis stabilization services for up to 23 hours
 - Voluntarily or involuntarily elect to receive services with the expressed goal of minimizing the time being on an involuntary 5150 hold

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- Provide front door integrated medical emergency and mental health crisis stabilization services that embrace the concept of whole person care, wellness and recovery
- Promote prevention by incorporating an assessment tool for early identification and intervention of first episodic psychosis that will be developed by the University of California Davis Medical Center's (UCDMC) Early Diagnosis and Preventive Treatment Program (SacEDAPT). Project services will also connect Sacramento County clients to ongoing care with SacEDAPT program, a project partner.
- It presents an new opportunity to serve both publically and privately insured residents from Sacramento and Placer County
- It creates an opportunity to develop a model for:
 - Sharing governance and regulatory responsibilities related to delivering seamless integrated medical emergency and crisis stabilization care on a hospital emergency department campus
 - Electronic medical records exchange for both clinical coordination of care and claiming processes with the goal of delivering effective and efficient seamless integrated crisis care
- A robust resource center under the same roof will allow multiple community-based partners to support the project by providing care coordination, peer support and navigation, and social services support at the point of care. This will ensure consumers are directly linked to aftercare and other resources necessary for ongoing management of conditions and wellness.
- Local Health Plans operating in Sacramento and Placer County will provide navigation and support services to their private and public enrollees that utilize project services.
- The project is a natural fit with collaborative efforts between Sacramento County and Sacramento City's Whole Person Care (WPC) initiative, and will serve as a direct access point for assessing eligibility, continuity of care, and referral opportunities for homeless individuals with serious mental health conditions in the northern part of Sacramento County.

By integrating mental and physical health care and social support services in one location, the project will ensure continuity of care and strengthen the region's continuum of care for an estimated 2,000 or more public and private clients annually.

Purpose

The primary purpose of this emergency care integration innovation project is to demonstrate improved behavioral health outcomes through a public/private collaboration that removes existing barriers to care, increases access to, and the quality and scope of, crisis stabilization and supportive mental health services that are integrated and coordinated. Project services, sited in the northern region of Sacramento County, will increase access to crisis services for underserved area residents.

The secondary purpose of this project is to improve the efficacy and integration of medical and mental health crisis stabilization services through a public/private partnership between a licensed acute care general hospital and an onsite provider of mental health

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rehabilitative crisis stabilization services. The project will result in the development of assessment, stabilization and treatment protocols between a hospital emergency department (ED) and an onsite mental health crisis stabilization service focused on timely intervention and restoration of civil rights, early psychosis identification and intervention, and reduced ED patient boarding. Treatment protocols will apply to two adjoining counties as well as Health Plans and will include best practices to change the trajectory of care for individuals seeking crisis services.

System Concerns

As a result of the economic recession in 2009, Sacramento County experienced an erosion of available mental health crisis response services in the community, including closure to direct access for adult residents seeking crisis services at the County's Crisis Stabilization Unit (CSU) and a loss of 50 psychiatric inpatient beds at the Mental Health Treatment Center (MHTC). The CSU provided voluntary and involuntary 24/7 emergency mental health assessment and treatment for all Sacramento County residents. Sacramento County opened the Intake Stabilization Unit (ISU) in 2012, a certified crisis stabilization unit; however, it has limited services and capacity as compared to the original CSU.

The loss of these critical crisis response resources severely impacted the community, placing new burdens and response responsibilities on system partners, specifically local EDs, law enforcement, as well as community partners delivering medical or mental health care. Individuals in crisis and in need of mental health treatment began seeking help at local EDs competing for the same resources available for medical crises. As a result, EDs reported being unable to manage the influx of individuals in psychiatric crisis due to a mental illness. Additionally, law enforcement officers and emergency responders were spending large amounts of time waiting with individuals who presented in EDs as a danger to self or others, taking officers and other first responders away from maintaining other vital community responsibilities. Many community members were unable to access needed crisis services or immediate help and were being unnecessarily hospitalized and/or incarcerated.

Recognizing the need to enhance mental health crisis services, both Sacramento and Placer County have each established the following services: (1) community-based mobile crisis teams that work in collaboration with local law enforcement agencies to provide crisis intervention services in community and natural settings; (2) crisis residential treatment programs; (3) respite programs. Additionally, both Sacramento and Placer County have leveraged Senate Bill (SB) 82 grant funding to enhance crisis services. Sacramento County established a Triage Peer Navigator program within local EDs, County Main Jail and the local homeless services campus. Placer County's SB82 crisis clinicians and contracted Peer Advocate Staff work in collaboration with all local law enforcement agencies providing field based (e.g. residence, streets, shelter) crisis response services. Both counties' SB82 programs primary objective is to reduce unnecessary hospitalization by navigating, supporting and linking individuals experiencing a mental health crisis to needed services and resources. The efforts described above have not been enough to impact the rapidly rising need for more mental

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health crisis services, specifically crisis stabilization services. Dignity Health's willingness to invest and partner in this Innovation Project will enable Sacramento and Placer County to further build on much needed services that goes beyond triage functions.

At a July 2009 Sacramento County Board of Supervisors meeting, the Hospital Council of Northern and Central California reported that in June and July 2009, at seven (7) local EDs, 716 patients required 27,209 hours of psychiatric treatment; time that is normally dedicated to medical ED visits. Local hospitals since then anecdotally report that the number of incidents where patients use the ED for a mental health crisis or because mental health treatment was unavailable elsewhere has dramatically increased. With few options for psychiatric care at most local EDs, individuals wait for a behavioral health/psychiatric evaluation that is necessary to determine the appropriate level of care and services. With increased demands and a scarcity of appropriate community alternatives, individuals remain in the ED extended periods of times until mental health treatment (e.g. inpatient bed) is secured. Consequently, when mental health treatment is delayed, the individual's stress increases, symptoms are exacerbated, EDs experience overcrowding and there are delays in care for other patients.

Placer County experiences similar challenges. With the exception of the Placer County Psychiatric Health Facility (PHF), there are no psychiatric treatment facilities available in Placer County and clients must be referred to facilities outside the County, often two to three hours away.

Placer County established a partnership with Sutter Health, local law enforcement agencies, Placer County Jail as well as contracted providers to collaborate regarding mental health crisis services. This partnership meets quarterly to review data related to mental health crisis services, explore alternatives and best practices to serve this population without delaying necessary treatment, and advocate for redesigning services that have the greatest impact. In FY 2015-16, there were 3,067 crisis evaluations completed in Placer County. In FY 2016-17, that number increased by 5% (3,215). Of the 3,215, 63% (2,033) were evaluated at Sutter Roseville Medical Center and 21% (698) at Sutter Auburn Faith Hospital. For individuals in crisis awaiting psychiatric placement, 50% wait over eight (8) hours and close to 25% wait over 24 hours from the time a crisis evaluation is requested.

The psychiatric ED boarding experienced in Sacramento and Placer County is a well-documented national phenomenon. From July 2012 to June 2016, Sacramento County participated in the Center for Medicaid Services (CMS) Medicaid Emergency Psychiatric Services Demonstration (MEPD) project. The MEPD was part of a requirement under the Affordable Care Act (Section 2707, ACA; P/L/ 111-148). Sacramento and Contra Costa represented California Counties in this national demonstration project. The demonstration project was designed to test whether the expansion of Medicaid coverage to include emergency services provided in private IMDs improves access to and quality of medically necessary care as well as discharging planning. It also explored a potential remedy to alleviate the psychiatric boarding and scatter beds burden to general hospitals and EDs. The overall evaluation of the MEPD project found little to no evidence of the MEPD effects

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on access to inpatient care, general hospital scatter beds, ED visits and ED boarding. On a local level, Sacramento County experienced positive outcomes such as increased access to inpatient beds for Medi-Cal beneficiaries, reduced recidivism rates, and improved discharge planning efforts. Sacramento County has the unique challenge in having three large free-standing private psychiatric hospitals – Sierra Vista, Heritage Oaks and Sutter Center for Psychiatry – none of which are eligible for federal funding for their inpatient beds as hospitals with over 16 beds (known as the Institutions for Medical Disease IMD Exclusion). Sacramento County was also able to reinvest savings generated by the MEPD project in a new community program that targeted greater community alternatives for high utilizers of inpatient hospitalization and EDs. While the results were promising at the local level, from the Sacramento County’s perspective, the project was not effective in addressing the root of the problem. It was evident that upon initial contact with individuals, immediate response and appropriate intervention was needed at the entry point of request in the ED. Sacramento County learned that by increasing access for Medi-Cal beneficiaries to inpatient hospitalization, the higher level of care could easily become the default. This would result in unnecessary inpatient admissions rather than determining the appropriate level of care to potentially prevent involuntary commitment. To change the trajectory of an individuals’ disposition, however, real time interventions at the point of entry (EDs) was needed. These interventions needed to be provided by trained providers with experience in assisting individuals experiencing a mental health crisis and restoring their rights as appropriate, thereby avoiding unnecessary transfer to an inpatient facility. Such interventions require buy-in and alignment by both hospital partners and county service delivery systems, and also require clear protocols and governance yet to be developed as a standard of care.

Throughout most all of Sacramento County’s MHSA Community Planning Processes (CPP), crisis services and help in a crisis have been a recurring community concern. In recent CPP discussions, consumers, family members, system partners and providers voiced concerns about the challenges associated with psychiatric onboarding, navigating busy EDs and timely access and transitions to follow up care/services. These challenges create barriers for individuals in crisis seeking help and accessing care in a community based setting.

These same concerns are expressed by Placer County community and provider stakeholders who meet quarterly to address ongoing service needs. Despite collaboration and ongoing improvement efforts, Placer County needs additional mental health crisis services and treatment options for psychiatric conditions. Resources mentioned are often at capacity and not available. Data reflects that a lack of resources and delays in care are resulting in higher acuity levels among consumers and longer lengths of stay once consumers are placed in care. Individuals presenting with low to moderate service needs receiving crisis intervention services are not receiving post-intervention or follow-up care and are returning with higher level service needs.

Sacramento and Placer County stakeholders support one of the unique approaches this project will take to help reverse the trend of rising acuity levels. A first break screening tool specific to the project will be developed by the University of California Davis Medical

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Center's (UCDMC) Sacramento Early Diagnosis and Preventive Treatment Program (SacEDAPT). Funded by Sacramento County, the SacEDAPT program currently provides care for transition age youth experiencing early stage psychosis. SacEDAPT utilizes assessment tools to determine appropriate diagnoses to guide ongoing treatment. There is an abundance of literature and data that supports the value of this type of early identification and intervention following the first episode of psychosis. Early identification, immediately followed by treatment that provides interventions aimed at shortening the course and decreasing the severity of a first break, is shown to improve both outcomes and recovery.

Unmet Need for Crisis Services

Sacramento County's MHTC provides short term comprehensive acute inpatient mental health services, 24/7, for adults 18 and older experiencing a mental health crisis and/or condition. The County's Intake Stabilization Unit (ISU), adjacent to the MHTC campus' 50 inpatient psychiatric beds, provides up to 23-hour crisis stabilization and intensive services in a safe environment. The ISU responds to hospital ED staff and law enforcement calls 24/7, provides direct access from the mobile crisis support teams and SB82 triage navigator program, and receives adults and minors that have been medically cleared for 24/7 crisis stabilization services. The ISU plays an invaluable role in the community but is located a significant distance away from the north area where this collaborative project will be based.

Placer County's array of mental health crisis services includes a 16-bed PHF/Crisis Stabilization Program, a 5-bed Peer-Run Crisis Respite Center Monarch House, and Nevada County's 23-hour CSU in Grass Valley. A majority of Placer County's crisis calls are generated from the Roseville and Lincoln areas. These areas are approximately 40 miles from Nevada County's CSU resulting in transportation challenges for Placer residents in crisis that need this service. Approximately 200 Placer County residents who need mental health crisis services present at Mercy San Juan Medical Center annually. Placer County's community stakeholders and MHSA Steering Committee agree that crisis services located in the northeastern area of Sacramento would be well utilized and improve the experience of Placer residents experiencing a mental health crisis who live on the border of Sacramento and Placer County in close proximity to Mercy San Juan Medical Center (MSJ). Having crisis stabilization services available at MSJ will also provide local law enforcement a resource in the northeastern area of Sacramento.

Figures 1 and 2 demonstrate the unmet need for crisis services from the perspective of Sacramento County residents that were referred to MHTC/ISU services but were unable to receive those services. In FY16/17, the MHTC/ISU received 8,207 referrals and 2,328 (28%) of those referrals resulted in either admit to ISU or admit to inpatient psychiatric services (see Figure 1). Most referrals come from the local EDs, Sacramento County Mobile Crisis Support Teams (MCST), local law enforcement, Sacramento County Main Jail, and inpatient psychiatric hospitals. Seventy-two percent (5,879) of those referred were not admitted to either ISU or for inpatient services (see Figure 1). Figure 2 depicts the number of referrals to the MHTC over the past five years regardless of referral source.

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“Admits from Referrals” in Figure 2 represents the number of referred individuals admitted to either the ISU, MHTC or MHTC authorized admission to other inpatient facilities.

Fig. 1: Unmet Need for Crisis Services from All Referrals

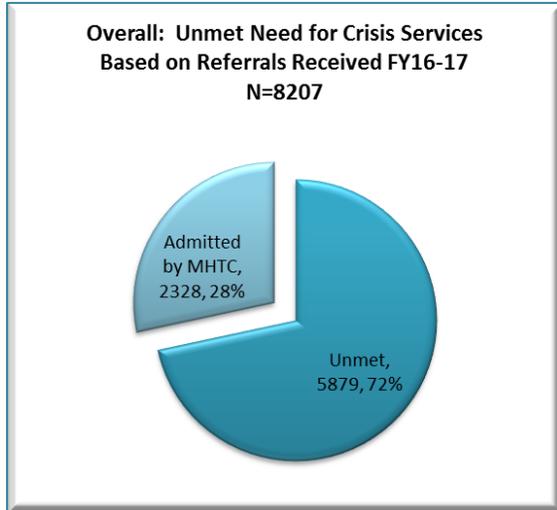
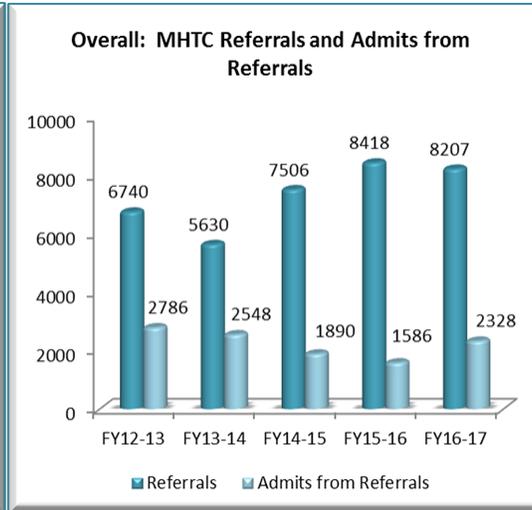


Fig. 2: MHTC Referrals and Admits from All Referrals

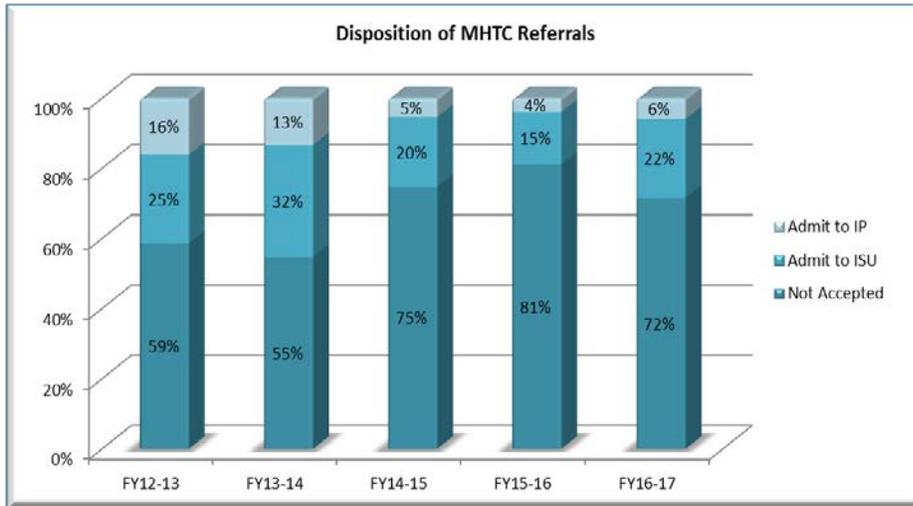


While the figures above demonstrate the need for crisis services from individuals referred to MHTC/ISU services, they do not include the number of other community residents seeking crisis related services that had no contact with Sacramento County’s access points.

With the implementation of Affordable Care Act (ACA) health insurance expansion through Medi-Cal in 2014, referrals to MHTC/ISU dramatically increased and Sacramento County’s ability to grow capacity to serve this increase in referrals has been a challenge (see Figure 3). In the two years preceding ACA implementation, an annual average of 29% of the clients referred to MHTC/ISU were admitted to the ISU compared to 19% in the past three years. Similarly in years prior to ACA implementation, an annual average of 15% of the clients referred to MHTC/ISU were admitted to MHTC (inpatient) versus 5% in the past three years. MHTC’s 50 inpatient beds typically see close to 50% administrative stays with long lengths of stay by clients with forensic involvement who remain without discharge plans. This lack of available subacute beds reduces access for the rest of the community.

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Fig. 3: Disposition of MHTC/ISU Referrals



The need for crisis services in the north areas of Sacramento

There are four local EDs that serve residents who live in the north areas of Sacramento: Mercy San Juan Medical Center (MSJ); Sutter Roseville Medical Center; Kaiser Roseville Hospital; and Mercy Hospital of Folsom. Specific to the northern areas of Sacramento, the MHTC/ISU received 1,431 referrals from north area EDs and only 24% of those referrals resulted in either admit to ISU or admit to inpatient psychiatric services in FY 16/17 (see Figure 4). Figure 5 compares the number of referrals from north area EDs to the MHTC and the number of referred individuals admitted to the ISU, MHTC or MHTC authorized admission to other inpatient facilities.

Fig. 4: Unmet Need for Crisis Services Based on Referrals from North Area EDs

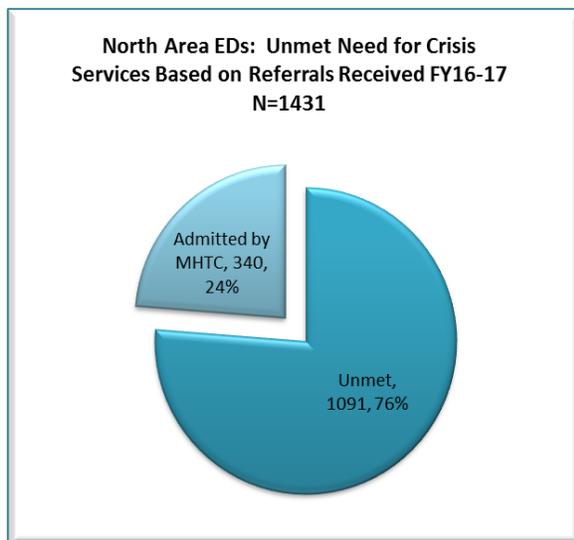
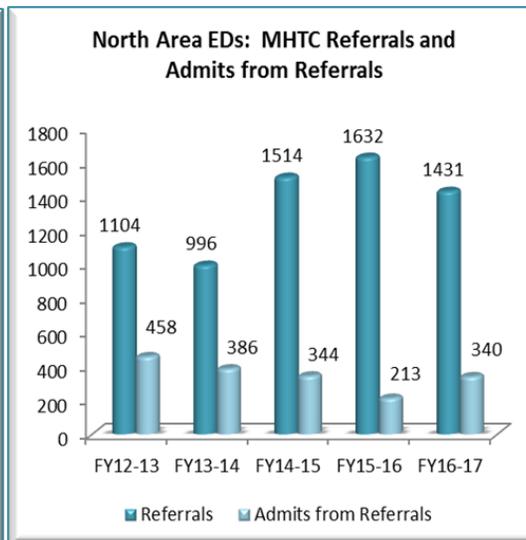


Fig. 5: MHTC Referrals and Admits from North Area ED Referrals



Based on MHTC/ISU services provided from May 2016 to April 2017, the maps (Figures 6 and 7) below illustrate where currently served individuals live. Of the 80% served, 37% live within a five mile radius of the MHTC/ISU and 43% live outside of that five mile radius.

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Twenty seven percent of served individuals live in the northern areas of Sacramento. There were some limitations to mapping all individuals served due to out of county addresses, error in address entry, and some individuals using a service provider address.

Fig. 6: Map of Where Individuals Served by MHTC/ISU Live

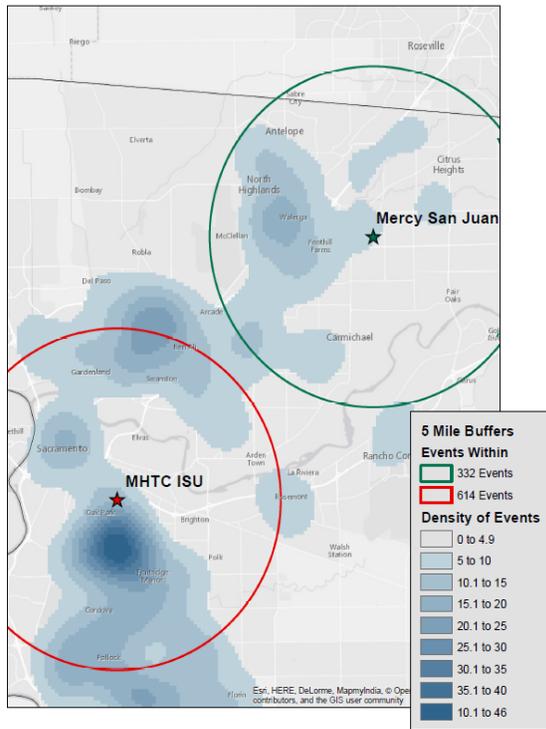
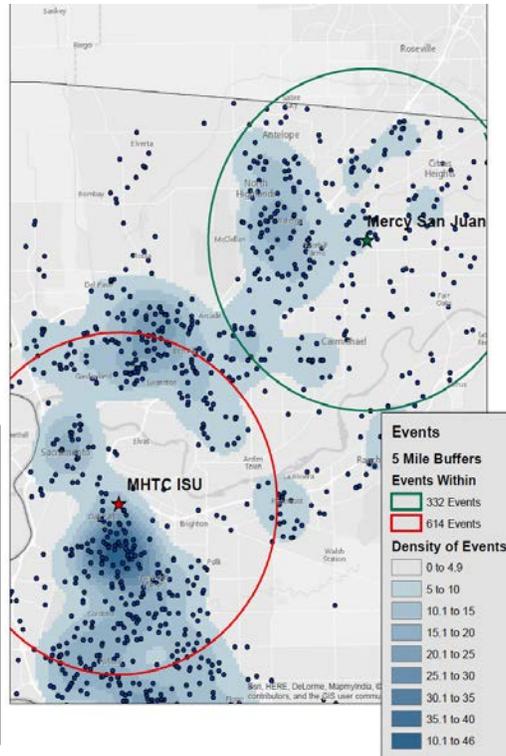


Fig. 7: Map of Where Individuals Served by MHTC/ISU Live With Data Points



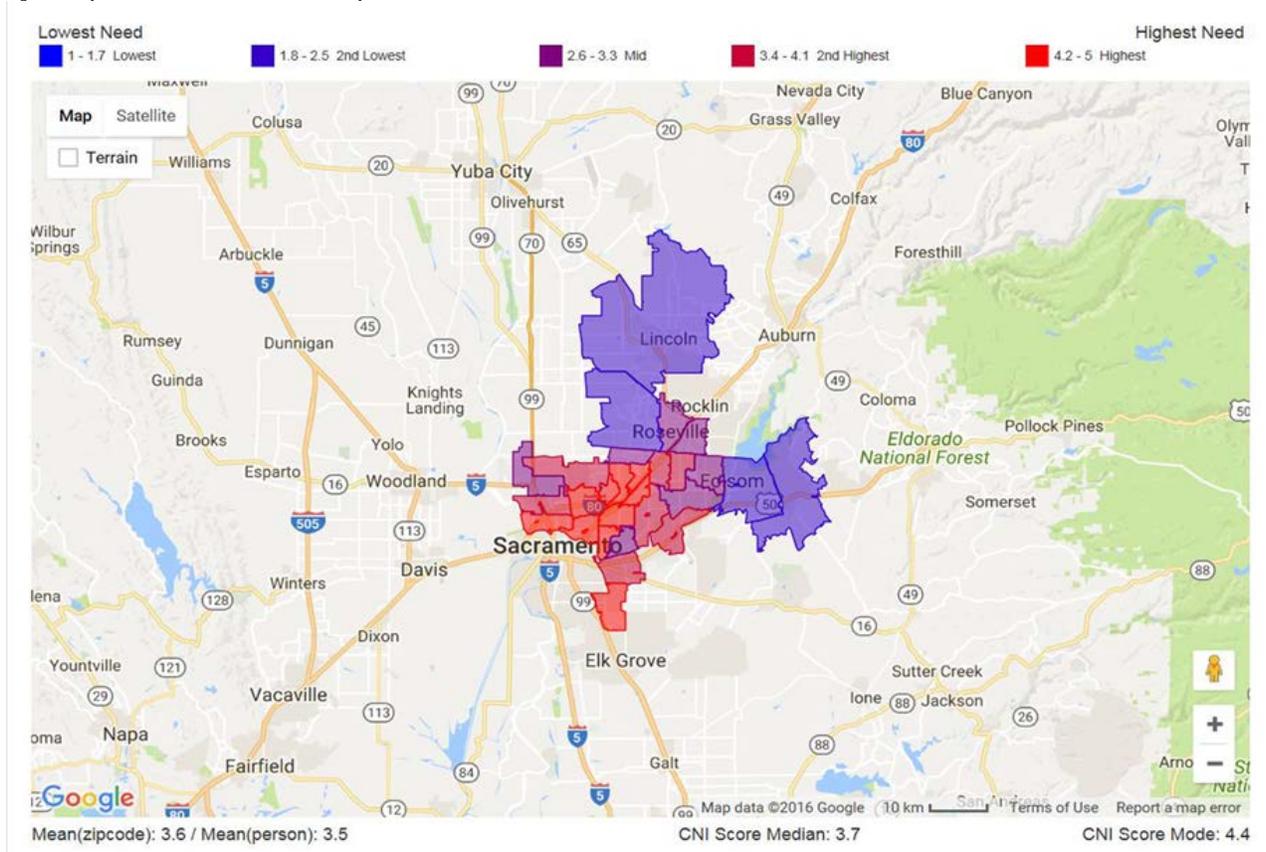
Mercy San Juan Medical Center (MSJ) Demographics

Located in the City of Carmichael, MSJ is a Level II trauma center with 370 acute care beds. The hospital has a broad primary service area that encompasses numerous communities within 28 zip codes primarily within Sacramento County, and extending to south Placer County. A number of communities within MSJ’s primary service area, including North Highlands, McClellan, Rio Linda, Antelope, Carmichael, Citrus Heights, Orangevale, Fair Oaks, and portions of Roseville and Lincoln, are designated as having underserved populations and as being medically underserved. Over half of the County’s total Medi-Cal-insured population (56%) resides within the hospital’s primary service area.¹ In Community Needs Index rankings (shown in Figure 8), MSJ’s primary service area scored 3.7, which is the second highest score for communities with significant barriers to health care access. The Community Needs Index is a tool that was developed by Dignity Health and Truven Health Analytics. It analyzes data at the zip code level on five factors known to contribute to barriers to health care access: income, culture/language, education, housing status and insurance coverage. Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a score for each zip code in the community. Research shows that communities with the highest scores experience twice the rate of hospital admissions as those with the lowest scores.

¹ Sacramento County Medi-Cal Beneficiaries by Zip Codes (09/08/2016), data source: CalWin (County SAWS)

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Fig. 8: Mercy San Juan Medical Center Community Needs Index



People needing mental health care experience even greater barriers in this part of the region, compounded by the lack of any crisis services and severely limited mental health treatment options altogether. Given the distance from existing crisis services that are more centrally located in Sacramento County, and more remotely located in Placer County, transportation is a significant problem for this area's underserved residents. Formal needs assessments conducted by Dignity Health show that lack of access to behavioral health services is the top priority health concern for residents in north Sacramento communities.²

As the only acute medical center in north Sacramento County, MSJ's 31-bed ED is constantly busy with high total patient volumes of more than 200 adults and children per day. A significant number of these patients, ranging from 9 up to 20 on any given day, are adults who have turned to the ED in need of mental health care, either in crisis, or self-identified. Providing timely and appropriate care and treatment for these individuals is a challenge in a crowded, fast-paced ED environment. Boarding times can be long; 32 hours on average for individuals needing to be transferred to an inpatient psychiatric hospital.

² 2016 Federal and State Mercy San Juan Medical Center Community Health Needs Assessment, <http://www.dignityhealth.org/sacramento/documents/hospital-reports-addressing-community-health-needs/mercy-san-juan-chna-2016>.

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The hospital has among the highest volume of individuals who present to the ED with mental health conditions, only second to the UC Davis Medical Center ED.³ In FY 2016/2017, 3,398 adults 18 years and older presented to MSJ's ED with mental health conditions. The majority of these individuals (3,198) resided in Sacramento County; 6%, or 200 individuals, were Placer County residents (see Figure 9 for insurance demographics by County). Many of these patients (247) are homeless adults with serious or chronic mental health conditions.

Fig. 9: Insurance Demographics by County

| | Sacramento County | Placer County |
|--------------------|-------------------|---------------|
| Medi-Cal Insured | 55% | 33% |
| Medicare Insured | 24% | 14% |
| Commercial Insured | 12% | 50% |
| Uninsured | 9% | 3% |
| TOTAL | 100% | 100% |

Project Considerations

Currently, hospital EDs have become a primary resource for an increasing number of individuals seeking care for many different conditions, health concerns and behavioral health needs; all representing varying levels of severity. Individuals that present at the ED may be there for a single first time access, episodically, or chronically. When EDs are faced with overcrowding, balancing care for individuals with varying needs and acuity levels, including behavioral/mental health needs, is extremely difficult. A large number of help-seeking individuals present at EDs needing specialized mental health crisis stabilization services and wait extended hours in EDs. Typically, the only disposition option includes a long wait for transfer to an inpatient psychiatric hospital which could be avoided if specialized crisis stabilization services were available through the hospital ED at the point of care. These individuals require adequate care that takes into account safety, dignity and privacy in an ED setting, immediate intervention and aftercare services. From consumer and family member perspectives, individuals seeking mental health crisis services need better outcomes. These views were shared through Sacramento County's CPP focus groups specific to this proposed project, as well as Placer County stakeholders. For a consumer experiencing a first psychotic break, all factors listed above are obstacles to changing the trajectory of prompt identification and prognosis for future recovery.

This dilemma can be overcome by the innovation of creating an integrated ED-based emergency/crisis stabilization program, which combines all of the compassionate, supportive and non-coercive aspects of a community-based setting with the capability to care for high-acuity and medically complicated patients. The long wait period and environment of a fast-paced highly stimulating ED is traumatic for individuals seeking a mental health service. Thus, rather than having individuals sit for hours or days in the ED awaiting mental health crisis services, they can instead be moved promptly to the ED-

³ Sacramento County Referrals and Admits by Referral Source 2014

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based co-located emergency/crisis stabilization program, where evaluation, crisis intervention and stabilization and healing can be initiated. This will eliminate delays before individuals can be seen by specialty trained staff in a therapeutic environment and quickly facilitate improvement in their conditions and distress. Having an integrated program available on-site to provide timely response at the point when individuals first enter the ED system also supports the broader regional care system. Not only does this proposed model reduce redirecting individuals to an off-site crisis unit and delays in care for this specific ED, but it also increases capacity at Sacramento County's existing ISU for that geographic area. Additionally, it will open space in the ED for acute medical patient care, and will result in improved utilization of psychiatric hospitals by admitting individuals who have been fully assessed as needing higher level inpatient care.

Much of the focus around behavioral health care up until this point has been on trying to establish responsibilities between hospitals and the county Mental Health Plans (MHP). This project's approach moves beyond this stalemate and places the focus on patient-centered care. The project is built on a partnership for integrated quality emergency care between a licensed private hospital and the county MHPs. Taking advantage of the strengths that each brings to the table, both Sacramento and Placer County intend to build an integrated health and mental health emergency and crisis stabilization service that can be replicated throughout the state. Instead of seeing emergency and mental health crisis care as an intractable weight without system ownership, both Counties view this project as a rare opportunity to join forces to promote early identification and intervention for psychotic disorders, address chronic co-morbid conditions and collaboratively develop transfer plans that reduce future use of emergency care. Waiting in a hospital emergency room for transfer to a specialized mental health treatment facility is not good care and leads to frustration for consumers as well as hospital staff. The only way to address this dilemma is to bring the specialized care to the individual. Mental health crisis stabilization services as outlined in the state Medi-Cal plan were designed to be rehabilitative and originally conceptualized as an opportunity to accomplish this goal. This project's intent is to take advantage of requirements outlined in the Medi-Cal state plan and to work with state representatives to remove any barriers to implementing integrated emergency and mental health crisis stabilization services. This proposed project presents a unique and innovative opportunity in that a hospital system serving publically and privately insured residents from two counties is partnering with both Sacramento and Placer County to build a model of care that may be replicated or adapted by other systems and providers.

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Innovation Work Plan Narrative

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (Suggested length - one page)

Facilities

Integrated emergency care and crisis stabilization services on the campus of Mercy San Juan Medical Center will provide timely access to appropriate specialty physical and mental health care for Sacramento and Placer County residents, 18 years and older, experiencing a mental health crisis. These individuals would be immediately transitioned to services after medical stabilization in the ED. Services will be located in a modular facility adjacent to the ED. The modular facility will be 3,400 square feet in size and built to meet OSHPD 3 standards. The facility has initial capacity to serve 12 consumers at any given time. Dignity Health will coordinate closely with Sacramento and Placer Counties on appropriate design recommendations and requirements.

Project Services

The intensive mental health outpatient crisis stabilization program will serve adults who present in the ED, are medically stabilized, and would benefit from multi-disciplinary mental health evaluation and crisis stabilization services for up to 23 hours. There will be continuity of care between the ED physicians and nurses and the mental health crisis stabilization program's clinical and support staff. Individuals needing mental health crisis stabilization will transition to the program once medically stabilized by ED staff. The primary objective is to provide timely integrated emergency care and crisis stabilization and support to the individual in the least restrictive therapeutic and calming environment possible. Individuals will receive nursing, clinical and psychiatric assessments to determine if they require admission to an inpatient psychiatric facility or can be safely discharged with emphasis on navigation and appropriate care planning. Operating under the hospital license will provide assurance that the program meets rigorous Joint Commission standards for assessment, particularly for suicidal patients, and risk management support to ensure safe discharge planning. On-site resources will be available to make direct connections for individuals to community based aftercare treatment, social services and supports.

Services include:

- Behavioral health assessment
- Psychiatric assessment
- Medication evaluation and management
- Administering first break screening for early identification and intervention of psychotic disorders
- Crisis stabilization, including individualized recovery oriented interventions directed towards resolution of the presenting mental health crisis
- Evaluation for voluntary or involuntary detention

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- Admissions evaluation for inpatient psychiatric hospitalization if necessary
- Peer support
- Family support
- Transportation
- Resource Center that will offer the following aftercare planning, information, referrals, linkages to a broad range of health, mental health and community based services and resources for both Sacramento and Placer County residents:
 - Direct linkage for both Sacramento County MHP and Alcohol Drug Treatment Services
 - Dignity Health community-based navigator (licensed clinical social worker) to ensure patients are linked to follow-up care and social support services
 - Onsite partnership with Geographic Managed Care Plans for comprehensive, intensive and individualized care planning and case management
 - Eligibility and referral into the Whole Person Care homeless initiative
 - Sacramento County/TLCS SB82 Triage Navigator will guide and follow patients over time to provide support and ensure that patients have engaged in mental health services and other necessary resources and supports. Sacramento County has plans to sustain this program once the grant cycle has ended.
 - Peer and Family support
- Secure clinical information exchange among hospital, county and other providers to ensure continuity of care

It is anticipated that the project will serve 2,000 individuals annually.

Project Principles that are consistent with the General Standards identified in the MHSA and Title 9, CCR, Section 3320:

To address unmet needs and to improve the quality of mental health crisis stabilization services, it is critical to significantly enhance the reach and scope of this project beyond conventional crisis stabilization services offered today. Project partners intend for this project to be a mainstream program that is integral to the health and mental health care continuums, and are incorporating five key principles considered to be new best practice approaches:

1. Mental health crisis services alone are insufficient, and must be integrated with and include health care services, early intervention/prevention, as well as post crisis services and support systems. Those support systems should include collaborating system partners/system providers and family, as appropriate.
2. To be effective, crisis services must have a strong system of connection to resources within the larger community behavioral health system.
3. Crisis services must always rely on the client to inform the service provider on what is helpful and needed to assist them. Crisis service must also be culturally competent, emphasize recovery and are very often a much better alternative to inpatient hospitalization for mental health crisis.
4. Peer-engaged crisis services are proving to be the cornerstone of the crisis system, and should be part of the integrated care team and involved in discharge and aftercare planning. The project will embed and gage peer interventions and supports bring the greatest benefit to individuals seeking crisis services.

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5. Crisis services must provide trauma-informed response and treatment.⁴

Partnerships

Aligned with the principles described above, this project will set a new standard for integrating medical emergency and mental health crisis stabilization services through collaboration with public systems, private systems, and community-based organizations to support the outpatient treatment and support that are essential to recovery, ongoing management of conditions and wellness of individuals served.

Sacramento County collaborating and referring partners include:

- Sacramento County Division of Behavioral Health contracted out-patient and prevention programs
- Dignity Health/Turning Point LCSW Navigator program
- UCDCMC's SacEDAPT Program
- Sacramento County/TLCS SB82 Triage Navigator Program
- El Hogar's ReferNet program for immediate intensive outpatient care
- Lutheran Social Services "Housing with Dignity" permanent supportive housing program
- Sacramento City's Whole Person Care (WPC)
- Local Law Enforcement
- Local in-patient psychiatric facilities

Placer County collaborating and referring partners include:

- Placer County Mobile Crisis Team
- Turning Point Community Programs
- Sierra Mental Wellness Group
- Telecare Corporation
- Advocates for Mentally Ill Housing
- Local Law Enforcement
- Placer County Whole Person Care
- Placer County Health 360 Services

Sacramento County, Placer County and the Geographic Managed Care (GMC) Plans operating in both counties will negotiate specific ways of collaborating on this project.

Expected Outcomes

The expected outcomes of this proposed project are as follows:

- Increase access to emergency medical and crisis stabilization services for underserved groups
- Improve the quality of crisis services, including better outcomes for clients project
- Promote interagency collaboration

⁴ Ganju, Vijay, *Tomorrow's Crisis Services: Six Trends that will Drive the Future* (National Council Magazine, 2016), Issue 1, 14.

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Innovation Work Plan Narrative

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (Suggested length - one page)

Learning Objectives

There are two (2) primary learning objectives for this innovation project:

1. Is integrated and coordinated emergency medical and mental health crisis services provided through a public and private collaboration an effective strategy in removing existing barriers in accessing mental health crisis stabilization services? Do the services provided through a public/private partnership improve the quality and scope of crisis stabilization services and improve mental health outcomes for consumers?
2. Does an interagency collaboration with shared governance and regulatory responsibilities improve the efficacy and integration of emergency medical and mental health crisis stabilization services?

The foundation of the learning opportunity is built on modeling a paradigm shift from debating responsibility and business as usual to forming a public/private partnership for quality emergency and mental health crisis care that puts the individual's needs first. The project creates a bi-directional learning opportunity across multiple systems of care. There has been much discussion about the importance of integrating behavioral health and mental health care in the outpatient system but not as much about opportunities in local emergency and hospital systems. This project is designed to balance this discussion by focusing on best practice opportunities for integrating hospital, emergency and mental health crisis care. The key is that the partners will implement emergency medical and mental health crisis care with the hope of demonstrating a best practice approach on a hospital campus in Sacramento County. By working through the implementation details with state and local representatives, both Sacramento and Placer County intend to identify and address any real or perceived barriers to integrated emergency/mental health crisis care.

Dignity Health's Mercy San Juan Medical Center, situated in the unincorporated city of Carmichael, will be the location where project services are established to test this integrated care model. Because the hospital serves both Sacramento and Placer County residents, this project will be implemented by a partnership that includes Sacramento County, Placer County and Dignity Health.

This project will introduce a new application of a successful non-mental health and mental health approach by integrating both front door out-patient mental health crisis stabilization services into an acute care hospital setting. The project will determine the effectiveness of the following innovative approaches and strategies:

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- Implementation of integrated emergency medical and mental health crisis services through a public and private partnership – Sacramento County, Placer County, Dignity Health
- Locating crisis stabilization services within a local ED campus, under the governance of a licensed acute care hospital
- Crisis stabilization services will:
 - Be sited in the northern region of Sacramento which is considered an underserved area
 - Serve Sacramento and Placer County residents that are 18 years and older, irrespective of insurance status
- Establishing continuity of and integrated care by:
 - Immediately transitioning individuals that present at the ED seeking mental health crisis services to crisis stabilization services once medically stabilized
 - Co-locating other services and resources on campus (e.g. Health Navigators, Triage Navigators, local health plans case managers)
- Providing peer and family member support
- Administering first episodic psychosis screening for early identification and intervention of psychotic disorders (SacEDAPT program)

These strategies will be tested to learn whether and how they are effective in:

- Improving the client experience and optimizing the client's continued wellness
- Improving and enhancing community continuity of care
- Improving the effectiveness of local EDs for addressing urgent mental health conditions
- Reducing unnecessary or inappropriate psychiatric hospitalizations

This proposed project will demonstrate the following:

- Development of a mental health treatment model that combines the expertise of community based crisis stabilization services with the expertise of an acute medical hospital will set a new standard for safer, collaborative and more comprehensive quality care
- Development of a model for integrating governance, regulatory responsibilities and electronic medical records exchange for both clinical coordination of care and claiming processes with the goal of delivering effective and efficient seamless integrated emergency and crisis care.
- Advancing the practice of existing crisis stabilization services by incorporating a resource center design with direct linkages to aftercare and social support services to ensure the presence of a continuum of care for recovery, ongoing management of conditions and wellness.

Project partners and consumers alike feel strongly that co-locating crisis services on an acute care hospital provides major advantages over existing community-based models. It is safer, ensures medical clearance and medical backup, and eliminates criteria that often bar individuals from accessing care in a community-based setting. Being co-located next to an emergency department ensures timely care by expediting medical and

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behavioral health assessment and treatment, especially for the significant number of individuals who have co-morbid conditions. From a consumer perspective, co-location allows people to get the care they need where they live, eliminating transportation concerns and making it easier to involve family and other support systems. It reduces long waits and the possibility of having conditions escalate during these waits. Consumers also believe that addressing physical and mental health in one location will help reduce stress, de-stigmatize mental illness and normalize a crisis experience.

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Innovation Work Plan Narrative

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (Suggested length - one page)

Implementation/Completion Dates: July 2018 – June 2022
MM/YY – MM/YY

This Innovation Project will span four (4) years and will be implemented in phases.

Phase One: July 2018 – December 2018 activities

1. In partnership, Sacramento County/Division of Behavioral Health Services (DBHS), Placer County Mental Health, and Dignity Health will develop an agreement that clarifies governance, roles and responsibilities, in implementing project services.
2. Partners will work through implementation details with state and local representatives to identify and address barriers to integrated emergency/mental health crisis care.
3. Partners will prepare program site, develop procedures and hire and train clinic staff.
4. Partners will share expertise and information during program start-up/initial implementation related to start-up tasks, data collection and evaluation framework.
5. DBHS will develop and facilitate a competitive selection process for third party evaluator to develop an evaluation core and framework.
6. DBHS will negotiate and enter into a contract/agreement with selected evaluator.

Phase Two: January 2019 – December 2019 activities

1. Services will be delivered.
2. Partners will outreach to the community, system partners, mental health service providers, local EDs, law enforcement, to provide information about project services and access.
3. Partners and third party evaluator will continue to share expertise and information related to project service delivery, data collection and evaluation activities.

Phase Three: January 2020 – June 2021 activities

1. Project services and evaluation framework will be fully implemented.
2. Routine meetings amongst the partners will be convened to report out on the evaluation framework and process.
3. Bi-Annual community meetings, to include consumers and family members, Workgroup members and MHSA Steering Committee, will be established to report out on the evaluation framework and process.
4. Sustainability options will be explored and discussed throughout project implementation.

Phase Four: July 2021 – June 2022

1. Evaluation framework and process will be in its final stages and a final report will be developed.
2. Feasibility of replication will be determined.

Innovation Work Plan Narrative

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Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

This project will be reviewed and assessed through on-going monitoring and review by Sacramento County Division of Behavioral Health Services staff (DBHS), Placer County Health and Human Services staff, as well as a formal evaluation through a third party independent evaluator.

1. On-going monitoring and review

DBHS Research, Evaluation and Performance Outcome Unit (REPO) will work with its partners, program staff and peers and Placer County staff to develop on-going quarterly reports that will track outcome indicators. These reports will be used to monitor and review the effectiveness of the innovative approaches and strategies put in place and to inform needed project changes and enhancements.

Quarterly reports will be compiled, disseminated, and reviewed with managers and program staff for continuous program monitoring purposes.

2. Third Party Evaluation

DBHS will contract with a third party evaluator to conduct a systemic and objective assessment of the Innovation project, its design, implementation and results. Both Sacramento and Placer data will be included in this third party review. The evaluation will report on the relevance, effectiveness, efficiency, impact and sustainability of the Innovation project. There will be a preliminary evaluation report completed at the end of the first year of the project and a final report at the conclusion of the Innovation Project.

Once an outside evaluator has been chosen, DBHS, Placer County, partners and stakeholders, inclusive of consumer and family representatives, will work with the evaluator on the development of a formal evaluation plan which will include both qualitative and quantitative evaluation techniques.

3. Bi-Annual meetings with the community, to include consumers and family members, Sacramento County MHSAs Steering Committee, Sacramento County Mental Health Board, Sacramento County Board of Supervisors, Hospital Systems, and Placer County stakeholders will be established to report out on project progress and outcomes.

Collection of Descriptive Data

Data describing the characteristics of populations of the crisis program and the populations served will be collected.

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| Population Characteristics | Program Characteristics |
|--|--|
| Age, gender, race, ethnicity, primary language, referral source, payer, legal status, housing status, diagnosis, including co-occurring substance use disorders, trauma history, chronic medical disease | Volume: # of encounters, age range served, law enforcement referral rate (% of visits arriving via law enforcement), involuntary referral rate (% of visits arriving under involuntary legal status), level of care (23 hr.), locked vs unlocked, accessibility (accept law enforcement drop offs, walk in, etc.), setting (hospital, community, etc.), staffing |

Data for the Measurement of Learning Objectives

Data that measure the extent to which the innovation project met its learning objectives will be collected.

Learning Objective 1: Is integrated and coordinated emergency medical and mental health crisis services provided through a public and private collaboration an effective strategy in removing existing barriers in accessing mental health crisis stabilization services? Do the services provided through a public/private partnership improve the quality and scope of crisis stabilization services, improve consumers' experience, and improve mental health outcomes for consumers?

| Objective | Indicator(s) | Measures |
|--|--------------------------------|--|
| Remove Barriers to Accessing Mental Health Crisis Stabilization Services | Utilization of Crisis Services | <ul style="list-style-type: none"> Number of individuals served Pre-Post Utilization of crisis services within the service area |
| | Timely access | <ul style="list-style-type: none"> Time from ED arrival to medical clearance ED to crisis services Left without being seen |
| Increase the quality and scope of Mental Health Crisis Services | Least Restrictive Intervention | <ul style="list-style-type: none"> Community dispositions Conversion to voluntary status Restraint use (hours/rate) |
| | Utilization of Resource | <ul style="list-style-type: none"> Number of individuals utilizing Resource Center Linkage to mental health services Referrals made |
| | Utilization of Peer Services | <ul style="list-style-type: none"> Number of peer services provided Satisfaction with peer services (as part of consumer survey) |
| | Early psychosis identification | <ul style="list-style-type: none"> Number of individuals identified Linkages to mental health services |
| | Consumer Satisfaction | TBD - satisfaction with timely access, functional status as a result of services, service provided, etc. |

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| Objective | Indicator(s) | Measures |
|---------------------------------|---------------------------|--|
| Improved Mental Health Outcomes | Effectiveness of Services | <ul style="list-style-type: none"> • Return to ED visits • Community disposition • Psychiatric hospitalizations • Linkages to mental health services |
| | Consumer Satisfaction | TBD - satisfaction with timely access, functional status as a result of services, service provided, experience of care, etc. |

Learning Objective 2: Does an interagency collaboration with shared governance and regulatory responsibilities improve the efficacy and integration of emergency medical and mental health crisis stabilization services?

| Objective | Indicator(s) | Measures |
|---|---|---|
| To establish an effective private/public collaboration that works together to accomplish a shared vision and mission using joint resources* | Service Access: <ul style="list-style-type: none"> • Point of Entry • Co-Location/ Coordination of Services | Extent to which: <ul style="list-style-type: none"> • Intake forms and procedures are integrated • Office space/location is shared |
| | Communication <ul style="list-style-type: none"> • Key Staff • Guiding Committee | Extent to which: <ul style="list-style-type: none"> • Management and line staff communicate • Committee exists and meets |
| | Program Enhancement <ul style="list-style-type: none"> • Sharing of Resources • Cross Training • Information Sharing | Extent to which: <ul style="list-style-type: none"> • Resources are shared • Staff from each partner receive cross training • Consumer information is shared across partners |
| | Accountability <ul style="list-style-type: none"> • Roles/Responsibilities • Decision Making • Mission/Values • Consumer Input • Project Planning/Coordination | Extent to which: <ul style="list-style-type: none"> • Partners establishes roles/responsibilities • Partners engage in decision making • Partners share a common mission/values • Partners solicit and utilize consumer feedback • Partners participate in joint project planning/coordination |
| | Outcomes <ul style="list-style-type: none"> • Consumer Outcomes • Goals & Objectives | Extent to which: <ul style="list-style-type: none"> • Establish, monitor and utilize results consumer outcomes |

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| Objective | Indicator(s) | Measures |
|--|---|---|
| | <ul style="list-style-type: none"> Monitoring of Collaboration | <ul style="list-style-type: none"> Partners establish goals & objectives Partners participate in the monitoring of collaboration |
| Improvement in the efficacy and integration of medical and mental health crisis stabilization services | Partnership Accessibility | <ul style="list-style-type: none"> Time from referral to acceptance/transfer Denied referrals for reasons other than capacity (% of referrals denied admission to the crisis program for any reason other than overcapacity) Hours on Divert (% of hours crisis center was unable to accept transfers from ED due to overcapacity) |
| | Continuity of Care | <ul style="list-style-type: none"> Transfer of ED evaluation information (% of transfers that are accompanied by ED evaluation information) |
| | Consumer Satisfaction | TBD - consumer satisfaction with transfer, coordination or care |
| | Interoperability | <ul style="list-style-type: none"> The ability to electronically share clinical data and billing information |

*The MECAP (Measuring Effective Collaborations and Partnerships) will be used to evaluate the private/public collaboration. The MECAP tool was created to measure existing partnerships as well as to define key components of partnerships and help structure conversations among partners to assist in their successful collaboration.

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Innovation Work Plan Narrative

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

Working in partnership with Sacramento and Placer Counties, Dignity Health is investing financial and in-kind support to establish crisis stabilization services program on the campus of Mercy San Juan Medical Center in Carmichael.

Dignity Health's commitment to the project includes:

- Facility, design and construction necessary to meet OSHPD 3 and CSU specifications in year one
- Facility maintenance
- Use of campus space
- Client transportation
- Supplies for program operation
- Use of Dignity Health Transfer Center for those patients who need more acute inpatient placement
- Other direct and indirect expenses

Existing hospital partnership program annual resources that will be aligned with this project include:

- Turning Point LCSW Navigation Program
- Lutheran Social Services Homeless Housing program
- El Hogar Immediate Outpatient Follow-Up Care
- Dignity Health funded transportation to resource linkages (County Urgent Care, Respite Centers, Regional Support Teams, etc.)
- SacEDAPT program extension working in collaboration with UC Davis

Placer County will take financial responsibility for Placer Specialty Mental Health Plan clients who receive services through this project. Placer County's additional resources committed to this project annually include:

- Client Services Practitioner (Mobile Crisis Team member)
- Program Manager for project coordination with Sacramento County
- Staff Analyst for project related data collection

INNOVATIVE PROJECT PLAN DESCRIPTION – Optional Template

County: Sacramento Date Submitted May 7, 2018

Project Name: Behavioral Health Crisis Services Collaborative

| A. New Innovative Project Budget By FISCAL YEAR (FY)* | | | | | | |
|---|-----------------------|-----------|-----------|-----------|-----------|------------|
| EXPENDITURES | | | | | | |
| PERSONNEL COSTs (salaries, wages, benefits) | | FY 18/19 | FY 19/20 | FY 20/21 | FY 21/22 | Total |
| 1. | Salaries | 1,535,004 | 3,217,763 | 3,311,549 | 3,411,347 | 11,475,663 |
| 2. | Direct Costs | 318,086 | 186,699 | 192,164 | 197,658 | 894,607 |
| 3. | Indirect Costs | 231,249 | 173,652 | 178,772 | 183,955 | 767,628 |
| 4. | Total Personnel Costs | 2,084,339 | 3,578,114 | 3,682,485 | 3,792,960 | 13,137,898 |

| OPERATING COSTs | | FY 18/19 | FY 19/20 | FY 20/21 | FY 21/22 | Total |
|-----------------|-----------------------|----------|----------|----------|----------|-----------|
| 5. | Direct Costs | 296,440 | 470,000 | 470,000 | 470,000 | 1,706,440 |
| 6. | Indirect Costs | | | | | |
| 7. | Total Operating Costs | 296,440 | 470,000 | 470,000 | 470,000 | 1,706,440 |

| NON RECURRING COSTS (equipment, technology) | | FY 18/19 | FY 19/20 | FY 20/21 | FY 21/22 | Total |
|---|---|-----------|----------|----------|----------|-----------|
| 8. | Modular Building Purchase and Improvements - Funded by Dignity Health | 1,688,000 | | | | 1,688,000 |
| 9. | Furnishings and Equipment | 500,000 | | | | 500,000 |
| 10. | Total Non-recurring costs | 2,188,000 | | | | 2,188,000 |

| CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation) | | FY 18/19 | FY 19/20 | FY 20/21 | FY 21/22 | Total |
|--|------------------------|----------|----------|----------|----------|-----------|
| 11. | Direct Costs | 220,903 | 220,903 | 220,903 | 220,903 | 883,612 |
| 12. | Indirect Costs | 94,673 | 94,673 | 94,673 | 94,673 | 378,692 |
| 13. | Total Consultant Costs | 315,576 | 315,576 | 315,576 | 315,576 | 1,262,304 |

| OTHER EXPENDITURES (please explain in budget narrative) | | FY 18/19 | FY 19/20 | FY 20/21 | FY 21/22 | Total |
|---|--------------------------|----------|----------|----------|----------|---------|
| 14. | Work Plan Management | 116,344 | 119,834 | 123,429 | 127,132 | 486,739 |
| 15. | | | | | | |
| 16. | Total Other expenditures | 116,344 | 119,834 | 123,429 | 127,132 | 486,739 |

| BUDGET TOTALS | | | | | | |
|---|--|-----------|-----------|-----------|-----------|------------|
| Personnel (line 1) | | 1,535,004 | 3,217,763 | 3,311,549 | 3,411,347 | 11,475,663 |
| Direct Costs (add lines 2, 5 and 11 from above) | | 835,429 | 877,602 | 883,067 | 888,561 | 3,484,659 |
| Indirect Costs (add lines 3, 6 and 12 from above) | | 325,922 | 268,325 | 273,445 | 278,628 | 1,146,320 |
| Non-recurring costs (line 10) | | 2,188,000 | | | | 2,188,000 |
| Other Expenditures (line 16) | | 116,344 | 119,834 | 123,429 | 127,132 | 486,739 |
| TOTAL INNOVATION BUDGET | | 5,000,699 | 4,483,524 | 4,591,490 | 4,705,668 | 18,781,381 |

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

INNOVATIVE PROJECT PLAN DESCRIPTION – Optional Template

| B. Expenditures By Funding Source and FISCAL YEAR (FY) | | | | | | | |
|---|--|------------------|------------------|------------------|------------------|--|-------------------|
| Administration: | | | | | | | |
| A. | Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources: | FY 18/19 | FY 19/20 | FY 20/21 | FY 21/22 | | Total |
| 1. | Innovative MHSA Funds | 2,837,123 | 3,278,488 | 3,196,634 | 3,310,812 | | 12,623,057 |
| 2. | Federal Financial Participation | 0.00 | 569,460 | 759,280 | 759,280 | | 2,088,020 |
| 3. | 1991 Realignment | 0.00 | | | | | |
| 4. | Behavioral Health Subaccount | 0.00 | | | | | |
| 5. | Other funding* | 1,848,000 | 320,000 | 320,000 | 320,000 | | 2,808,000 |
| 6. | Total Proposed Administration | 4,685,123 | 4,167,948 | 4,275,914 | 4,390,092 | | 17,519,077 |
| Evaluation: | | | | | | | |
| B. | Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources: | FY 18/19 | FY 19/20 | FY 20/21 | FY 21/22 | | Total |
| 1. | Innovative MHSA Funds | 315,576 | 315,576 | 315,576 | 315,576 | | 1,262,304 |
| 2. | Federal Financial Participation | | | | | | |
| 3. | 1991 Realignment | | | | | | |
| 4. | Behavioral Health Subaccount | | | | | | |
| 5. | Other funding* | | | | | | |
| 6. | Total Proposed Evaluation | 315,576 | 315,576 | 315,576 | 315,576 | | 1,262,304 |
| TOTAL: | | | | | | | |
| C. | Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources: | FY 18/19 | FY 19/20 | FY 20/21 | FY 21/22 | | Total |
| 1. | Innovative MHSA Funds | 3,152,699 | 3,594,064 | 3,512,210 | 3,626,388 | | 13,885,361 |
| 2. | Federal Financial Participation | | 569,460 | 759,280 | 759,280 | | 2,088,020 |
| 3. | 1991 Realignment | | | | | | |
| 4. | Behavioral Health Subaccount | | | | | | |
| 5. | Other funding* | 1,848,000 | 320,000 | 320,000 | 320,000 | | 2,808,000 |
| 6. | Total Proposed Expenditures | 5,000,699 | 4,483,524 | 4,591,490 | 4,705,668 | | 18,781,381 |
| *If "Other funding" is included, please explain. | | | | | | | |

INNOVATIVE PROJECT PLAN DESCRIPTION – Optional Template

| C. New Innovative Project Budget Narrative | | |
|---|---|---|
| EXPENDITURES | | |
| PERSONNEL COSTs (salaries, wages, benefits) | | |
| 1. | Salaries | Contracted salaries include the following direct service staff: 1.00 FTE Manager, 8.42 FTE Psychiatric Nurse, 2.00 FTE Licensed Psychiatric Technician, 2.00 FTE Mental Health Peer Mentor, 0.50 Social Worker, 1.00 FTE Peer Advocate, 1.00 FTE Family Advocate, 1.75 FTE Psychiatrist, 0.53 FTE Tele-Psychiatric Consult. Staffing covers the 24 hour per day, 7days per week operations, including staffing the client resource center operations. |
| 2. | Direct Costs | Direct costs include staff health benefits, payroll taxes and retirement. |
| 3. | Indirect Costs | Indirect costs include overhead and allocated costs. |
| 4. | Total Personnel Costs | See above. |
| OPERATING COSTs | | |
| 5. | Direct Costs | Includes staff training (WRAP, etc.), ADL supplies, Avatar Electronic Health Record interoperability costs including a one-time setup cost. |
| 6. | Indirect Costs | Not applicable. |
| 7. | Total Operating Costs | See above. |
| NON RECURRING COSTs (equipment, technology) | | |
| 8. | Modular Building Purchase and Improvements – Funded by Dignity Health | Includes one-time costs of a new modular building, cubicles, outside patio configurations and major improvements funded by Dignity Health. |
| 9. | Furnishings and Equipment | Includes computers, interior and outside patio furnishings, and other features to ensure a warm, family-friendly environment. |
| 10. | Total Non-recurring Costs | See above. |
| CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation) | | |
| 11. | Direct Costs | Includes the cost of an independent evaluator, health benefits, payroll taxes, and retirement. |
| 12. | Indirect Costs | Indirect costs include overhead and allocated costs. |
| 13. | Total Consultant Costs | See above. |
| OTHER EXPENDITURES (please explain in budget narrative) | | |
| 14. | Work Plan Management | County support staff including Research, Evaluation, and Performance Outcomes Program Planner, as well as Contract Administration support services. Includes salaries, health benefits, SSI, retirement and insurance. |
| 15. | | |
| 16. | Total Other Expenditures | See above. |
| OTHER FUNDING (If “other funding” is included, please explain) | | |
| Other funding | | Includes funding contributed by Dignity Health for non-recurring modular building purchase and improvements, as well as ongoing operating costs. |
| PROJECT SUSTAINABILITY | | |
| If the project is determined to be successful, it is anticipated that MHSA Community Services and Supports (CSS) component funding, leveraged with Medi-Cal (as appropriate), will be identified to sustain the project services. | | |



6001 Coyle Avenue
 Carmichael, CA 95608
 Direct: 916.337.5001
 Fax: 916.337.3111

April 9, 2018

Sacramento County Board of Supervisors
 700 H Street
 Sacramento, CA 95814

Subject: Mental Health Services Act Innovation Project III – Behavioral Health Crisis Services Collaborative,

Dear Members of the Sacramento County Board of Supervisors:

Months of joint planning by the County Behavioral Health Services Division, Dignity Health, other project partners and stakeholders have gone into the Behavioral Health Crisis Services Collaborative Innovation Project to shape a unique model of integrated care. Dignity Health is pleased and excited to work in partnership with the County on this integrated initiative that aims to establish a new benchmark for crisis stabilization services, improve outcomes and positively impact the mental health delivery system for our region.

Our commitment to this project starts with recognizing that mental health is too large of an issue to be addressed by any one entity. It is a shared community issue and responsibility that requires collaboration and leveraging of resources, expertise and efficiencies in order to advance needed improvements in access, delivery, quality, and continuity and coordination of care. We are investing our resources along with dedicating space and ongoing in-kind commitments to support the success of this innovative project.

Importantly, the model of care this project represents places patient-centered care at the forefront. By locating the project on our Mercy San Juan Medical Center campus, we benefit both Sacramento and Placer County residents. This is a geographic area of unmet need, and together, we can bring services to the consumer, providing integrated medical emergency and mental health crisis stabilization and treatment. Delays in treatment, emergency department boarding and barriers to care will be eliminated through timely access to specialty services at the point of entry. An onsite resource center housing peer and family navigators, case managers and health plan care coordinators will ensure direct linkages to aftercare and the social support services that are essential for recovery, ongoing management of conditions and wellbeing of individuals who will be served. Emphasis will be given to prevention by incorporating the evidence-based University of California Davis Medical Centers Early Diagnosis and Preventative Treatment Program. The project is also a natural fit with collaborative efforts between Sacramento County and Sacramento City's Whole Person Care initiative with the capability to serve as a direct access point for eligibility assessments and referrals. These are all components that set this project apart from other like services across the state.

The Behavioral Health Crisis Services Collaborative is an important extension of enhanced services for our community. It can serve as a model for the future, here and elsewhere. We are proud to be a part of this effort, fully invested in ensuring its success, and stand ready to move forward quickly with project development. Working together with Sacramento County and other project partners and stakeholders who share the same values and common purpose, our goal is to demonstrate the highest quality of care and services promised. You have our commitment on this.

Sincerely,



Michael Korpiel
President
Mercy San Juan Medical Center

C: Uma K. Zykofsky, Deputy Director, Sacramento County Behavioral Health Services



February 27, 2018

Uma Zykofsky
 Director, Sacramento County Division of Behavioral Health Services
 Grantland L. Johnson Center for Health & Human Services
 7001-A East Parkway, Suite 400
 Sacramento, California 95823

Dear Uma,

Anthem Blue Cross is writing to express support of Sacramento County's proposed Mental Health Services Act (MHSA) Innovation Project, the Behavioral Health Crisis Services Collaborative. This unique public/private partnership between Sacramento County, Placer County and Dignity Health offers a new best practice model of care for emergency and crisis stabilization services that will help fill a major gap for much needed mental health services in our region.

This project represents a rare opportunity to leverage a commitment by a large health system and two Counties willing to invest in, and work together on, the development of integrated physical and mental health crisis services on a hospital campus situated in an area where the need is great. The project is far more comprehensive than other services existing today. It goes beyond emergency and crisis stabilization by incorporating a resource center to house peer and family navigators, health plan staff and community-based partners to provide care coordination, peer support and navigation, and social support services to consumers at the point of care. This will ensure consumers do not leave without first being linked directly to resources they need, including drug and alcohol treatment, for ongoing management of conditions, recovery and wellness. The UC Davis SacEDAPT first break screening is also being built into the program for early identification and intervention for psychotic disorders.

The Behavioral Health Crisis Services Collaborative embraces the concept of whole person care, strengthens the continuum of care in our region, and will advance the current state of crisis stabilization services in California by offering significant improvements. Delays in treatment, emergency department boarding and barriers to care will be addressed through timely access for consumers at the point of entry. Quality of care and clinical outcomes will be improved through appropriate intervention in a therapeutic and calming setting. Continuity and coordination of care will be assured through real time collaboration among emergency, mental health, plan, peer and family, and community-based providers. Co-location of crisis services on an acute care hospital campus will also enhance safety, ensure medical stabilization and medical backup and eliminate criteria that often bar consumers from accessing care in a community-based setting.



The project moves our community past the existing stalemate of trying to establish responsibilities between hospitals and the County for mental health and instead places the focus on integrated patient-centered care. It can also serve as a new standard for future crisis stabilization services across our State. We urge you to support this important effort.

Sincerely,

A handwritten signature in black ink, appearing to read "Nicholas Osterman", written over a horizontal line.

Nicholas Osterman
Director Behavioral Health Services
Cell 213.407.196

www.anthem.com/ca/medi-cal

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Blue Cross of California Partnership Plan, Inc. are independent licensees of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. Blue Cross of California is contracted with L.A. Care Health Plan to provide Medi-Cal Managed Care services in Los Angeles County.

City of
SACRAMENTO
Office of the City Manager

Howard Chan
City Manager

City Hall
915 I Street, Fifth Floor
Sacramento, CA 95814-2604
916-808-5704

January 22, 2018

Uma Zykofsky
Deputy Director
Sacramento County Behavioral Health Services
Mental Health Director
Alcohol & Drug Administrator
7001 A East Parkway, Suite 400
Sacramento, CA 95823

Dear Ms. Zykofsky:

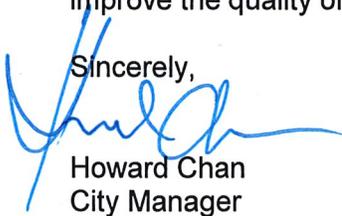
The City of Sacramento writes in support of the behavioral health crisis services collaborative proposal: a regional approach to provision of services for emergency department patients dealing with mental health issues. We believe that the proposed joint approach by the counties of Placer and Sacramento will provide an important and needed resource to the community.

Through this proposed collaborative, the County of Sacramento, working with Placer, will reduce the pressure on the emergency department (ED) at Mercy San Juan Medical Center by increasing the quality and scope of services available to patients experiencing mental health crises. Additionally, this collaborative uses an integrated health and mental health emergency and crisis stabilization service approach. These integrated services will seek to identify and intervene early for patients reporting to the ED with psychotic disorders. Such early identification and intervention will also provide adult patients dealing with mental health issues multi-disciplinary evaluation and treatment for up to 23 hours at a dedicated facility. The program intends to continue beyond the initial 23 hours by ensuring that patients receive ongoing services, including after care planning and support.

The City of Sacramento believes that the collaboration will supplement and enhance the work of the Pathways to Health and Home Program, the City's Whole Person Care pilot, for individuals experiencing homelessness. Pathways and the proposed collaborative share many of the same goals (better care coordination, connecting patients with needed resources, and reducing pressure on emergency services and emergency departments) while focusing on distinct, but similar, patient population. The City looks forward to collaborating with the County of Sacramento on the Pathways program to allow for greater integration of approaches to patients experiencing homelessness and living with mental health issue to improve care and reduce long-term costs.

The proposed collaboration, between the counties of Placer and Sacramento, has the potential to reduce health care costs, and improve patient outcomes. Should this proposal be approved, we look forward to working closely with the County during the planning process for the proposed collaborative to improve the quality of life for vulnerable individuals in our region.

Sincerely,



Howard Chan
City Manager



Health Net of California, Inc.
 11971 Foundation Place
 Rancho Cordova, CA 95670
www.healthnet.com

March 1, 2018

Uma Zykofsky
 Director, Sacramento County Division of Behavioral Health Services
 Grantland L. Johnson Center for Health & Human Services
 7001-A East Parkway, Suite 400
 Sacramento, California 95823

Dear Uma,

On behalf of Health Net Community Solutions, I am writing to express our support of Sacramento County's proposed Mental Health Services Act (MHSA) Innovation Project, the Behavioral Health Crisis Services Collaborative. This unique public/private partnership between Sacramento County, Placer County and Dignity Health offers a new best practice model of care for emergency and crisis stabilization services that will fill a major gap for much needed mental health services in our region. In support of this model, Health Net will be committing a staff member to provide support on-site at the Crisis Center.

Health Net currently service more than 2 million Medi-Cal beneficiaries through direct and subcontracted relationship across California. In Sacramento, we are proud to provide health care coverage for more than 110,000 individuals through our robust provider and hospital partnerships. We have a long-standing commitment to the local community and low income populations.

This project represents a rare opportunity to leverage a commitment by a large health system and two Counties willing to invest in, and work together on, the development of integrated medical and mental health crisis services. By incorporating a resource center on site at the Dignity facility, consumers will be quickly linked to needed resources need such as drug and alcohol treatment, care management, recovery and wellness services. The use of peer and family navigators, health plan staff and community-based partners will provide care coordination, peer support, navigation, and social support services to consumers at the point of care.

The Behavioral Health Crisis Services Collaborative embraces the concept of integrated care delivery and will significantly advance crisis stabilization services in Sacramento. Delays in treatment, emergency department boarding and barriers to care will be eliminated through timely access for consumers at the point of entry. Quality of care and clinical outcomes will be improved through appropriate intervention in a therapeutic and calming setting. We are excited to partner on this innovative project and urge your support of this important effort.

Sincerely,

A handwritten signature in black ink that reads 'Abbie A. Totten'.

Abbie A. Totten
 Vice President, Government Programs Policy & Strategic Initiatives



March 5, 2018

Uma Zykofsky
 Director, Sacramento County Division of Behavioral Health Services
 Grantland L. Johnson Center for Health & Human Services
 7001-A East Parkway, Suite 400
 Sacramento, California 95823

Dear Uma,

Hospital Council of Northern and Central California is writing to express support of Sacramento County's proposed Mental Health Services Act (MHSA) Innovation Project, the Behavioral Health Crisis Services Collaborative. This unique public/private partnership between Sacramento County, Placer County and Dignity Health offers a new best practice model of care for emergency and crisis stabilization services that will fill a major gap for much needed mental health services in our region.

The Hospital Council of Northern and Central California is a nonprofit hospital and health system trade association established in 1961, representing 185 hospitals and health systems in 50 of California's 58 counties—from Kern County to the Oregon border. The Hospital Council's membership includes hospitals and health systems ranging from small, rural hospitals to large, urban medical centers, representing more than 37,000 licensed beds. We've been deeply involved with Sacramento County and other healthcare stakeholders in recent years seeking solutions to the mental health crisis. We strongly feel that this proposal is an important part of that solution.

This project represents a rare opportunity to leverage a commitment by a large health system and two Counties willing to invest in, and work together on, the development of integrated medical and mental health crisis services on a hospital campus situated in an area where the need is great. The project is far more comprehensive than other services existing today. It goes beyond emergency and crisis stabilization by incorporating a resource center to house peer and family navigators, health plan staff and community-based partners to provide care coordination, peer support and navigation, and social support services to consumers at the point of care. This will ensure consumers do not leave without first being linked directly to resources they need, including drug and alcohol treatment, for ongoing management of conditions, recovery and wellness. The UC Davis SacEDAPT first break screening is also being built into the program for early identification and intervention for psychotic disorders.

Hospital Council
March 5, 2018
Page 2 of 2

The Behavioral Health Crisis Services Collaborative embraces the concept of whole person care, strengthens the continuum of care in our region, and will advance the current state of crisis stabilization services in California by offering significant improvements. Delays in treatment, emergency department boarding and barriers to care will be eliminated through timely access for consumers at the point of entry. Quality of care and clinical outcomes will be improved through appropriate intervention in a therapeutic and calming setting. Continuity and coordination of care will be assured through real time collaboration among emergency, mental health, plan, peer and family, and community-based providers. Co-location of crisis services on an acute care hospital will also enhance safety, ensure medical stabilization and medical backup and eliminate criteria that often bar consumers from accessing care in a community-based setting.

The project moves our community past the existing stalemate of trying to establish responsibilities between hospitals and the County for mental health and instead places the focus on integrated patient-centered care. It can also serve as a new standard for future crisis stabilization services across our State. We urge you to support this important effort.

Sincerely,



Brian Jensen
Regional Vice President

BJ:ks



TODD HARMS
Fire Chief

Sacramento Metropolitan Fire District

10545 Armstrong Ave., Suite 200 • Mather, CA 95655 • Phone (916) 859-4300 • Fax (916) 859-3702

February 27, 2018

Uma Zykofsky
Director, Sacramento County Division of Behavioral Health Services
Grantland L. Johnson Center for Health & Human Services
7001-A East Parkway, Suite 400
Sacramento, California 95823

Dear Uma,

Sacramento Metropolitan Fire District is writing to express support of Sacramento County's proposed Mental Health Services Act (MHSA) Innovation Project, the Behavioral Health Crisis Services Collaborative. This unique public/private partnership between Sacramento County, Placer County and Dignity Health offers a new best practice model of care for emergency and crisis stabilization services that will fill a major gap for much needed mental health services in our region.

Sacramento Metropolitan Fire District serves 359 square miles of Sacramento County and the cities of Citrus Heights and Rancho Cordova. We are the third largest transporting Fire Agency in the State of California. We consistently transport over 50,000 patients annually. This project will assist our agency in providing timely intake and evaluation to the patients encountered that are experiencing a behavioral crisis.

This project represents a rare opportunity to leverage a commitment by a large health system and two Counties willing to invest in, and work together on, the development of integrated medical and mental health crisis services on a hospital campus situated in an area where the need is great. The project is far more comprehensive than other services existing today. It goes beyond emergency and crisis stabilization by incorporating a resource center to house peer and family navigators, health plan staff and community-based partners to provide care coordination, peer support and navigation, and social support services to consumers at the point of care. This will ensure consumers do not leave without first being linked directly to resources they need, including drug and alcohol treatment, for ongoing management of conditions, recovery and wellness. The UC Davis SacEDAPT first break screening is also being built into the program for early identification and intervention for psychotic disorders.

The Behavioral Health Crisis Services Collaborative embraces the concept of whole person care, strengthens the continuum of care in our region, and will advance the current state of crisis stabilization services in California by offering significant improvements. Delays in treatment, emergency department boarding and barriers to care will be eliminated through timely access for consumers at the point of entry. Quality of care and clinical outcomes will be improved through appropriate intervention in a therapeutic and calming setting. Continuity and coordination of care will be assured through real time collaboration among emergency, mental health, plan, peer and family, and community-based providers. Co-location of crisis services on an acute care hospital

will also enhance safety, ensure medical stabilization and medical backup and eliminate criteria that often bar consumers from accessing care in a community-based setting.

The project moves our community past the existing stalemate of trying to establish responsibilities between hospitals and the County for mental health and instead places the focus on integrated patient-centered care. It can also serve as a new standard for future crisis stabilization services across our State. We urge you to support this important effort.

Sincerely,

A handwritten signature in black ink that reads "Randall Hein". The signature is written in a cursive style with a large initial "R" and "H".

Randall Hein
Director of EMS
Sacramento Metropolitan Fire District



Received

MAR 05 2018

By BHS Admin

March 2, 2018

Uma Zykofsky, Director
 Sacramento County Division of Behavioral Health Services
 Grantland L. Johnson Center for Health & Human Services
 7001-A East Parkway, Suite 400
 Sacramento, California 95823

Dear Uma,

The Sierra Sacramento Valley Medical Society (SSVMS) is writing to express support of Sacramento County's proposed Mental Health Services Act (MHSA) Innovation Project, the Behavioral Health Crisis Services Collaborative. We applaud Sacramento County for collaborating with Dignity Health to bring this important project to fruition.

The Sierra Sacramento Valley Medical Society is dedicated to bringing together physicians from all modes of practice to promote the art and science of quality medical care and to enhance the physical and mental health of our entire community.

In July 2015, SSVMS published a white paper, "*Crisis in the Emergency Department: Removing Barriers to Timely and Appropriate Mental Health Treatment*," to address the increase in the number of patients in mental health crisis in the region's emergency departments. The white paper proposed three overarching recommendations to improve the quality of care for patients experiencing mental crises, aimed at providing better access to the right care at the right time.

The three recommendations are: 1) Implementation of an electronic Health Information Exchange (HIE) in the Sacramento region to help coordinate care of patients seeking emergency psychiatric services; 2) Standardize the medical clearance process across all EDs and inpatient psychiatric treatment programs to facilitate the timely transfer of patients to appropriate treatment centers; and 3) Establish dedicated psychiatric emergency services (PES) to ensure that patients experiencing a mental health crisis receive the right care at the right time.

The Behavioral Health Crisis Services Collaborative is directly in line with the Medical Society's third recommendation. Significantly, the Collaborative goes beyond emergency and crisis stabilization by incorporating a resource center to house peer and family navigators and community-based partners to provide care coordination, peer support and navigation, and social support services to consumers at the right time and the right place. This project will ensure that individuals in mental health crisis will be linked directly to resources, including drug and alcohol treatment, recovery and wellness programs. The project is far more comprehensive than other services existing today.

Page Two
March 2, 2018
Uma Zykofsky, Director
Sacramento County Division of Behavioral Health Services

SSVMS believes the Behavioral Health Crisis Services Collaborative offers a best practice model of care for emergency and crisis stabilization services that will fill a major gap for much needed mental health services in our region. We urge your support of this important effort.

Sincerely,



Aileen E. Wetzel
Executive Director

AEW:cs



**STEINBERG
INSTITUTE**

1130 K Street, Suite LL50
Sacramento CA 95814
T 916.553.4167
steinberginstitute.org

ADVANCING BRAIN HEALTH POLICY & INSPIRING LEADERSHIP

March 2, 2018

Uma Zykofsky
Director, Sacramento County Division of Behavioral Health Services
Grantland L. Johnson Center for Health & Human Services
7001---A East Parkway, Suite 400
Sacramento, California 95823

Dear Director Zykofsky,

The Steinberg Institute supports Sacramento County's proposed Mental Health Services Act (MHSA) Innovation Project, the Behavioral Health Crisis Services Collaborative. This unique public/private partnership between Sacramento County, Placer County and Dignity Health offers a best practice model of care for emergency and crisis stabilization services that will fill a major gap for much needed mental health services in our region.

This project represents an opportunity to leverage a commitment by a large health system and two Counties willing to invest in, and work together on, the development of integrated medical and mental health crisis services on a hospital campus. The project is far more comprehensive than other services existing today. It goes beyond emergency and crisis stabilization by incorporating a resource center to house peer and family navigators, health plan staff and community---based partners to provide care coordination, peer support and navigation to clients. This will ensure consumers are linked to the community resources they need for ongoing management of conditions, recovery and wellness. We are particularly impressed that the UC Davis SacEDAPT first break screening is being built into the program for early identification and intervention for psychotic disorders.

The Behavioral Health Crisis Services Collaborative embraces the concept of whole person care, strengthens the continuum of care in our region, and will advance the current state of crisis stabilization services in California by offering significant improvements. It can also serve as a new standard for future crisis stabilization services across our State. Thank you for your leadership.

Sincerely,

Maggie Merritt
Executive Director