

## Chapter Six

# Health Services

### **Section 1: General Principles**

Counties are mandated to protect Californians against threats of widespread disease and illness and are tasked with promoting health and wellness. This chapter deals specifically with health services and covers the major segments of counties' functions in health services. Health services in each county shall relate to the needs of residents within that county in a systematic manner without limitation to availability of hospital(s) or other specific methods of service delivery. The board of supervisors in each county sets the standards of care for its residents.

Local health needs vary greatly from county to county. Counties support and encourage the use of multi-jurisdictional approaches to health care. Counties support efforts to create cost-saving partnerships between the state and the counties, and other organizations to achieve better health outcomes. Therefore, counties should have the maximum amount of flexibility in managing programs. Counties should have the ability to expand or consolidate facilities, services, and program contracts to provide a comprehensive level of service and accountability and achieve maximum cost effectiveness. Additionally, as new federal and state programs are designed in the health care field, the state must work with counties to encourage maximum program flexibility and minimize disruptions in county funding, from the transition phase to new reimbursement mechanisms.

Counties also support a continuum of preventative health efforts – communicable disease control and chronic disease prevention – and the inclusion of public health in the design and planning of healthy communities. Counties also support efforts to prevent and treat substance use and mental health disorders. Preventative health efforts have proven to be cost effective and provide a benefit to all residents.

Federal health reform efforts, including the Patient Protection and Affordable Care Act (ACA) of 2010, provide new challenges, as well as opportunities, for counties. Counties, as providers, administrators, and employers, are deeply involved with health care at all levels and must be full partners with the state and federal governments to expand Medicaid and provide health insurance and care to a broader population of Californians. Counties believe in maximizing the allowable coverage for their residents in accordance with eligibility criteria, while also preserving access to local health services for the residual uninsured. Counties remain committed to serving as an integral part of any effort to reform California's health system.

At the federal level, counties also support economic stimulus efforts that help maintain services levels and access for the state's neediest residents. Counties strongly urge that any federal stimulus funding, enhanced matching funds, or innovation grants that have a county share of cost be shared directly with counties.

## **Section 2: Public Health**

County health departments and agencies are responsible for protecting, assessing and assuring individual, community and environmental health. Public health agencies are tasked with controlling the spread of infectious diseases through immunizations, surveillance, disease investigations, laboratory testing and planning, preparedness, and response activities. Furthermore, county health agencies are tasked with evaluating the health needs of their communities and play a vital role in chronic disease and injury prevention through education, policy, system, and environmental changes promoting healthier communities.

County health departments are also charged with responding to public health emergencies, ranging from terrorist and biomedical attacks to natural disasters and emerging infectious diseases, including maintaining the necessary infrastructure – such as laboratories, medical supply, and prescription drug caches, as well as trained personnel – needed to protect our residents.. Currently, counties are concerned about the lack of funding, planning, and ongoing support for critical public health infrastructure.

County health departments are also working to reduce health inequities with efforts to eliminate barriers to good health and support the equitable distribution of resources necessary for the health of California’s diverse population. Strategies include working with other sectors to maintain and expand affordable, safe, and stable housing; ensuring a health equity lens is applied to economic and social policies to identify and address unintended consequences and potential effects on vulnerable populations; and collecting, analyzing, and sharing information to understand and address the health impacts of discrimination and bias.

- 1) To effectively respond to these local needs, counties must have adequate, sustained funding for local public health communicable disease control, epidemiological surveillance, chronic disease and injury prevention, emergency preparedness, planning and response activities, and other core public health functions.
- 2) Counties support the preservation of the federal Prevention and Public Health Fund for public health activities, and oppose any efforts to decrease its funding. Counties support efforts to secure direct funding for counties to meet the goals of the Fund.
- 3) Counties believe strongly in comprehensive health services planning. Planning must be done through locally elected officials, both directly and by the appointment of quality individuals to serve in policy and decision-making positions for health services planning efforts. Counties must also have the flexibility to make health policy and fiscal decisions at the local level to meet the needs of their communities.

## **Section 3: Behavioral Health**

Counties provide community-based treatment for individuals living with severe mental illness and with substance use disorders (SUD). Counties have responsibility for providing treatment and administration of mental health and substance use disorder programs. Counties should have the flexibility to design and implement behavioral health services that best meet the needs of their local communities. The

appropriate treatment of people living with substance use and severe mental health issues should be in the framework of local, state, and federal criteria.

*Proposition 63: Mental Health Services Act*

The adoption of Proposition 63, the Mental Health Services Act of 2004 (MHSA), assists counties in service delivery. It is intended to provide new funding that expands and improves the capacity of existing systems of care and provides an opportunity to integrate funding and innovate at the local level. MHSA funding is also dedicated to meeting the needs of each community, via stakeholder input, to determine spending priorities.

- 1) Counties oppose additional reductions in state funding for behavioral health services that will result in the shifting of state or federal costs to counties, or require counties to use MHSA funds for that purpose. These cost shifts result in reduced services available at the local level and disrupt treatment options for behavioral health clients. Any shift in responsibility or funding must hold counties fiscally harmless and provide the authority to tailor behavioral health programs to individual community needs.
- 2) Counties also strongly oppose any effort to redirect the MHSA funding to existing state services instead of the local services for which it was originally intended. The realignment of health and social services programs in 1991 restructured California's public behavioral health system. Realignment required local responsibility for program design and delivery within statewide standards of eligibility and scope of services, and designated revenues to support those programs to the extent that resources are available.
- 3) MHSA funds have been diverted in the past due to economic challenges and the establishment of the No Place Like Home Program. Any further diversions of MHSA funding will be disruptive to programming at the local level.
- 4) Counties support timely and clear reporting standards, including reversion timelines, for MHSA expenditures and seek guidance from the Department of Health Care Services on all reporting standards, deadlines, and formats.
- 5) Counties support the fiscal integrity of the MHSA and transparency in stakeholder input, distributions, spending, reporting, and reversions.

*Specialty Mental Health Plans*

Counties are committed to service delivery that manages and coordinates services to persons with behavioral health needs and that operates within a system of performance outcomes that assures funds are spent in a manner that provides the highest quality of care. Integration of care and parity requirements require county specialty mental health plans to adapt to new models and lead collaborative efforts in the next era of behavioral health care.

Counties supported actions to consolidate the two Medi-Cal behavioral health systems, one

operated by county behavioral health departments and the other operated by the state Department of Health Services, and to operate Medi-Cal behavioral health services as managed care program. Counties chose to operate as a Medi-Cal Mental Health Plans, and many counties have chosen to operate as managed care plans for substance use disorder services under the Drug Medi-Cal Organized Delivery System waiver program. There is a negotiated sharing of risk for services between the state and counties, particularly because counties became solely responsible for managing the nonfederal share of cost for these behavioral health services under 2011 Realignment.

- 1) Counties have developed a range of locally designed programs to serve California's diverse population, and must retain the local authority, flexibility, and funding to continue such services.
- 2) Counties anticipate increased demand for behavioral health services including substance use disorder services, under Medi-Cal parity, and must seek collaboration at the local level to meet care standards for these populations.
- 3) Behavioral health services can reduce criminal justice costs and utilization through prevention, diversion, and during, or post incarceration.
- 4) Counties continue to work across disciplines and within the 2011 Realignment structure to achieve good outcomes for persons with mental illness and/or substance abuse issues to help prevent incarceration and to treat those who are about to be incarcerated or are newly released from incarceration and their families.

#### *Substance Use Disorder Prevention and Treatment*

Counties provide community-based treatment for individuals who meet income eligibility requirements and qualify for medically necessary substance use disorder treatment services and provide individual and community-based prevention services. Counties support federal parity requirements and are working to ensure evidence-based treatment capacity, but are also challenged by new managed care requirements that may strain local systems. .

- 1) Counties support and seek additional housing options for people with substance use disorders, including recovery and treatment housing options within the community, as well as residential treatment services.
- 2) Adequate early intervention, substance use disorder prevention, and treatment services have been proven to reduce criminal justice costs and utilization. However, appropriate funding for diagnosis and treatment services must be available. Appropriate substance use disorder treatment services benefits the public safety system. Counties will continue to work across disciplines to achieve good outcomes for persons with substance use disorder issues and/or mental illness.
- 3) Counties support cross-sector, multi-jurisdictional collaboration to promote education on substance use disorders, and prevent overdoses and substance use

related deaths.

- 4) Counties continue to support state and federal efforts to provide substance use disorder benefits under the same terms and conditions as other health services and welcome collaboration with public and private partners to achieve substance use disorder services and treatment parity.
- 5) The courts may still refer individuals to counties for treatment under Proposition 36 or by court order, but counties are increasingly unable to provide these voter and judge-mandated services without adequate dedicated state funding.
- 6) Counties recognize that access to high quality substance use disorder prevention and treatment services for adolescents and young adults can be improved, and support fiscally viable strategies for building a more comprehensive continuum of substance use disorder prevention and treatment services for this age group.
- 7) Counties support technical assistance for counties and providers to ensure timely and accurate billing, as well as compliance with quality and service requirements.

#### **Section 4: Public Guardians/Administrators/Conservators**

Public Administrators, Public Guardians and Public Conservators act under the authority granted by the California Superior Court, but are solely a county function and funded with county General Funds. The recent rise in interest in conservatorships as vehicles to help manage justice involved and homeless populations also places significant fiscal pressure on county guardians and conservators.

- 1) CSAC supports the acquisition of additional and sustainable non-county resources for public guardians, conservators, and administrators to ensure quality safety-net services for all who qualify.
- 2) CSAC opposes additional duties, mandates, and requirements for public guardians, conservators, and administrators without the provision of adequate funding to carry out these services.
- 3) CSAC will work to support placement capacity for public guardians, conservators, and administrators as California severely lacks safe and secure housing for the majority of residents under conservatorship.

#### **Section 5: Children's Health**

##### *California Children's Services*

Counties administer the California Children's Services programs on behalf of the State. Recent implementation of the Whole Child Model within County Organized Health Systems (COHS) counties, moved service authorization and case management services to local managed care plans. Under the Whole Child Model, counties also are still responsible for determination of residential, medical, and financial eligibility for the program. Counties also provide Medical

Therapy Program services for California Children's Services children, and retain a share of cost for services to non-Medi-Cal children.

- 1) Maximum federal and state matching funds for The California Children's Services program must continue to avoid the shifting of costs to counties. Counties cannot continue to bear the rapidly increasing costs associated with both program growth and eroding state support.
- 2) Counties also support efforts to test alternative models of care under pilot programs.
- 3) As counties shift towards the Whole Child Model, counties seek to ensure these high-need patients continue to receive timely access to quality care, there are no disruptions in care, and there is an adequate plan for employee transition.

#### *State Children's Health Insurance Program*

- 1) CSAC supports sustained funding for the federal Children's Health Insurance Program (CHIP/Healthy Families). In 2018, the CHIP program was reauthorized through 2023. However, the federal match rate decreases over time during this period and limits the requirement to provide coverage for children in families with income at or below 300% of the federal poverty level. Without federal funding, some families risk losing coverage for their children if their income is too high to qualify for Medicaid/Medi-Cal and too low to purchase family coverage.

#### *Proposition 10: The First 5 Commissions*

Proposition 10, the California Children and Families Initiative of 1998, provides significant resources to enhance and strengthen early childhood development at the local level and created First 5 commissions in all 58 counties.

- 1) Local children and families commissions (local First 5 Commissions), established as a result of the passage of Proposition 10, must maintain the full discretion to determine the use of their share of funds generated by Proposition 10.
- 2) Local First 5 commissions must maintain the necessary flexibility to direct these resources address the greatest needs of communities surrounding family resiliency, comprehensive health and development, quality early learning, and systems sustainability and scale. Counties oppose any effort to diminish Proposition 10 funds or to impose restrictions on local First 5 Commissions' expenditure authority.
- 3) Counties oppose any effort to lower or eliminate state support for county programs with the expectation that the state or local First 5 commissions will backfill the loss with Proposition 10 revenues. Further, counties will support the backfill that Proposition 10 now receives from the state's most recent tobacco tax, Proposition 56 (2016), just as Proposition 10 pays to the previous tobacco initiatives.

- 4) Counties support local and state collaborations and leveraging First 5 commissions funding to sustain and expand critical services for children and families in our communities.

### **Section 6: Medi-Cal: California's Medicaid Program**

California counties have a unique perspective on the state's Medicaid program, Medi-Cal. Counties are charged with preserving the public health and safety of communities; they also operate health plans, provide direct services, specialize in care for patients with complex social needs, conduct eligibility for benefits, and bear a significant amount of risk for financing the program. As the local public health authority, counties are vitally concerned about health outcomes. Undoubtedly, changes to the Medi-Cal program, including efforts to integrate and coordinate care for Medi-Cal enrollees, will affect all counties.

- 1) Counties remain concerned about state and federal proposals that would decrease access to health care or shift costs and risk to counties.
- 2) Any Medi-Cal reform that results in decreased access to or funding of county hospitals and health systems will be devastating to the safety net. The loss of Medi-Cal funds translates into fewer dollars to help pay for safety net services for all persons served by county facilities. Counties are not in a position to absorb or backfill the loss of state and federal funds. Rural counties already have particular difficulty developing and maintaining health care infrastructure and ensuring access to services.
- 3) County welfare departments determine eligibility for the Medi-Cal program and must receive adequate funding for these duties.
- 4) County behavioral health departments provide Medi-Cal Managed Care Specialty Mental health services, and must receive adequate funding for these critical services. Changes to the Medi-Cal program, including the move toward integrated care, will undoubtedly affect the day-to-day business of California counties.
- 5) It is vital that changes to Medi-Cal preserve the viability and innovations of the local safety net and not shift additional costs to counties.
- 6) Counties oppose any efforts to decrease funding for or reverse expansions to the Medi-Cal program, which will shift the responsibility of providing these individuals with healthcare from the Medi-Cal program to counties, which are required to provide services to the medically indigent.
- 7) The state should continue to provide options for counties to implement managed care systems that meet local needs. The state should work openly with counties as primary partners in this endeavor.
- 8) The state needs to recognize county experience with geographic managed care and make strong efforts to ensure the sustainability of county organized health systems. The Medi-Cal program must offer a reasonable reimbursement and rate mechanism for managed care.

- 9) Changes to Medi-Cal must preserve access to medically necessary behavioral health care and drug treatment services.
- 10) The carve-out of specialty behavioral health services within the Medi-Cal program must be examined in the era of integrated care, but must preserve federal funding, and minimize county risks to continue the effective delivery of rehabilitative community-based mental health services to local Medi-Cal enrollees.
- 11) Counties recognize the need to continue to innovate under the Drug Medi-Cal Organized Delivery System Waiver program in ways that maximize federal funds, ensure access to medically necessary evidence-based practices, allow counties to retain authority and choice in contracting with accredited providers, and minimize county risks.
- 12) Any reform effort must recognize the importance of substance use disorder treatment and services in the local health care continuum, as well as the evidence of good outcomes under integrated care models.
- 13) Counties will not accept a share of cost to locally support the Medi-Cal program. Counties also believe that Medi-Cal long-term care must remain a state-funded program and oppose any cost shifts or attempts to increase county responsibility through block grants or other means.
- 14) The state should fully fund county costs associated with the local administration of the Medi-Cal program.
- 15) Complexities of rules and requirements should be minimized or reduced so that enrollment, retention and documentation and reporting requirements are not unnecessarily burdensome to recipients, providers, and administrators and are no more restrictive or duplicative than required by federal law.
- 16) The State should consider counties as full partners in the administration of Medi-Cal, and consult with counties in formulating and implementing all policy, operational and technological changes.

#### *Medicare Part D*

Medicare Part D led to an increase in workload for case management across many levels of county medical, social welfare, criminal justice, and behavioral health systems.

- 1) Counties strongly oppose any change to realignment funding that may result and would oppose any reduction or shifting of costs associated with this benefit that would require a greater mandate on counties.

#### *Medicaid and Aging Issues*

- 1) Counties are committed to addressing the unique needs of older and dependent adults in their communities, and support collaborative efforts to build a continuum

of services as part of a long-term system of care for this vulnerable but vibrant population.

- 2) Counties also believe that Medi-Cal long-term care must remain a state-funded program and oppose any cost shifts or attempts to increase county responsibility through block grants or other means.
- 3) Counties support the continuation of federal and state funding for the In-Home Supportive Services (IHSS) program, and oppose any efforts to shift additional IHSS costs to counties.
- 4) Counties support the IHSS Maintenance of Effort (MOE) as negotiated in the 2012-13 state budget.
- 5) Counties support moving collective bargaining for the IHSS program to the Statewide IHSS Authority or another single statewide entity.
- 6) Counties also support federal and state funding to support Alzheimer's disease and dementia research, early detection and diagnosis, community education and outreach, and resources for caregivers, family members and those afflicted with Alzheimer's disease and dementia.

### **Section 7: Health Reform Efforts**

Counties support affordable, comprehensive health care coverage for all persons living in the state. The sequence of changes and implementation of federal or state healthcare reform efforts must be carefully planned, and the state must work in partnership with counties to successfully realize any gains in health care and costs.

Under AB 85, Counties must also retain sufficient health realignment revenues for residual responsibilities, including existing Medi-Cal non-federal share responsibilities to care for the remaining uninsured, and public health. Any changes to AB 85 must also allow counties to retain sufficient health realignment revenues for these residual responsibilities and future needs.

- 1) Counties support offering a truly comprehensive package of health services that includes mental health and substance use disorder treatment services at parity levels and a strong prevention component and incentives.
- 2) Counties support the integration of health care services for inmates and offenders of county and state correctional institutions, detainees, and undocumented immigrants into the larger health care service model.
- 3) Health reform efforts must address access to health care in rural communities and other underserved areas and include incentives and remedies to meet these needs as quickly as possible.

- 4) Counties strongly support maintaining a stable and viable health care safety net with adequate funding.
- 5) The current safety net is grossly underfunded. Any diversion of funds away from existing safety net services will lead to the dismantling of the health care safety net and will hurt access to care for all Californians.
- 6) Counties believe that delivery systems that meet the needs of vulnerable populations and provide specialty care – such as emergency and trauma care and training of medical residents and other health care professionals – must be supported in any health care reform effort.
- 7) Counties strongly support adequate funding for the local public health system as part of a plan to reform health care and achieve universal health coverage. A strong local public health system will reduce medical care costs, contain or mitigate disease, reduce health inequities, and address disaster preparedness and response.
- 8) Counties support access to affordable, comprehensive health coverage through a combination of mechanisms that may include improvements in and expansion of the publicly funded health programs, increased employer-based and individual coverage through purchasing pools, tax incentives, and system restructuring. The costs of universal health care and health care reform shall be shared among all sectors: government, labor, and business.
- 9) Health reform efforts, including efforts to achieve universal health care, should simplify the health care system – for consumers, providers, and overall administration. Any efforts to reform the health care system should include prudent utilization control mechanisms that are appropriate and do not create barriers to necessary care.
- 10) The federal government has an obligation and responsibility to assist in the provision of health care coverage.
- 11) Counties encourage the state to pursue ways to maximize federal financial participation in health care expansion efforts, and to take full advantage of opportunities to simplify Medi-Cal, and other publicly funded programs with the goal of achieving maximum enrollment and provider participation.
- 12) County financial resources are currently overburdened; counties are not in a position to contribute permanent additional resources to expand health care coverage.
- 13) Counties strongly encourage public health to be a key component of any health care coverage expansion. Public health prevention activities in addition to access to health education, preventive care, and early diagnosis and treatment will assist in controlling costs through improved health outcomes.
- 14) Counties, as both employers and administrators of health care programs, believe that every employer has an obligation to contribute to health care coverage, and counties advocate that such an employer policy should also be pursued at the federal level and be consistent with the goals and principles of local control at the county government level.

- 15) Reforms of health care coverage should offer opportunities for self-employed individuals, temporary workers, and contract workers to obtain affordable quality health coverage.

### **Section 8: California Health Services Financing**

- 1) Those eligible for Temporary Assistance for Needy Families (TANF)/California Work Opportunity and Responsibility to Kids (CalWORKs), should retain their categorical linkage to Medi-Cal.
- 2) Counties are concerned about the erosion of state program funding and the inability of counties to sustain current program levels. As a result, we strongly oppose additional cuts in county administrative programs as well as any attempts by the state to shift the costs for these programs to counties. With respect to the County Medical Services Program (CMSP), counties support efforts to improve program cost effectiveness and oppose state efforts to shift costs to participating counties, including administrative costs and elimination of other state contributions to the program. Due to the unique characteristics of each county's delivery system, health care accessibility, and demographics of client population, counties believe that managed care systems must be tailored to each county's needs, and that counties should have the opportunity to choose providers that best meet the needs of their populations. Where cost-effective, the state and counties should provide non-emergency health services to undocumented immigrants and together seek federal and other reimbursement for medical services provided to undocumented immigrants.
- 3) Counties support the continued use of federal Medicaid funds for emergency services for undocumented immigrants. Counties support increased funding for trauma and emergency room services.
- 4) Although reducing the number of uninsured through expanded health care coverage will help reduce the financial losses to trauma centers and emergency rooms, critical safety-net services must be supported to ensure their long-term viability.

#### *Realignment*

- 1) Counties believe the integrity of realignment should be protected. However, counties strongly oppose any change to realignment funding that would negatively impact counties.
- 2) Counties remain concerned and will resist any reduction of dedicated realignment revenues or the shifting of new costs from the state and further mandates of new and greater fiscal responsibilities to counties in this partnership program.
- 3) Any effort to realign additional programs must occur in the context of Proposition 1A constitutional provisions and must guarantee that counties have sufficient revenues for residual responsibilities, including public health programs.
- 4) In 2011, counties assumed fiscal responsibility for Medi-Cal Specialty Mental

Health Services, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); Drug Medi-Cal; drug courts; perinatal treatment programs; and women's and children's residential treatment services as part of the 2011 Public Safety Realignment. Please see the Realignment Chapter of the CSAC Platform and accompanying principles.

- 5) Counties bear significant responsibility for financing the non-federal share of Medi-cal services in county public health systems. They also continue to have responsibility for uninsured services.

### *Hospital Financing*

Public hospitals are a vital piece of the local safety net, and serve as indispensable components of a robust health system, providing primary, specialty, and acute health services, as well as physician training, trauma centers, and burn care. California's public hospitals are increasingly providing funding for the non-federal share of the state's Medicaid program, and these local expenditures are made at the sole discretion of the county Supervisors.

- 1) Counties have been firm that any proposal to change hospital Medicaid financing must guarantee that county hospitals do not receive less funding than they currently do, and are eligible for more federal funding in the future as needs grow.
- 2) Counties strongly support the continuation of a robust Medicaid Section 15000 waiver to help ensure that county hospitals are paid for the safety net care they provide to Medi-Cal recipients and uninsured patients.
- 3) Counties support a five-year state Medicaid Waiver that provides funding to counties at current levels. The successor waiver should: 1) support a public integrated safety net delivery system; 2) build on previous delivery system improvement efforts for public health care systems so that they can continue to transform care delivery; 3) allow for the creation of a new county pilot effort to advance improvements through coordinated care, integrated physical and behavioral health services and provide robust coordination with social, housing and other services critical to improve care of targeted high-risk patients.; 4) improve ability to share and integrate health data and systems; 5) and provide flexibility for counties/public health care systems to deliver more coordinated care and effectively serve individuals who will remain uninsured.
- 4) Counties are supportive of opportunities to reduce costs for county hospitals and health systems, particularly for mandates such as seismic safety requirements and nurse-staffing ratios. Therefore, counties support infrastructure bonds that will provide funds to county hospitals for seismic safety upgrades, including construction, replacement, renovation, and retrofit.
- 5) Counties also support opportunities for county hospitals and health systems to make delivery system improvements and upgrades, which will help these institutions, compete in the modern health care marketplace.

- 6) Counties support proposals to preserve supplemental payments to public and private hospitals as the Federal Medicaid Managed Care rules are implemented in California. Any loss of federal funds through changes to waiver agreements or modifications to federal managed care rule implementation must address through other support to ensure the continued viability of the safety net.

### **Section 9: Family Violence**

CSAC remains committed to raising awareness of the toll of family violence on families and communities by supporting efforts that target family violence prevention, intervention, and treatment. Specific strategies for early intervention and success should be developed through cooperation between state and local governments, as well as community and private organizations addressing family violence issues, taking into account that violence adversely impacts Californians, particularly those in disadvantaged communities, at disproportionate rates.

### **Section 10: Healthy Communities**

Built and social environments significantly impact the health of communities. Counties support public policies and programs that aid in development of healthy communities including food and beverage policies that increase access to healthier food in county-operated no/low cost food programs (e.g., USDA Summer Lunch, inmate programs, and senior meals) or concession and vending operations. Counties support the concept of joint use of facilities and partnerships, mixed-use developments and walkable and safe developments, to promote healthy community events and activities.

### **Section 11: Veterans**

Specific strategies for intervention and service delivery to veterans should be developed through cooperation between federal, state and local governments, as well as community and private organizations serving veterans.

Counties support coordination of services for veterans among all entities that serve this population, especially in housing, treatment, and employment training.

### **Section 12: Emergency Medical Services**

- 1) Counties do not intend to infringe upon the service areas of other levels of government who provide similar services, but will continue to discharge our statutory duties to ensure that all county residents have access to the appropriate level and quality of emergency services, including medically indigent adults.
- 2) Counties support ensuring the continuity and integrity of the current emergency medical services system, including county authority related to medical control, trauma planning, and alternative destination efforts.
- 3) Counties recognize that effective administration and oversight of local emergency medical services systems includes input from key stakeholders, such as other local governments, private providers, state officials, local boards and commissions, and the people in our communities who

depend on these critical services.

- 4) Counties support maintaining the authority and governing role of counties and their local emergency medical services agencies to plan, implement, and evaluate all aspects and components of the local Emergency Medical Services system.
- 5) Counties oppose efforts that would weaken the local authority of local medical services agencies or lead to system fragmentation and safety issues.

### **Section 13: Court-Involved Population**

Counties recognize the importance of enrolling the court-involved population into Medi-Cal and other public programs. Medi-Cal enrollment provides access to important behavioral health, substance use, and primary care services that will improve health outcomes and may reduce recidivism. CSAC continues to look for partnership opportunities with the Department of Health Care Services, foundations, and other stakeholders on enrollment, eligibility, quality, and improving outcomes for this population. Counties are supportive of obtaining federal Medicaid funds for inpatient hospitalizations, including psychiatric hospitalizations, for adults and juveniles while they are incarcerated.

### **Section 14: Incompetent to Stand Trial**

Counties affirm the authority of County Public Guardians under current law to conduct conservatorship investigations and are mindful of the potential costs and ramifications of additional mandates or duties in this area.

Counties support collaboration among the California Department of State Hospitals, county Public Guardians, Behavioral Health Departments, and County Sheriffs to find secure placements for individuals originating from DSH facilities, county jails, or who are under conservatorship. Counties support a shared funding and service delivery model for complex placements, such as the Enhanced Treatment Program.

Counties recognize the need for additional secure placement options for adults and juveniles who are conserved or involved in the local or state criminal justice systems, including juveniles.