RESPONSE TO PROPOSAL ON THE FUTURE STATE OF BEHAVIORAL HEALTH SERVICES SET FORTH BY LEADERSHIP ON FRIDAY, JULY 17TH

Thank you for the opportunity to continue dialogue about the future state of our behavioral health services offered at AHS. In response to leadership's proposal, we are in general support of Option #3 and we are thankful that we can continue IOP. That said, we have significant concerns about aspects of Option #3 as well as some suggestions about how to make Option #3 the best possible version of itself. The following are our recommendations in light of currently having no information about proposed budgets for any of these programs. As such, our recommendations are frugal. You will find these suggestions and concerns described as they relate to the three pillars of Option #3: PHP/IOP, A Wellness Center, and an Outpatient Clinic.

PHP/IOP

A. **MFT's in PHP/IOP** – MFT's are crucially needed to run IOP/PHP. We believe any change based strictly on the idea of replacing MFT's with "credentialed" (eligible Pro-fee billers) staff to raise revenue disregards the detrimental clinical implications of removing MFT's. The idea that MFTs cannot bill Medicare in the IOP model is technically not true – MFT's have been providing services which are billed under the license of our program's medical director. This has been the case since the beginning of our program more than 20 years ago. Furthermore, there is no need to shift MFT staff out of IOP in order to benefit from additional pro fee revenue. We have seven eligible pro fee providers who can bill for at least 2 to 3 groups of 10 Pts each week for a total of 140 to 160 fees per week. That translates to $438,000 to $500,000 additional revenue per year without altering the current staffing structure of IOP. ($60 pro fee X 140 to 160 X 52 equals $438,000 to $500,000).

B. **Pro Fees** - IOP has a long and successful track record of being profitable and until recently has not needed to bill for pro fees. As a way to address the current financial situation, it was our IOP staff that first identified pro-fees as a way to increase revenue and we are happy to bill for pro fees. Our tenured MFT's, who have been fundamental to and instrumental in building our program, and without whom, our program would not be the success that it is, should not be targeted for reassignment based solely on pro fees when there are numerous other methods available to us to increase revenues. For future hires we can prioritize pro-fee eligible clinicians.

C. **Length of Stay** - Length of stay in the IOP is determined by clinical necessity for each patient. Medical necessity is clearly defined by CMS for PHPs and IOPs to assist our medical staff and treatment team in making those decisions on our population of SPMI Pts' length of stay. Length of stay can vary widely in duration and has many determinants. Patients should be evaluated at regular intervals using clinically established parameters to determine their ongoing treatment needs and when they can

be safely stepped down to a lower level of care. With an appropriate drop-down option on site (as well as the step-up option back to IOP), there is a greater likelihood of stepping appropriate clients down to it.

D. **Transportation** – Our Transportation Department is essential to accessing our services both in the Wellness center and PHP/IOP. It ensures accessibility and increased attendance.
    - We estimate an increased attendance rate of 40% with our own transportation, and we expect a significant drop in attendance without it. The dollars invested in our transportation return to us multifold in increased revenue.
    - Individuals who go to Wellness Centers or IOPs often have symptoms such as paranoia, thought disorganization, and depression that prevent them from driving or taking public transportation. Coordinating transportation is next to impossible for many IOP/PHP clients.
    - Having drivers that are an integral part of our Tx program who understand how to interface with severe mental illness increases Pts' sense of safety significantly, and improves treatment outcomes.
    - Transportation is fundamental to the IOP model as intended. It facilitates easy transition from inpatient to IOP which enables continuity of care.
    - Dr. Sidhartha has suggested we use coordinated transportation as a selling point for patients and case managers. Our shared goal is to bring more Pt's from John George to Fairmont IOP/PHP.

Wellness Center

A. **Budget & Staffing For Wellness Center** – We suggest that the staffing for a Wellness Center be comprised of the following:

    - 2 - 4 Best Now peer support specialists supported by county funding
    - 5 additional student interns
    - The necessary licensed staff from IOP to support daily operations
    - Continued sharing of established transportation services with IOP when needed to make services accessible for clients

    We need MFT expertise to support the wellness center. The wellness center is supposed to be staffed with peers and students with only a minimal number of licensed staff to support it. We feel, given the level of acuity of moderate to severely mentally ill participants expected to come to the wellness center, as well as the inherent management and liability issues that will inevitably arise, wellness center success will require an increased licensed therapist presence to provide guidance oversight, program planning and supervision.

Clinical staffing needs between the IOP/PHP and Wellness Center levels of care may be reassessed after the first year as we gain a better sense of the population size within each therapy group, crisis support needs of the wellness center, and supervision of interns for Wellness Center and Outpatient clinic.

This staffing from IOP assumes that we will move a percentage of the currently most stabilized IOP clients to the Wellness Center to allow for continuity of care for them as the IOP transitions to have an in-house step down program.

B. Location for the Wellness Center - The top floor of H building has recently been vacated and offers an ideal location for a Wellness Center. H Building is well suited for the following reasons:

- It is within a short walking distance of the current IOP program which facilitates ease of transfer between programs.
- It has several large rooms which could be well-configured for various activities.
- It is on the second floor which would permit first floor security screening prior to anyone accessing the space.
- It is a short distance from John George Psychiatric Hospital

Our current IOP program, when up to capacity, utilizes all available group rooms on the top floor of C-Building, and sometimes at least one on the 1st floor. A blending of both IOP and Wellness Center patients in the same space would potentially be problematic for some the following reasons:

- Increases the potential for conflict between patients who would otherwise be unknown to one another.
- We want ease of access for people with mild to moderate Sx's who might be intimidated by people with more severe Sx's.
- Increases the potential for crowding in our restroom and break room facilities.
- Increases the potential for increased communication of infectious diseases like Covid-19, the flu, and colds.

Keeping patient populations and respective program staff housed in their own designated locations will be essential for the functioning health of both programs!

We are also expected to operate a large outpatient clinic in the C building space further exacerbating the above concerns.

C. Security – Fairmont Hospital IOP clinic and staff have experienced a number of incidents of unwelcome intruders that included physical threats of violence and at least 2 incidents of actual violent behavior directed at staff. This raises a number of security

concerns that need to be addressed with a wellness center that is drop-in by design and that accepts clients who may be currently using substances, medication non-compliant, and/or with acute symptoms.

- How to keep unstable clients from destabilizing stable clients, particularly in IOP/PHP. (As suggested earlier, it will be vital to keep Wellness Center and PHP/IOP patients separate from one another)
- Clients will need to be screened before being allowed entry into the building and clinic, and this will need to be carefully developed.
- How to protect staff and other clients from verbal and physical abuse from destabilized clients. (e.g. having an internal security presence)
- How to protect other staff in the building that are not associated with OBHS.

Outpatient Program

Concerns about the current and future Outpatient Program – Over the last 3 years we have attempted an Outpatient Pilot Program with 3-5 part-time MFT and LCSW providers, who are also providing IOP services. A number of unresolved challenges remain:

1. During the times when the outpatient program was accepting patients there was a 50 - 60% no-show rate for intakes and on-going sessions. The average number of sessions attended varied significantly per patient, but it was very difficult to maintain an average of 6 sessions per day per staff member. The reasons for no-shows included transportation challenges, no sessions available after 6pm or before 8am (work hours), and a variety of other reasons. There was low interest in group therapy offerings, and moderate interest in individual sessions.
2. The largest request for services was for a prescribing psychiatrist. Many referrals were under the impression that they could receive medication through the outpatient clinic. Our IOP psychiatrists were able to provide some consultation for PCP prescribers but were unable to prescribe medications directly as we are NOT a med clinic for mild to moderate insurance. When some patients learned that they would not be offered medication they stopped attending sessions
3. Currently we have one staff member (not Medi-Cal certified) that sees children and adolescents. A high number of referrals were for children and adolescent services. Many of these requests were for psychiatric evaluations and pediatric medication evaluations that had been recommended/referred by schools or pediatricians. Currently we have no staff that are able to provide psychiatric evaluations or psychiatric medications for children and/or adolescents. Finding referrals for these patients was difficult and time-consuming. None of our staff currently meet contracted Medi-Cal certification standards for providing services to children and we have no pediatric psychiatrist or psychologists who are able to provide psychiatric evaluations or

medication evaluations. We need certified, profession child therapists at the outpatient clinic.

4. English as a second language or non-English speakers comprised 40-50% of the referrals received in the outpatient clinic. Providing therapy through a translator was awkward and made it quite difficult to establish rapport with patients, resulting in poor attendance. Hiring providers that can speak Spanish, Tagalog and Cantonese is the highest necessity in the outpatient clinic. Utilizing MFT's currently from the IOP program will not fill this need.
5. Currently the staff in the outpatient program are working to build infrastructure and appropriate measures of mental health services. Leadership to date has not provided: sufficient intake paperwork, assessment tools, referral options, nor general guidelines clarifying the level, type or duration of services provided. We are not at this time able to provide sufficient substance use treatment, autism spectrum treatment, or severe trauma intervention based on the short-term model of care that has been adopted.
6. Billing has been a monumental problem over the last 3 years of the outpatient program. At least 12 to 18 months of services were never billed due to the lack of administrative support and Billing Department confusion around billing procedures. Patients in the outpatient program often gain, lose or change their insurance benefits, and require regular assessment and verification of coverage in order to receive consistent payment for services.
7. The outpatient clinic needs to have more staff than three part-time IOP therapists (who are also running IOP) to function. Numerous proposals have been submitted that provide the minimum staffing to adequately operate.

To date, none of these issues have been acknowledged or addressed in the current outpatient program proposals. Instituting an outpatient program in the current format, without significant support or revision, will almost certainly result in a significant loss in revenue return. All of these issues will need to be addressed to ensure a successful outpatient program.

We again thank you for your consideration of these important concerns, and look forward to developing together a mental health delivery line that is comprehensive, well-staffed and meets the needs of everyone needing mental health services in our community.