COUNTY OF SAN DIEGO

AGENDA ITEM

DATE: **September 27, 2022** **23**

TO: Board of Supervisors

SUBJECT

RECEIVE AN UPDATE ON ADVANCING THE BEHAVIORAL HEALTH CONTINUUM OF CARE, AUTHORIZE CONSTRUCTION CONTRACT FOR THE EAST REGION CRISIS STABILIZATION UNIT, AND RECEIVE THE OPTIMAL CARE PATHWAYS MODEL (DISTRICTS: ALL)

OVERVIEW

Under the leadership of the San Diego County Board of Supervisors (Board), behavioral health care in San Diego County is in the midst of a profound transformation. The County of San Diego (County) is taking action and making strategic investments to move the local behavioral health care delivery system from a model of care driven by crises to one centered on continuous, coordinated care and prevention. These efforts, broadly referred to as the Behavioral Health Continuum of Care (Continuum of Care), are guided by data, focused on equity, and designed to engender collaborative work across silos, within and outside of government.

Today's update outlines the progress that the County Health and Human Services Agency, Behavioral Health Services (BHS) continues to make to advance work across the Continuum of Care in Crisis Diversionary, Behavioral Health Hub and Long-Term Care strategic domains. These have been established as key categories for work that is enabling the transformative vision toward continuous care and have provided a general framework for shifting proportional investments. BHS has not modeled or specified the *scale* at which different service categories are needed in order to make care best for San Diego County residents. While there has been much attention placed on the numbers of psychiatric inpatient beds needed across the county, BHS remains committed to setting quantitative service level goals and plans to approach the task with the broadest perspective, reflecting the entire Continuum of Care.

In order to accomplish this, BHS developed the Behavioral Health Continuum of Care Optimal Care Pathways (OCP) model, a data-informed algorithm that quantifies optimal utilization across service areas within the system. The OCP model recalibrates and expands current services, and suggests some additional types of services, to remove barriers to care, reduce per capita cost, and most importantly, connect individuals to the care they need, when they need it to ensure wellness over the long-term.

More specifically, the OCP compels us to *redefine long-term care* by expanding it to include community-based care services that provide continuous care and housing to people with behavioral health conditions who may have other complex health conditions and to incorporate enhancements to community crisis diversion services to ensure new care pathways are available to divert individuals from unnecessary utilization of expensive acute care. These community crisis diversion services are part of a full crisis continuum that includes existing crisis stabilization units, mobile crisis response teams, and crisis residential services.

Finally, BHS recognizes that the primary focus of much of the Continuum of Care work over the last few years has been to address the behavioral health needs of adults. Today's update will include a focus on upstream efforts currently underway to develop a broad strategy to advance the behavioral needs of children, youth, and transition age youth, and their families, across the region to support this vulnerable population.

These items support the County's vision of a just, sustainable, and resilient future for all, specifically those communities and populations in San Diego County that have been historically left behind, as well as the ongoing commitment to the regional *Live Well San Diego* vision of healthy, safe, and thriving communities. This will be accomplished by working across systems to support better care of individuals, better health for local populations, and more efficient health care resourcing.

RECOMMENDATION(S)
CHIEF ADMINISTRATIVE OFFICER

1. Receive an update on the Behavioral Health Continuum of Care.
2. Find that the proposed activities are exempt from the California Environmental Quality Act (CEQA) pursuant to Sections 15061(b)(3) and 15262 of the State CEQA Guidelines.
3. Authorize the Director, Department of Purchasing and Contracting to take any action authorized by Article XXIII, Section 401, et seq. of the Administrative Code and Public Contract Code Section 20146 to advertise and award a single Construction Manager at Risk contract for the East Region Crisis Stabilization Unit with Co-Located Sobering Services capital project, to authorize Phase 1 of the contract for preconstruction services, and to return to the Board for appropriations and authority to execute the option for Phase 2, construction.
4. Designate the Director, Department of General Services, as the County officer responsible for administering the Construction Manager at Risk contract.
5. Authorize the planning and formation of a behavioral health equity community alliance, co-created in partnership with community stakeholders of shared racial, ethnic, and cultural identity, to inform the design, planning, and implementation of behavioral health services to address inequity and build capacity for communities that have historically faced systemic barriers to wellness.
6. In accordance with Board Policy A-87, Competitive Procurement, and Administrative Code Section 401, authorize the Director, Department of Purchasing and Contracting,

subject to successful negotiations and a determination of a fair and reasonable price, to amend the contracts listed below to extend the contract term up to September 30, 2023, and up to an additional six months, if needed, and expand services, subject to the availability of funds; and amend the contracts as required in order to reflect changes to services and funding allocations, subject to the approval of the Agency Director, Health and Human Services Agency.

a. Father 2 Child (Mental Health America of San Diego County, Contract #541201)
b. Positive Parenting (Jewish Family Service, Contract #553898)

EQUITY IMPACT STATEMENT

The County of San Diego (County) Health and Human Services Agency, Behavioral Health Services (BHS) serves as the specialty behavioral health plan for Medi-Cal eligible residents within San Diego County who are experiencing serious mental illness or serious emotional disturbance, and the service delivery system for Medi-Cal eligible residents with substance use disorder care needs. As a steward of public health for the region, BHS must ensure that the resources and services offered through County-operated and contracted programs promote equitable outcomes, advance wellness across the continuum of need, and are equitably distributed based on the needs of the region's diverse communities.

In support of these efforts, BHS utilizes a population health approach, incorporating evidence-based practices and robust data analysis, to identify need and design services that are impactful, equitable, and yield meaningful outcomes for clients. This includes facilitating ongoing engagement and input from stakeholders, consumers, family members, community-based providers, and healthcare organizations through formal and informal convenings, along with cross-collaboration with other County departments and community partners. Additionally, through the establishment of the Community Experience Partnership, in collaboration with the University of California San Diego, BHS is leading the development of the Behavioral Health Equity Index, a tool to help measure behavioral health equity that will inform program planning, siting of services, and allocation of resources in a way that supports the most pressing community needs.

If approved, today's actions will set a course for the region's behavioral health system by progressing crisis and diversionary services, addressing the lack of step-down capacity, and supporting efforts to enhance care for youth. These actions will ultimately aim to reduce behavioral health inequities among the region, advancing services that will impact vulnerable populations including individuals experiencing homelessness and those with justice involvement.

SUSTAINABILITY IMPACT STATEMENT

Transforming the behavioral health continuum of care in San Diego County will result in sustainability enhancements in terms of health, wellbeing, and equity as we advance the regional distribution of services that will allow individuals to receive care that is in close proximity to their support systems and provides a wider availability and range of connections to care.

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Today's actions will transform our approach to supporting individuals with behavioral health conditions in need of long-term community-based care and housing to address the barriers and parity issues that have historically prevented individuals from receiving the right care at the right time in the right place. Additionally, the County of San Diego (County) Health and Human Services Agency, Behavioral Health Services will continue to explore thoughtful and sustainable building designs for facilities as opportunities arise in alignment with the County's Sustainability Goals.

FISCAL IMPACT

Recommendation #3: East Region Crisis Stabilization Unit Facility with Co-Located Sobering Services
Funds for this request are included in the Fiscal Year (FY) 2022-23 Operational Plan in the County of San Diego Health Complex Fund for Capital Project 1024603, East Region Crisis Stabilization Unit Co-Located Sobering Services. If approved, this request would result in costs and revenue of $1.0 million in FY 2022-23. The funding source is Realignment and Intergovernmental Transfer revenues. The department will return to the Board with future recommendations and to establish additional appropriations for future phases of the project. There will be no change in net General Fund cost and no additional staff years.

Recommendation #6: Authorization to Extend and Amend Contracts
Funds for this request are included in the FY 2022-23 Operational Plan in the Health and Human Services Agency. If approved, today's recommendations will result in approximate costs and revenue of $1.0 million in FY 2022-23 and $0.3 million in FY 2023-24. The funding source is Mental Health Services Act. There will be no change in net General Fund cost and no additional staff years.

BUSINESS IMPACT STATEMENT
N/A

ADVISORY BOARD STATEMENT
At their regular meeting on September 1, 2022, the Behavioral Health Advisory Board voted to support the recommendations.

BACKGROUND
Under the leadership of the San Diego County Board of Supervisors (Board), behavioral health care in San Diego County is in the midst of a profound transformation. The County of San Diego (County) is taking action and making strategic investments to move the local behavioral health care delivery system from a model of care driven by crises to one centered on continuous, coordinated care and prevention. These efforts, broadly referred to as the Behavioral Health Continuum of Care (Continuum of Care), are guided by data, focused on equity, and designed to engender collaborative work across silos, within and outside of government. The County Health

and Human Services Agency, Behavioral Health Services (BHS) has advanced Continuum of Care efforts by addressing the immediate needs and setting a more appropriate care trajectory for individuals experiencing behavioral health crises, which has resulted in major investments in:

- Psychiatric acute inpatient beds to support the increasing number of people in need of hospitalization;
- Regionally distributed crisis stabilization units to divert individuals experiencing a behavioral health crisis from unnecessarily utilizing emergency departments; and
- The implementation of mobile crisis response teams countywide to respond in the field to individuals who are experiencing a behavioral health crisis with a team of behavioral health professionals rather than unnecessarily deploying law enforcement personnel.

To further build out regionally distributed crisis services, included today and outlined in Attachment A is a recommendation to authorize the Director, Department of Purchasing and Contracting to advertise and award a single Construction Manager at Risk contract for preconstruction services for the East Region Crisis Stabilization Unit with Co-Located Sobering Services. The department will return to the Board in the future with additional recommendations and to establish additional appropriations, as needed.

The County has also made significant investments in outpatient treatment and traditional wrap-around services over the past few years to meet the urgent needs of the community in the challenging context of the COVID-19 pandemic. Though these are critical aspects of the Continuum of Care, expansion of these services is just the beginning of a broader shift towards more thoughtful upstream prevention and care by establishing a coordinated network of community-based care and housing that meets the unique needs of individuals over the long-term. The Behavioral Health Continuum of Care Optimal Care Pathways (OCP) model, built on a foundation of comprehensive need and utilization analysis, outlines the need to establish new care pathways to address long-term care needs of individuals with a focus on prevention, community supports, and diversion from unnecessary utilization of high acuity care.

Optimal Care Pathways Model

The OCP model was developed to identify with specificity, the current capacity and utilization of care for individuals within our system, and to set service specific infrastructure and utilization goals reflecting appropriate lengths of stay and durations of connection with the right services for an optimal future Continuum of Care that would best to support people with critically limited opportunities for placement due to complex needs, lack of existing services in the continuum, inadequate capacity, and/or other specialty care needs that present barriers to care.

Developing the Optimal Care Pathways Model

BHS has been engaged in rigorous efforts, in partnership with Public Consulting Group, to research and compile national, state, and local data to develop a comprehensive assessment of our local system and formulate the OCP model that quantifies the optimal capacity required across

each level of care to build a system that meets the unique needs of individuals with behavioral health conditions.

BHS utilized key concepts from the Crisis Resource Need Calculator within the Crisis Now model. Crisis Now is a community-based crisis care model with a "no wrong door" philosophy of integrated crisis care as outlined in the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit. The model outlines high-level estimates in key critical areas and explores different system-design scenarios for the provision of behavioral health crisis care, including inpatient and emergency department resources, and estimated potential healthcare costs and resource requirements for each scenario. It also incorporates key components, including demand for in-person crisis services, resource capacity for in-person services, utilization patterns, and annual healthcare costs to meet these needs.

BHS also reviewed the recent RAND study commissioned by the California Mental Health Services Authority titled *Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California—2021*, which evaluated adult psychiatric bed needs across California and offered f-year bed projections by geographical region and outlined key findings across the state. The study included a projected shortfall of psychiatric beds statewide across inpatient, subacute, and residential levels of care, including approximately 1,971 beds at the acute level (6.4 additional beds required per 100,000 adults), 2,796 subacute beds (9.1 additional beds required per 100,000 adults), excluding state hospital beds and 2,963 community residential beds, with significant regional differences in the estimated shortfalls within each level of care.

Adding an additional layer of intricacy is the difficulty in placing individuals with complex conditions, including those with justice system involvement, who often do not have long-term options for care and housing. Though helpful in outlining the broad psychiatric acute care needs across California and locally, the RAND study included combined information for San Diego and Imperial Counties, beds inclusive of all payors, and narrowly focused recommendations on a few categories of services to mitigate immediate pain points within the system.

Building upon these studies, BHS opted for a more comprehensive approach in developing the OCP model to assess and quantify the needs and barriers across the system, focusing specifically on Medi-Cal eligible individuals within San Diego County. The approach addressed the needs across all levels of care and within broader context that considers social determinants of health and larger system challenges. It also outlines client care pathways and the development of infrastructure beyond psychiatric beds to include subacute care, community-based care, and community crisis diversion services, including services that are not available to BHS clients.

The OCP model focuses significantly on diversion to the least restrictive environment and opportunities to serve individuals with medical, social, and environmental needs more effectively through whole person care and supports. The model utilizes assumptions for crisis diversion and

re-entry into acute care developed as part of the Crisis Now model, along with anticipating the needs of individuals experiencing barriers to care, including those experiencing justice-involvement and homelessness.

BHS' broader and more comprehensive effort assesses the current state of community crisis diversion, acute care, subacute care, and community-based care infrastructure and services, along with identifying gaps and bottlenecks that have led to an unbalanced system characterized by restricted client flow across key points of transition. The analysis also maps clinical pathways to determine where clients with behavioral health conditions are entering from, which levels of care they are going to, what barriers stand in their way and prevent them from receiving optimal care, and identified common characteristics and specialty needs amongst clients. Finally, it identifies missed opportunities that would have prevented acute admissions, along with excessive lengths of stays in restrictive settings for clients waiting for lower levels of care.

To inform the OCP model BHS utilized local data, including point-in-time utilization, average length of stay, waitlist information, and capacity data, which account for concurrent referrals and data mis-categorization, along with acute inpatient administrative day data, clinical data, and other key information to quantify local need with a focus on addressing the unique needs of individuals across the region.

To address the imbalance and barriers within the system, the model quantifies the optimal utilization needed across the various levels of care and specifically demonstrates the urgent need to develop and expand dedicated community-based care and community crisis diversion services, inclusive of infrastructure and services, specifically for Medi-Cal eligible clients who have behavioral health needs to facilitate acute and step downs, diversion from higher levels of care, and elimination of waitlists. The model also outlines the need to shift capacity and specialized care within and across service areas as new services and capacity become available. The OCP model also addresses unmet need by accounting for clients with serious mental illness (SMI) currently in jail settings, and clients experiencing homelessness. Implementation of strategies to achieve the optimal state outlined in the OCP model is anticipated to rebalance utilization across the system and the capacity necessary to ensure individuals are connected to the right level of care.

Optimal Bed Utilization and Anticipated Impact

The OCP establishes three service categories: Community Crisis Diversion, Subacute Services, and Community-Based Care. As outlined in *Figure A.*, the OCP recommends a *recalibration and more than doubling of capacity utilization across these three service areas to focus on growth within* lower levels of short-term community crisis diversion, subacute care, and community-based care to alleviate the existing bottlenecks, reduce unnecessary utilization of higher levels of care, and connect individuals to the care they need.

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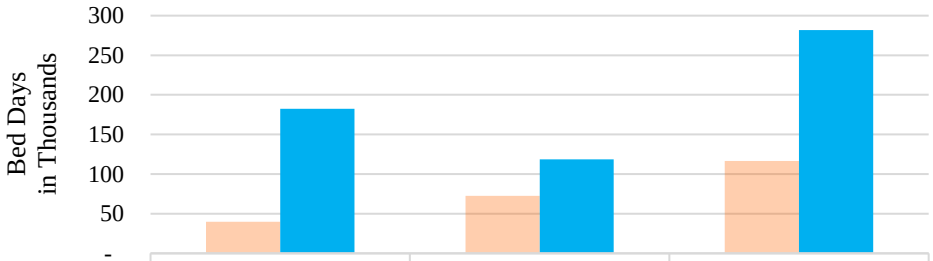
Figure A. Optimal Care Pathways Model - Anticipated Impact



	Community Crisis Diversion	Subacute Services	Community Based Care
Current Utilization	39,799	72,568	116,531
Optimal Utilization	182,521	118,652	281,690

Each of the primary OCP service categories comprise an array of services and the OCP model recommends varying levels of utilization change to achieve the projected best pathways through care and best outcomes, as outlined in *Figure B.*

Figure B. Projected Bed Day Utilization Change Across Service Categories

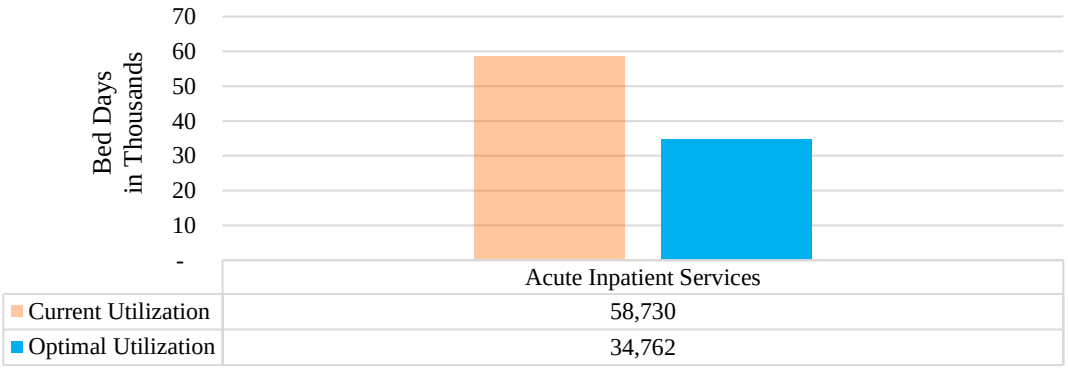
Service Area	*Community Crisis Diversion*	*Subacute Services*	*Community-Based Care*
Service Array	• Crisis Stabilization Units • Crisis Residential • Short-Term Crisis Respite	• Mental Health Rehabilitation Centers (MHRCs) • Skilled Nursing Facility (SNF) Special Treatment Programs (STPs) • County Funded SNFs • SNF Patch beds • SNF Neurobehavioral Unit (NBU)	• Adult Residential Facilities (ARF) • Residential Care Facilities for the Elderly (RCFEs) • Augmented Services Program (ASP) • Recuperative Care • Transitional Residential Services
Increase in % Utilization Over Current Level	+359%	+64%	+142%
Increase in Bed Day Utilization Over Current Level	+142,722	+46,084	+165,159

To achieve the optimal utilization, substantial recalibration across the three service categories is necessary, including over a 350% increase in utilization within community-based crisis diversion, over a 60% increase in utilization within subacute services, which includes substantial rebalancing of services, and nearly a 150% increase in utilization across community-based care. This would be achieved through incentivizing payment models, infrastructure and services, redistribution of services to best align with client needs, and an intentional effort toward prevention and health maintenance to divert unnecessary utilization of high acuity and restrictive care when there are more cost-effective and clinically appropriate alternatives.

As outlined in *Figure C.*, implementation of the OCP is projected to result in a reduction of approximately 40% in acute inpatient service utilization, including a decrease in administrative

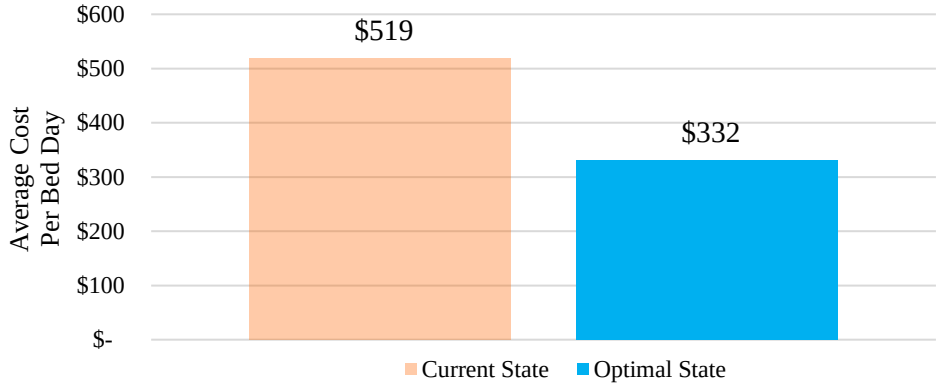
days. Psychiatric acute inpatient care, the most intensive level of care, provides crisis care to Medi-Cal eligible adults with acute symptoms of mental illness in need of 24-hour observation and intensive treatment in a locked hospital setting. Acute inpatient care is often utilized because of the lack of community crisis diversion services, subacute care, and community-based care.

Figure C. Projected Decrease in Acute Inpatient Utilization in Optimal Future State



Implementation of the OCP model is anticipated to *reduce the average cost per bed day across the services above by nearly 40%*, from an estimated $519 per bed day to about $330 per day, as outlined in *Figure D*. This change will occur because care pathways will be established to connect individuals in crisis to the care they need in the least restrictive setting, thereby reducing the unnecessary utilization of acute inpatient services. This transformation will likely take years and can only be achieved through a long-term commitment and coordinated efforts with facility operators, community partners, hospitals, those receiving services and their families, and other stakeholders.

Figure D. Estimated Average Cost per Bed Day



Optimal Care Pathways Service Categories

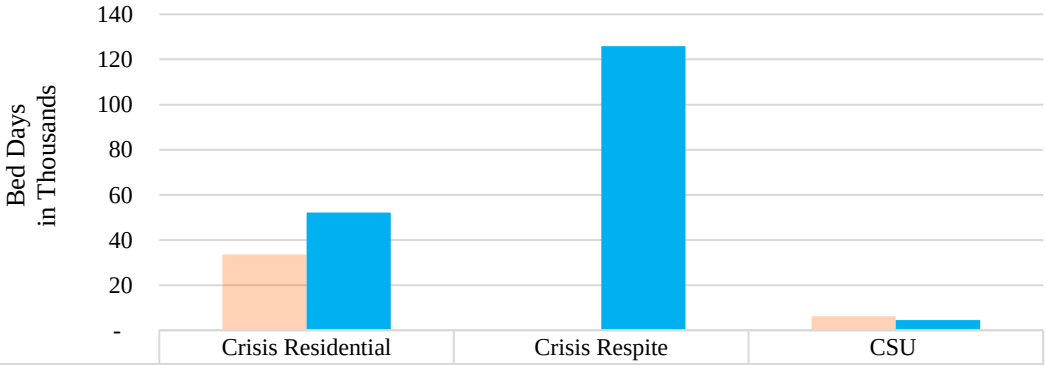
The OCP model data suggests that total bed utilization will need to *more than double current utilization levels* to meet the needs of all individuals who would otherwise be on waitlists, languishing in acute care, waiting to step down to lower levels of care, or not receiving care at all. However, to address capacity challenges and alleviate administrative days, the solution is not to increase acute inpatient capacity but rather to recalibrate and establish new capacity in subacute, community-based care, and community crisis diversion services that more effectively meet the unique needs of individuals in the least restrictive setting and can be offered at a substantially lower cost.

Community Crisis Diversion

Community crisis diversion services provide services that divert individuals in crisis from higher levels of care when their needs can be addressed via a lower level of care. Services include existing treatment programs, such as crisis stabilization units, mobile crisis response teams, and crisis residential services, along with short-term crisis respite services, which does not currently exist within the Continuum of Care.

To support the optimal flow of services across the system, the OCP model recommends the need to increase utilization capacity across community crisis diversionary services, as outlined in *Figure E.*, by *over 350% over current utilization, equivalent to an increase of over 140,000 bed days.* This includes an increase across short-term crisis residential services of approximately 55% or nearly 18,500 bed days and an establishing over 125,000 bed days in short-term crisis respite services as a new service to build out the full array of crisis continuum services.

Figure E. Optimal Community Crisis Diversion Utilization



	Crisis Residential	Crisis Respite	CSU
Current Utilization	33,643	-	6,156
Optimal Utilization	52,125	125,848	4,549

Crisis residential treatment programs provide crisis treatment services to adults with SMI who have high clinical needs, many of whom are experiencing homelessness. Services are offered as an alternative to hospitalization or to adults stepping down from acute inpatient care and may also include non-clinical models that are peer-led. Treatment services, including psychiatry, nursing, clinical and peer services are provided in a community-based residential setting by a

multidisciplinary team. Individuals are stabilized and connected to community supports and ongoing care. According to a SAMHSA report titled *Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies,* crisis residential services are an effective alternative to acute inpatient care at improving a client's symptoms and functioning, and overall costs are less than inpatient care.

Short-term crisis respite services provide person-centered behavioral health crisis and social support in a warm and welcoming setting for adults experiencing a behavioral health crisis. They may be peer-operated or a hybrid setting that includes peers and clinical staff. Services are voluntary and provided in a supportive residential environment as an alternative to psychiatric emergency services and provide critical service connection pathways to crisis stabilization units and mobile crisis response teams. Short-term crisis respite services are a critical care pathway within the crisis continuum because they divert individuals in crisis from unnecessarily hospitalization, and instead provide support in a less acute setting by peers and/or clinical staff. A SAMHSA presentation titled *Peer-run Respites: An Effective Crisis Alternative* indicates that respite guests were 70% less likely to use inpatient or emergency services, and respite days were associated with significantly fewer inpatient and emergency service hours. The OCP model projects that implementation of short-term crisis respite will yield on average *estimated cost avoidance of approximately $243,000 per bed annually* on average across all sectors.

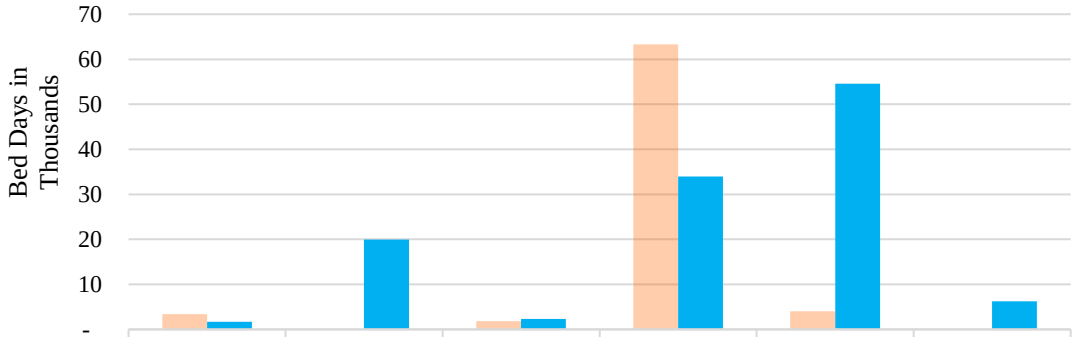
Subacute Services
Subacute care has historically been associated with long-term care within the San Diego County region and is provided to individuals who are stepping down from acute psychiatric care or for individuals whose acuity may have intensified and need a higher level of care. Services are provided on a 24/7 basis in a secured setting to adults who are unable to live safely in the community, and include room and board, health monitoring, medication therapy, individual, group and/or family therapy, case management, and discharge planning. Services offered provide structured daily programming to assist clients in improving functioning so they can return to live in the community.

Subacute care includes Skilled Nursing Facility (SNF) Patches, County-Funded SNFs, Department of State Hospital (DSH) beds, SNF-Specialized Treatment Program (STP) beds, County-funded SNFs, Mental Health Rehabilitation Centers (MHRCs), SNF Neuro-Behavioral Unit (NBU) beds, and DSH beds. Within subacute care, challenges continue with identifying care options for individuals who are incompetent to stand trial, forensic patients, and those waiting for State Hospital placement.

Within the OCP model, a key focus is to recalibrate current utilization within subacute care through investments in enhanced reimbursement rates to secure specialized beds that meet the needs of individuals with complex conditions, including NBU beds and County-funded SNF beds, along with some shifting across the system to optimize other bed types that are anticipated to be utilized less frequently once the new beds are established. As demonstrated in *Figure F*., across subacute

care the OCP model demonstrates the need to increase utilization by over 46,000 bed days, almost a 65% increase over the current utilization level.

Figure F. Optimal Subacute Care Utilization



	SNF (Patch)	County Funded SNF	SNF STP	MHRC	SNF-NBU	State Hospital
Current Utilization	3,400	-	1,861	63,277	4,031	-
Optimal Utilization	1,662	19,990	2,299	33,923	54,546	6,233

SNF patches are an enhanced daily rate paid to SNFs that provide mental health services to Medi-Cal eligible individuals on Lanterman-Petris-Short (LPS) conservatorship who cannot safely receive care in a less restrictive level setting due their acuity. SNF patches allow residential care to be provided full time and includes both a nursing and a clinical support within these facilities. The OCP model demonstrates minimal change in needs within this service.

County-funded SNFs provide nursing care, rehabilitation, custodial care, and other related health services to adults with a primary mental health condition who do not require hospitalization and for whom other types of less restrictive care has not met their needs. The OCP model demonstrates a dramatic increase in need within this service, by nearly 20,000 bed days.

Institute of Mental Disease (IMD) facilities provide treatment to individuals with mental health conditions in facilities that have more than 16 beds. SNF-STPs are IMDs that provide mental health services for patients who have a diagnosed chronic psychiatric condition and whose adaptive functioning is moderately impaired. The OCP model demonstrates minimal change in needs within this service.

MHRC are also IMDs that provide 24-hour intensive support and rehabilitative services to adults with mental illness who would have been placed in a state hospital or another mental health facility to develop skills to become self-sufficient and capable of increasing levels of independence and functioning. The OCP model demonstrates a decrease in the utilization capacity across MHRCs in the optimal state of nearly 30,000 bed days, or almost a 50% decrease from current utilization. This would be dependent on establishing additional utilization across SNFs, SNF-STPs, DSH, and

SNF-NBUs, along with the enhancements to community crisis diversion services and community-based care.

DSHs are State operated psychiatric hospitals for adults that provide evaluation and treatment for individuals with SMI and is the highest level of care available within subacute care serving clients who are unable to have their needs met in other settings. Adults in State Hospital care are on permanent LPS conservatorship and may be harmful to themselves or others. Currently, there are no clients from San Diego County in the State hospital because there is no capacity available, which has been the historical pattern due to inadequate availability of beds. As of August 2022, 36 clients were waiting placement for State Hospital beds. Within the OCP model there is a need for a modest utilization increase within this service by over 6,000 bed days.

SNF-NBU beds provide specialized neurobehavioral treatment and care to individuals who are Medi-Cal eligible and diagnosed with Traumatic Brain Injury or Neuro-Cognitive Impairment and SMI. An additional daily rate is paid to the facility by the County. As with the SNF patch, individuals are on conservatorship and unable to safely receive care in a lower level of care. This service is where perhaps the most dramatic increase is demonstrated within the OCP model of nearly 50,500 bed days.

BHS has continued to increase capacity across subacute care, as reported in previous Continuum of Care updates, expanding access to beds to individuals who cannot be placed in a less restrictive setting. BHS has increased capacity across the region by 165 beds since Fiscal Year (FY) 2018-19, with planning and negotiation efforts underway to further increase capacity through the addition of 51 beds in FY 2022-23.

Community-Based Care

The OCP model redefines long-term care, which has historically referred to beds within locked and secure facilities and institutions, expanding it to include community-based services and supports for individuals with ongoing care needs. Community-based care pathways are cost-effective and create step down pathways from higher levels of care along with diversion and prevention, when clinically appropriate, from unnecessary acute and subacute care, which is more expensive and often not the appropriate level of care. Offering a full array of client-centered services will provide individuals with the care they need to support positive health outcomes over their lifetime.

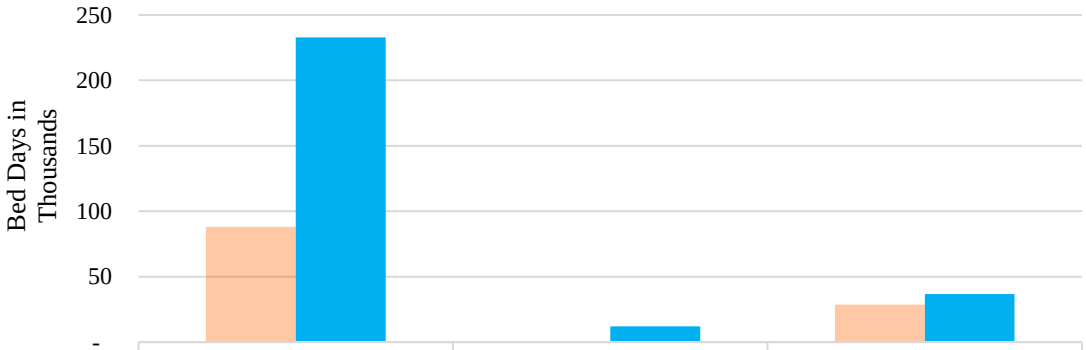
Community-based care is provided in adult residential facilities (ARFs) and residential care facilities for the elderly (RCFEs) that offer 24/7 care and supervision to Medi-Cal eligible individuals with various levels of clinical and social care to support recovery and rehabilitation within the community. Augmented Services Programs (ASP) provide enhanced support within licensed ARFs and RCFEs reimbursed through a daily rate with the goal of enhancing and improving recovery, developing client strengths, managing symptoms, and supporting self-sufficiency. BHS contracts with ARFs and RCFEs that accept the federal SSI rate to provide

additional individualized services to adults with SMI who are enrolled in case management or Assertive Community Treatment programs. BHS also provides rate enhancements through contracted ASPs. Over the last decade, BHS has experienced significant capacity loss across community-based care within ARFs and RCFEs, which has negatively impacted service delivery across the Continuum of Care.

Recuperative care services support individuals stepping down from secure settings by offering a welcoming environment that sustains stabilization; recuperative care prevents the likelihood of readmission by providing whole person care interventions.

The historical inequity and lack of parity that has plagued this level of care specifically for those with behavioral health conditions, continues to have devastating impacts resulting in people who remain in unnecessary higher levels of care, individuals who continue to be stuck in a cycle of homelessness because they do not have housing options, individuals who are incarcerated, and individuals who are unable to get care at all. Increases will be necessary within community-based care, as outlined in *Figure G.*, to meet the optimal utilization outlined within the OCP model.

Figure G. Optimal Community-Based Care Utilization



	ARF/RCFE/ASP	Recuperative Care	Transitional Residential
Current Utilization	87,965	-	28,566
Optimal Utilization	232,875	12,064	36,751

As demonstrated within the OCP model, a shift will be necessary to achieve the optimal state within community-based care, specifically within ARFs, RCFEs, ASPs, and transitional residential care, which project utilization increasing nearly 150% or over 165,000 bed days in the optimal state, to meet the unique needs of adults in the least restrictive setting.

Also included within the community-based care service area is recuperative care, which provides adults with behavioral health conditions who are experiencing homelessness a safe place to be discharged following hospitalization, when they would otherwise be transitioning in and out of expensive and unnecessary hospital care. This service provides short-term housing for adults to recover while receiving case management and connection to primary care, behavioral health services, and other supportive services, including transportation, food, and housing.

As outlined within the OCP model, a utilization increase of at least 12,000 new bed days is projected within recuperative care, a service which does not yet exist within the continuum of care. Additionally, the BHS model projects that implementation of recuperative care services is estimated to *yield average cost avoidance of approximately $132,000 per bed annually* across all sectors.

The final service that demonstrates a need for increased utilization in the optimal state is transitional residential care. This service provides a therapeutic environment to support adults in acquiring and applying interpersonal and independent living skills, while supporting the development of a personal community support system to minimize the risk of hospitalization. Within the optimal model, transitional residential care demonstrates an increased utilization of nearly 30%, equivalent to over 8,000 bed days. Community-based care capacity is critical to shift away from unnecessary utilization of high acuity services utilization and high-cost crisis care.

BHS continued to expand community-based care with the addition of new capacity in 2021, including nine enhanced ASP beds for older adults in an RCFE, and 48 enhanced ASP beds for adults within a new ARF. BHS will pursue an additional 100 new ASP beds that will include enhanced reimbursement rates through a Request for Statement of Qualification process to further build capacity within the system. Additionally, BHS will continue to evaluate rate reimbursement for existing ARFs, RCFEs, and ASPs to preserve current capacity to ensure capacity is not diminished and bring forth funding recommendations in future Operational Plans.

Inequity and Lack of Parity in Community-Based Care

One of the more palpable symptoms that continues to plague our region and illustrates the need for expanded step-down and community-based care is the disproportionate rate of psychiatric acute inpatient administrative days. Administrative days occur when a client is no longer in need of acute hospital care and is unable to step down to a lower level of care due to a lack of available placement to meet their individual needs. Essentially, they remain "stuck" in acute care. Additionally, on the front end, the lack of community-based care placement options has resulted in missed opportunities for diversion from unnecessary utilization of acute care. Consistent overutilization of administrative days across the system is driven by a need for additional options for lower levels of care.

Historically, California has lacked parity as it relates to care and supervision for people with SMI, and the disparities in access to long-term care between those enrolled in Medi-Cal and those with commercial insurance or who are able to pay privately is especially pronounced. A 2018 report released by the California Behavioral Health Planning Council cited insufficient funding, staffing, and "Not in My Back Yard" (aka "NIMBYism") as the most common factors contributing to the loss of licensed beds, with funding highlighted as the most significant issue. ARFs accepting the federal SSI rate, which in 2021 was slightly over $1,200 per month, were typically unable to support the costs to staff a facility on a 24/7 basis, training, insurance, licensure, utilities, food, transportation, routine maintenance, and other costs necessary to license and operate an ARF, thus

causing ARFs to typically operate at a loss unless they received substantial patch funding. Additionally, ARFs serving more than six residents are subject to zoning and permitting requirements, which is often where NIMBYism presents a barrier.

Locally, the majority of ARF operators in San Diego County do not accept the federal rate opting instead to serve private pay clients at more lucrative rates that may exceed $6,000 per month, or *nearly five times the federal reimbursement rate.* Facilities also may opt to serve individuals with physical or developmental needs due to the higher tiered funding. The Lanterman Developmental Disabilities Services Act guarantees services and supports to individuals with developmental disabilities through regional centers who may place clients in ARFs and RCFEs at reimbursement rates ranging from $1,211 per month (Level 1) to $9,891 per month (Level 4) depending on level of acuity. In contrast, as mentioned above, adults with SMI who are Medi-Cal eligible only receive reimbursement of the federal SSI rate of slightly over $1,200 making placements within these settings challenging. Due to the low reimbursement rates, many of the ARFs and RCFEs do not serve Medi-Cal eligible individuals with SMI. The outcome is often individuals with behavioral health needs that are left homeless, institutionalized, and/or on extended stays in acute care settings - all resulting in a higher risk of poor health outcomes.

These challenges combined with the escalating cost of real estate have incentivized or forced licensed community-based care facilities in California that serve individuals with SMI at a federal rate to close their doors, thereby reducing capacity across the region and hindering individuals from accessing proper care and housing. According to the State's Community Care Licensing Division data, since 2017, 146 of the 781 licensed ARFs in San Diego County, or 19%, have closed decreasing the number of available beds by over 2,500. Additionally, 138 of the 719 unique RCFEs in the county, or 19%, closed their doors reducing the number of people served by over 1,350. The decreasing number of ARF and RCFE facilities paired with the even fewer that accept individuals who are Medi-Cal eligible continues to be a barrier to client flow across all levels of care, often leaving people unable to step down out of higher levels of care.

Strategies to Advance the Optimal Care Pathways Model

Strategy: Establishing Dedicated Infrastructure and New Services

Community-Crisis Diversion

To build out a full continuum of crisis services, additional crisis residential services and new short-term crisis respite services will be needed. These services will divert individuals from unnecessary utilization of higher levels of care, reduce hospital re-admissions, unnecessary involvement with law enforcement, and support clients in achieving permanent housing. Establishing these new services will open new less expensive care pathways, thereby reducing the cost per capita to care to alleviate the ongoing pressure of administrative days. Recommendations to establish and enhance short-term crisis respite and crisis residential services will be brought before the Board in the future.

Subacute Care
The collaborative efforts with Alvarado Hospital, as described in Attachment A, will enable the County to shift acute inpatient care provision from the San Diego County Psychiatric Hospital (SDCPH), an IMD revenue-excluded facility, to Alvarado Hospital, a General Acute Care Hospital. This uniquely situates the County with an opportunity to establish new subacute services within the SDCPH. BHS will also bring forward recommendations for the new array of services at the SDCPH facility at a future Board meeting.

Community-Based Care
To expand community-based care capacity BHS is recommending the commencement of planning efforts, in partnership with County Department of General Services (DGS), to design and construct a new Central Region Community-Based Care facility on the Third Avenue property. Planning is underway to determine the design and array of services, which will likely include ARF, RCFE, and recuperative care dedicated for individuals with behavioral health conditions who are Medi-Cal eligible. Recommended actions will be brought before the Board in the future.

In addition to establishing new dedicated capacity in the Central Region, BHS is also working with DGS to design and develop a new East Region Community-Based Care facility. The service array planned for this facility will also be likely to include ARF, RCFE, and recuperative care dedicated for individuals with behavioral health conditions who are Medi-Cal eligible. Recommended actions will be brought before the Board in the future.

To support the capital development of the Central Region Community-Based Care and East Region Community-Based Care projects, BHS will be submitting applications for Community Care Expansion (CCE) Capital Expansion grant funds. CCE Capital Expansion grant funds are available through a competitive process to support the acquisition, construction, and rehabilitation of residential care settings, including ARFs, RCFEs, peer respite, recuperative care, permanent supportive housing, and other residential care that serve the target population. Funding available to the Southern California region totals approximate $100.5 million. If awarded the grant, BHS will return to the Board at a future date with recommended actions.

Strategy: Innovating Payment Models
Subacute Services
To achieve more person-centered care, remove barriers, and improve utilization of beds across the system, additional capacity and rate enhancements are needed to serve individuals with specialized needs within the lowest level of care, including those with forensic involvement, individuals on the State hospital waitlist, and/or those with complex conditions who often languish in higher levels of care because they are difficult to place or lack options within community-based care. More specifically, this will require enhanced rates to increase utilization capacity within County-funded SNF, DSH beds, and NBU beds to place individuals with complex needs.

Innovating payment models will establish new care pathways and rebalance utilization thereby opening capacity to support individuals with specialized needs to ensure they can receive the proper type of care that meets their needs. It is anticipated that removing these barriers will result in higher quality clinical care and reduce the pressure on crisis stabilization units, the unnecessary utilization of acute care, and reduce the waitlist for MHRCs. It will also provide transitional support for people experiencing an acute behavioral health need when they are discharged from an inpatient psychiatric hospital.

Community-Based Care
To minimize the diminishing community-based care capacity across the region, a commitment to innovating payment models for existing ARFs, RCFEs and ASPs will be critical to stabilize these critical services. In the immediate term, this will be supported partially through the disbursement of one-time, non-competitive CCE Preservation Program Operational Subsidy Payment funding of $3.4 million authorized for acceptance by the Board on June 28, 2022 (4). This funding will be available for licensed residential and senior care facilities serving applicants and recipients of Supplemental Security Income/State Supplementary Payment (SSI/SSP) or Cash Assistance Program for Immigrants (CAPI), including those who are experiencing or at risk of homelessness. Planning for the disbursement of these funds is underway and will be submitted to the State for approval prior to being allocated.

Beyond the CCE Preservation Program funding a commitment will be necessary to increase ongoing investments to support existing ARFs, RCFEs, and ASPs long-term and to entice new operators to begin serving Medi-Cal eligible individuals, including individuals with specific needs such as clients with forensic involvement, and other populations that have historically faced barriers to placement. Making substantial investments over the next several years to preserve existing capacity and ramp up new community-based care capacity will result in future cost avoidance attributed to diversion of clients from higher levels of care and the ability to step clients down into lower and less expensive levels of care. Reducing unnecessary utilization of higher levels of care is also expected to free up acute inpatient and subacute beds for those in need, which is projected to decrease psychiatric inpatient administrative days.

Strategy: Preserving Existing Infrastructure
Community-Based Care
Through the same CCE Preservation Program, the County has been tentatively allocated one-time, non-competitive funds for Capital Preservation totaling $9,109,544. This funding will be allocated to licensed residential adult and senior care facilities that serve individuals receiving SSI/SSP and CAPI for physical repairs or upgrades that support facility compliance with licensing standards to avoid closure. Planning for the disbursement of these funds is underway and will be submitted to the State for approval prior to being allocated.

In 2020, California Assembly AB-2377 established a requirement that counties and cities be given the first opportunity to make an offer to purchase facilities planned for closure and to take over

operations. This legislation offers a unique opportunity to acquire existing properties. Once receiving the notice of sale, a county only has 60 days to notify the owner of its intent to purchase a property. To further support for counties in expanding community-based care opportunities, on May 1, 2021, California Assembly AB-1766 began requiring the Community Care Licensing Division to provide county behavioral health departments with quarterly reports that include licensed ARFs and RCFEs accepting the federal rate and serving individuals with SMI that have closed in the prior quarter. It includes community-based care facilities for sale, with counties having the first opportunity for purchase. The County will explore opportunities and possible funding as a result of AB-2377 and return to the Board at a later date with recommendations.
Additionally, BHS has commenced planning efforts, in partnership with DGS, to identify potential real estate opportunities that would accelerate the build out of community-based care options within the region. Due to the extensive array of capital projects underway and planned, DGS is developing a Strategic Facilities Plan (SFP) to identify infrastructure requirements for BHS. SFPs are professionally prepared reports analyzing portfolios of current facilities, their condition, location, program requirements, and any gaps in service provision. The SFP will support a data-driven and coordinated approach for assessing the placement and need of new facilities or replacement of existing facilities, along with supporting the regional distribution of services across the county.

Strategy: Enhancing Equity through Community Engagement
To advance equity and to ensure services are regionally distributed and built to meet the needs of populations who have been disproportionally underserved, BHS will thread the work outlined within the OCP model to efforts currently underway through the Community Experience Partnership (CEP). The CEP is a collaboration between BHS and the University of California San Diego to integrate data and community engagement to advance behavioral health equity. The Behavioral Health Equity Index allows the public to view behavioral health equity data through dashboards that include data from surveys, vital records, hospitalization, and emergency departments, along with service and outcome data for individuals receiving services through BHS. It also includes indicators of equity over time and across neighborhoods by race/ethnicity, gender, sexual orientation, age, justice involvement and more.

BHS will pursue efforts to connect the Behavioral Health Equity Index work to the OCP model integrating two immensely impactful bodies of work to inform where the highest priority area of future investment to address inequity that currently exists. This will support regional distribution of services across the communities most in need to ensure they have access to behavioral health care in close proximity to where they live.

Additionally, to advance equity across the behavioral health continuum of care, planning is underway to establish ongoing convenings organized around shared community identity, including racial and ethnic identity, in San Diego County. These convenings will include representation from communities that have been disproportionately impacted by behavioral health issues, including people of color, LGBTQ+, low-income families, and individuals from underserved communities

and will be touchpoints for the culturally variable and community-specific social construction and stigmatization of mental illness and substance use disorder. They will inform the design, program planning, and implementation of behavioral health services to support the development of a system that addresses inequity and builds capacity for communities that have historically faced systemic barriers to wellness. The councils will advise, guide, develop, and make recommendations on advancing equity for unserved and underserved children, youth, transition age youth, adults, and older adults with behavioral health needs across the region.

Strategy: Building a Sustainable Public Behavioral Health Workforce
Enhancing services across the region will also result in an increased need for the public behavioral health workforce and other health workers that are critical in providing care for clients. As outlined in the recent *Behavioral Health Workforce – Addressing San Diego's Behavioral Health Worker Shortage* report facilitated by the San Diego Workforce Partnership, the region is roughly in need of over 8,100 new public behavioral health workers across the county to meet today's need across the system. Continued advocacy and action will be necessary to bolster the workforce in a meaningful way that can attract and retain essential behavioral health professionals.

Strategy: Advocating for Parity Across Reimbursement Rates
As outlined previously, the system of community-based care was constructed in a way that unintentionally results in parity across reimbursement rates for individuals with behavioral health conditions who are Medi-Cal eligible and in need of care within ARFs and RCFEs. To preserve the existing infrastructure and services, and to incentivize new service providers to provide services to individuals with behavioral health conditions the County must strongly advocate for State and federal legislation that supports adequate reimbursement for community-based care. Without adequate reimbursement rates the system will continue to struggle in identifying providers willing to accept clients who are Medi-Cal eligible with behavioral health conditions.

Strategy: Aligning the Office of the Public Conservator
In alignment with the OCP model, a companion Board action brought forward today will recommend formal action to shift the Office of the Public Conservator (Public Conservator), which is currently situated within the County HHSA, Aging & Independence Services, under the oversight of BHS. If approved, the realignment of the Public Conservator under BHS will align clinical oversight and management of services in support of adults with SMI who are on a Lanterman-Petris-Short conservatorship. It will support collaborative and centralized coordination of services to ensure conservatees have access to all necessary treatment, resources, and community supports to facilitate recovery.

It also optimally situates BHS in anticipation of the implementation of Community Assistance, Recovery and Empowerment (CARE) Court, which will require close collaboration across care teams. Under CARE Court, adults with behavioral health conditions who meet certain criteria may be referred by family members, first responders, and other health professions for a clinical evaluation, which may result in court-ordered participation in CARE Court for up to 12 months,

with the possibility to extend for an additional 12 months. CARE Court centers around adherence to an individualized CARE plan, which may include treatment and medications, wellness and recovery services, and connection to social supports, including housing.

The Impact of the Optimal Care Pathways Model

Advancing toward the future state of the Optimal Care Pathways model is anticipated to have a resounding impact on the behavioral health continuum of care and result in more client-centered outcomes that advance health equity and address the lack of parity for individuals with behavioral health conditions, as follows:

- Clients will have new diversionary care pathways that connect them to ongoing care long term to *prevent homelessness and/or incarceration*.
- Clients will have *improved access to care through regionally distributed services* that are in close proximity to where they live.
- Clients will be connected to the level of long-term care that meets their unique needs over their lifetime *advancing equity and enhancing population health outcomes*.
- Capacity across the system will increase while the *cost per capita decreases* as less expensive care pathways are established that reduce unnecessary utilization of higher levels of care.

If the optimal system is fully built out through increases in capacity, supported by infrastructure preservation and investments, rate enhancements, and improved administrative processes, a decrease of over 40% in acute care utilization is anticipated due to new care pathways being available. However, it can only occur if a long-term commitment is made to recalibrate and establish adequate ongoing resources that support the expansion of community crisis diversion, community-based care, and subacute services, and infrastructure.

The OCP model guides where additional enhancements and investments are needed to support client-centered care and is expected to evolve as new care pathways are opened and as new initiatives, including CARE Court and CalAIM are operationalized. BHS will continue to assess and update the algorithm and bring forth recommendations to pivot strategies and will bring forward recommendations in future Board actions.

Strengthening and Innovating Services for Children and Youth

The broad aim of the Continuum of Care strategy is applicable to all ages in that integrated and preventative services are the key to improved outcomes over time and should be tailored in ways that reduce health disparities. According to the U.S. Department of Health and Human Services, one in five children 17 and under experience a mental or emotional disorder, with 50% of mental illness beginning around age 14. Data also demonstrates there has been a steady increase in suicide rates among youth on a national level. Locally, we see indications in screening data that demonstrate our youth are vulnerable to future behavioral health conditions. Middle schoolers (ages 12-14) in particular, have 200% higher rates of psychological distress compared to adults (ages 18+).

While children are growing, they have distinct clinical needs and social considerations which warrant a strategic approach different from how we care for adults. Moreover, the evidence is clear that implementing earlier interventions in the lives of young people is the best way to build protective factors, promote resiliency, and wellbeing. Current strategies to further build and enhance the Continuum of Care for children and youth are outlined below and detailed in Attachment A.

Strategic Domain #1: Family System Work and Supports

Results from the National Survey of Children's Health indicate that 1 in 14 youth have a parent who has poor mental health and that those youth are more likely to have poor general health or have a mental health or behavioral disorder themselves. Youth rely on their families and the adults who care for them to meet their needs, and their involvement is crucial to ensuring optimal health outcomes.

BHS envisions programs serving youth and families focused on:

- Offering family visits and/or requiring family therapy whenever clinically appropriate,
- Ensuring programs are connecting youth to enriching social activities (e.g., community sport teams, local library groups, etc.) which are fundamental to healthy development, and
- Continued partnerships with cities and other organizations to provide enriching activities in safe environments that are accessible and available to all residents.

Critical to mental health development in children is parent and caregiver engagement. Parenting and caregiver skill development and strengthening engagement of fathers have been demonstrated as practices which support positive childhood experiences and reduction of the impacts of Adverse Childhood Experiences (ACEs). The impacts of the COVID-19 pandemic over the past several years have contributed to increases in youth and adult anxiety, depressive symptoms, and family stress. In alignment with efforts to support youth and families, BHS has provided parenting and caregiver skills development services and services to improve attitudes towards fathering and strengthening engagement of fathers in their children's lives to prevent and address risks associated with ACEs through contracts for the Positive Parenting Program and the Father 2 Child Program.

BHS, with its community partners, plans to conduct a community engagement and program development process to include focus group discussions with parents and caregivers of young children, and mental health and child development professionals. This process aims to identify innovative, new approaches and best practices to build stronger resiliency in children, supports for parents and caregivers, and increase family involvement and engagement to strengthen emotional wellness in children and activate protective factors for children and their families. Culturally and community specific services will be explored as part of this development of prevention and early intervention efforts. The lessons from this process will inform procurement planning for new services to support children and families.

To ensure there is no disruption in services while this community engagement is underway, today's action requests authority to extend the following two contracts through September 30, 2023:

- Contract #541201 Father 2 Child (Mental Health America of San Diego County)
- Contract #553898 Positive Parenting Program (Jewish Family Service)

Strategic Domain #2: School Engagement and Care Opportunities

As noted above, an estimated one in five children ages 3 to 17 have a mental, emotional, developmental, or behavioral disorder and as early as 7th grade, one in eight youth report having suicidal thoughts. Aside from the home, there is no other place where youth spend more time than schools making them an ideal setting to identify and engage youth in needed services. This domain focuses on continued engagement and screening of children in schools to identify opportunities for early interventions and prevent more advanced behavioral health conditions from developing. The Screening to Care initiative, further described in Attachment A, is a key service within this domain that provides universal screening and intervention to middle school students, regardless of their insurance status.

Strategic Domain #3: Healthcare Integration

Accessing care early and at the lowest level of need is important in promoting positive outcomes. Often stigma, fear, and other factors can be barriers to care. In 2020, 1 in 3 teens locally reported needing help for an emotional and/or mental health condition, yet over a fifth did not receive counseling within the previous year. Many families trust and access physical health care for their children through primary care providers who can offer integrated access to behavioral health services, when needed. This domain focuses on creating a strong connections and pathways to behavioral health care through the primary care to improve the family experience and provide opportunities for earlier intervention, which yield better health outcomes.

ENVIRONMENTAL STATEMENT

Today's actions for authorizing a construction contract for the East Region Crisis Stabilization Unit first phase of design are exempt from CEQA pursuant to Sections 15061(b)(3) and 15262 of the State CEQA Guidelines. Section 15061(b)(3) is applicable because it can be seen with certainty that this action has no potential to cause a significant effect on the environment. At this time, the Board is only authorizing pre-construction services for the East Region Crisis Stabilization Unit. Once design is complete, staff will return to the Board for direction and approval to potentially move forward, make changes to, or not move forward with the project, at which time the appropriate CEQA review will accompany any future Board actions. Section 15262 is equally applicable because the actions before the Board include feasibility analysis and design for possible future actions that do not commit the County to any definitive course of action. Subsequent actions would be reviewed pursuant to CEQA and presented to the Board as required for consideration prior to implementation or use of any acquired property.

SUBJECT: RECEIVE AN UPDATE ON ADVANCING THE BEHAVIORAL HEALTH CONTINUUM OF CARE, AUTHORIZE CONSTRUCTION CONTRACT FOR THE EAST REGION CRISIS STABILIZATION UNIT, AND RECEIVE THE OPTIMAL CARE PATHWAYS MODEL (DISTRICTS: ALL)

LINKAGE TO THE COUNTY OF SAN DIEGO STRATEGIC PLAN
Today's proposed actions support the County of San Diego's 2022-2027 Strategic Plan initiatives of Equity (Health) and Community (Quality of Life) as well as the regional *Live Well San Diego* vision, by reducing disparities and disproportionality of individuals with mental illness and substance use disorders and ensuring access to a comprehensive continuum of behavioral health services administered through accessible behavioral health programs.

Respectfully submitted,

HELEN N. ROBBINS-MEYER
Chief Administrative Officer

ATTACHMENT(S)
Attachment A – Behavioral Health Services Continuum of Care Key Updates