California Department of Health Care Services

Application for the

U.S. Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

Planning Grants for Certified Community Behavioral Health Clinics

Request for Applications Number SM-16-001

Catalogue of Federal Domestic Assistance Number: 93.829

Abstract

The California Department of Health Care Services (DHCS), in partnership with county Mental Health Plans and their contracted providers, proposes to use Substance Abuse and Mental Health Services Administration's (SAMHSA's) Planning Grant for Certified Community Behavioral Health Clinics (CCBHCs) to address the physical and behavioral health needs of California's beneficiaries who are high-cost Medi-Cal utilizers, often referred to as "superutilizers." A recent DHCS analysis showed that these beneficiaries utilize emergency room services at a rate that is approximately 3 times higher, and have inpatient hospitalizations that are longer (about 7 times more days and 1 ½ times longer average lengths of stay, conservatively), than the general Medi-Cal population. Almost half of these individuals have a serious and persistent mental illness. To address the needs of this population, DHCS plans to design CCBHCs that will function as "behavioral health homes," providing high-quality, cost effective, intensive care coordination for physical and behavioral health services during the two-year demonstration program, with the goal of improving overall health and well-being and reducing the overuse of emergency and inpatient services, as appropriate. Consistent with the grant requirements, DHCS will continue working to reduce disparities by providing culturally competent services, including those for veterans and their family members. Furthermore, in recognition of the high prevalence rates of smoking, and the detrimental effects of such behavior on quality of life and longevity, DHCS will ensure that CCBHCs incorporate smoking cessation programs. CCBHCs will also be designed consistent with the CCBHC requirements to serve anyone who appears for services.

As the SSA, DHCS administers physical health care and mental health services for beneficiaries with mild to moderate mental health impairments through its care through its Medi-Cal Managed Care and fee-for-service delivery systems, and specialty behavioral health care through a 1915(b) Specialty Mental Health Services System and Drug Medi-Cal / Substance Abuse Prevention and Treatment Block Grant System. This integrated and comprehensive service delivery design, and significant investment in innovative service delivery practices, particularly through the Mental Health Services Act, leaves California well-positioned to design and implement CCBHCs throughout the State. For the Planning Phase, DHCS will develop a Steering Committee, comprised of key State and local partners, as well as subject matter experts; leverage the existing DHCS Behavioral Health Forum to engage, inform and solicit feedback from consumers, family members and any other interested individuals; and will form specialized workgroups focusing on rate-setting, application development, certification standards, care coordination, and data and reporting. By the end of the Planning Phase, DHCS will submit to SAMHSA a competitive application for the Demonstration Project that will support the provision of integrated and coordinated, cost-effective health and behavioral health services to improve the quality of life and outcomes for a very unique population of California beneficiaries.

Table of Contents

Abstract 2
Project Narrative 4
Section A-1 Current System Design 4
Section A-2 Prevalence Rates 7
Section A-3 California's Medicaid State Plan 9
Section A-4 Nature of the Problem 10
Section B-1 Expansion of Current Capacity, Access and Availability 11
Section B-2 Input from Partners/Stakeholders 13
Section B-3 CCBHC Selection 14
Section B-4 CCBHC Service Provision 15
Section B-5 Evidence-based Practices 24
Section B-6 CCBHC Certification 25
Section B-7 Transition to Implementation 25
Section B-8 PPS Rate Selection and Justification 27
Section B-9 Establishment of CCBHC PPS Rates 27
Section B-10 Participation from Other Organizations 28
Section B-11 CCBHC Board Governance 28
Section C-1 DHCS Capability and Experience with Similar Projects and Populations 29
Section C-2 AND Section C-3 List of Staff Positions and their Demonstrated Experience 29
Section D-1 Section I-2.2 Performance Measure Data Collection and Reporting 30
Section D-2 State Support for CCBHC Performance Measurement Infrastructure 30
Section D-3 Section H Performance Measure Data Collection and Reporting 31
Section D-4 Data Collection and Reporting Challenges 31
Section D-5 Preliminary Plan to Construct a Comparison Group 32
Section D-6 Data Collection Capacity 33
Section E Biographical Sketches and Job Descriptions 34
Section F Confidentiality and SAMHSA Participant Protection/Human Subjects 56
Attachment 1 Single Entity SSA/SMHA Confirmation 61
Attachment 2 Data Collection Instruments/Interview protocols 62
Attachment 3 Sample Consent Forms 67
Attachment 4 Statement of Assurance 85

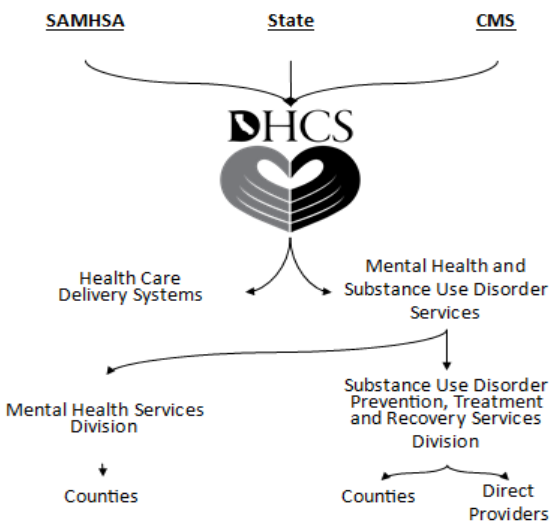
Project Narrative

Section A-1 Current System Design

Organization of Services

The California Department of Health Care Services (DHCS) is the Single State Agency (SSA) responsible for the administration of the federal Medicaid program, called Medi-Cal through two areas: Health Care Delivery Systems, which oversees contracts with managed care plans (MCPs) and Mental Health and Substance Use Disorder Services, the latter of which consists of three Divisions (Mental Health Services; Substance Use Disorder Prevention, Treatment and Recovery Services; and Substance Use Disorder Compliance). DHCS contracts with MCPs for the provision of behavioral health services delivered in the primary care setting to beneficiaries with mild to moderate mental health issues. DHCS administers Medi-Cal specialty mental health services (SMHS) through county mental health plans (MHPs) that ensure comparability of services that are provided directly through county-operated programs or through a network of organizational contract providers.[1] DHCS administers Drug Medi-Cal (DMC) and Substance Abuse Prevention and Treatment (SAPT) Block Grant (BG) programs through a community-based system for substance use disorder (SUD) services through counties or through direct contracts with service providers. MCPs can and do refer beneficiaries to MHPs for SMHS and/or SUD services, hereafter referred to as behavioral health. MHPs and MCPs have developed memoranda of understanding (MOUs) that include agreements for coordinating beneficiary care. Figure 1 provides an overview of California's public behavioral health service system.

Figure 1. California's Behavioral Health System Hierarchy



Funding

California funds behavioral health services through multiple dedicated revenue sources. These sources include 1991 Realignment,[2] 2011 Realignment,[3] Federal Financial Participation,[4] Mental

[1] DHCS administers the provision of SMHS through MHPs through Medi-Cal SMHS Managed Care Contracts (MHP Contract) and the Mental Health Performance Contracts (Performance Contract). The MHP contracts guide the coverage and provision of SMHS under CA 1915(b) SMHS Waiver while the Performance Contract guides the provision of non-Medi-Cal mental health services.

[2] 1991 Realignment was a legislatively-driven effort initiated in 1991 that approved a half-cent increase in state sales tax and dedicated a portion of vehicle license fees fund local community mental health services.

[3] 2011 Realignment codified the Behavioral Health Services Subaccount that currently funds SMHS, DMC, residential perinatal drug services and treatment, drug court operations, and other non-DMC programs. See AB 109 (Chapter 15, Statutes of 2011) and SB 1020 (Statutes of 2012) for more information.

[4] Counties receive federal funding for public mental health care for services provided to Medi-Cal beneficiaries. Federal payments match state spending based on the federal Medicaid assistance percentage, which in California is set at 50% for most expenditures.

Health Services Act,[5] SAMHSA Block Grants (Mental Health, Projects for Assistance in Transition from Homelessness (PATH) and SAPT) and locally-generated revenue (i.e., Maintenance of Effort (MOE)[6]). See Table 1 for State Fiscal Year 2013-14 funding for behavioral health services by each of these funding sources. *Note: Behavioral health services provided through MCPs are paid using a capitation rate,[7] which is a flat fee that is paid in advance to provide health care for each member of the plan who needs care to cover all costs for a defined population group. The capitation rates are calculated based on methods that are determined in part by the Centers for Medicare and Medicaid Services (CMS), which oversees the state/federal program.*

Table 1. State Fiscal Year 2013-14 Funding for Behavioral Health Services by Funding Source

Department of Health Care Services Specialty Mental Health Service and Substance Use Disorder Services FY 2013-14 Program Funding Breakdown							
1991 Realignment		2011 Realignment		SMHS FFP		MHSA	
Funding Amount	% of Total	Funding Amount	% of Total	Funding Amount	% of Total	Funding Amount	% of Total
$1,166,240,058	22%	$996,320,428	19%	$1,432,382,000	27%	$1,235,772,421	24%
SMHS		SMHS+SUDS		SMHS		SMHS	

SAMHSA Grants (MHBG+PATH)		Drug Medi-Cal FFP		SAPT Block Grant		**Total All Funds**	
Funding Amount	% of Total	Funding Amount	% of Total	Funding Amount	% of Total	Funding Amount	% of Total
$60,497,020	1%	90,390,041	2%	249,086,920	5%	$5,230,688,888	100%
SMHS		SUDS		SUDS		SMHS+SUDS	

*Percentages may be slightly more or less than 100% due to rounding.

Provision of Services

California expanded "Optional Benefits" for Medi-Cal beneficiaries with mental health conditions who do *not* meet the SMHS medical necessity criteria to have access to a limited scope of primary care-based, non-emergency mental health and substance use disorder services provided by MCPs. Table 2 reflects the Medi-Cal Managed Care mental health services and substance use disorder services now available under the Optional Benefit expansion.

[5] MHSA revenues, established by Proposition 63, which passed in 2004 and is generated through a 1% surtax on personal income over $1 million, are allocated directly to counties and have helped to significantly fund rehabilitative and preventive mental health services to underserved populations.

[6] A portion of local revenue generated from property taxes, patient fees, and some payments from private insurance companies is used to fund mental health services, referred to as a Maintenance of Effort (MOE).

[7] While MCPs pay providers a capitation rate, there are many variations on this payment model, as a MCP might pay some providers in the network on a capitated basis, but others on a fee-for-service basis.

Table 2. Medi-Cal Managed Care mental health and substance use disorder services.

Mental Health Services	***Substance Use Disorder Services***
Psychological testing when clinically indicated to evaluate a mental health condition	Voluntary Inpatient Detoxification (fee-for-service)
Outpatient services for the purposes of monitoring drug therapy	
Outpatient laboratory, drugs, supplies and supplements	
Psychiatric consultation	

In addition to expanding the provision of substance use disorder services, effective January 1, 2014, California began offering the Screening, Brief Intervention, and Referral to Treatment (SBIRT) benefit to adult Medi-Cal beneficiaries, thereby implementing Affordable Care Act Section 4106, which states that preventive services will be offered to all Medi-Cal beneficiaries 18 years and older in primary care settings. California Medi-Cal-funded primary care practitioners must provide SBIRT, which includes a brief behavioral counseling intervention provided by a health care professional to include feedback and advice aimed to reduce alcohol misuse and/or make appropriate referrals to mental health and/or alcohol use disorder services.

The 1915(b) SMHS Waiver provides California with the opportunity to deliver SMHS to children and adults through a managed care delivery system, with MHPs functioning as Prepaid Inpatient Health Plans. The SMHS covered under the 1915(b) SMHS Waiver are outlined in the California State Plan and include a range of interventions to assist beneficiaries with serious emotional and behavioral challenges, and include the following Rehabilitative Mental Health Services:

- Mental Health Services
- Medication Support Services
- Day Treatment Intensive
- Day Rehabilitation
- Crisis Intervention
- Crisis Stabilization
- Adult Residential Treatment
- Crisis Residential Treatment Services
- Psychiatric Inpatient Hospital Services
- EPSDT Services, including supplemental services (i.e. Therapeutic Behavioral Services; Therapeutic Foster Care; Intensive Home-Based Services)
- Targeted Case Management
- Psychiatric Health Facility Services

Individuals enrolled in Medi-Cal receive SUD treatment through DMC, which is a carve-out of the Medi-Cal program.[8] Treatment is offered on demand (i.e., no referral necessary) for all Medi-Cal beneficiaries when medically necessary. For SUD services, California's State Plan authorizes the DMC program to provide the following five treatment modalities:

[8] The statutes that govern the DMC Program reside in Welfare and Institutions Code §14021, 14124, and 14043.38, as well as the Health and Safety Code §11750-11975. The primary regulations that govern DMC are contained in the California Code of Regulations Title 22, Sections 51341.1 (program requirements), 51490.1 (claim submission requirements), and 51516.1 (reimbursement rates and requirements). Other regulations pertaining to the DMC program are in Title 9 CCR §9533.

- Outpatient Drug Free Treatment (group and/or individual counseling)
- Intensive Outpatient Treatment
- Residential Treatment (limited to pregnant and perinatal clients)
- Naltrexone Treatment
- Narcotic Treatment (methadone)

The DMC system establishes a structure for SUD services. However, due to the limited services provided through DMC and the fact that not all individuals are eligible for Medi-Cal, SAPT BG funding supports a significant portion of California's SUD treatment services. The SAPT BG includes outpatient and residential treatment designed to augment the DMC program's SUD services.[9] The SAPT BG requires providers to adhere to a hierarchy of priority populations and all beneficiaries must indicate active substance use within the previous 12-months to be eligible for SAPT funded treatment services. This also includes individuals who were incarcerated and reported using while incarcerated.

The current DMC delivery system places emphasis on state-wideness, resulting in many SUD treatment facilities spread unevenly across California. Challenges arising from this approach include difficulty targeting the needs of specific populations and issues with ensuring quality across providers. To address these challenges, DHCS is pursuing an ODS Waiver to allow counties an opportunity to implement a managed care delivery system. The ODS Waiver will operate under the rehabilitation option, which allows counties to arrange for the provision of services outside of a clinic by certified providers. In addition, participating counties will waive "freedom of choice" requirements and will be able to selectively contract with State-certified providers. California intends to use the ODS Waiver to demonstrate that an organized system of care will increase coordination and integration of services across behavioral health systems and primary care while ensuring quality and program integrity.

Section A-2 Prevalence Rates

The following prevalence estimates for serious mental illness (SMI), serious emotional disturbance (SED), and substance use and SUD in California primarily come from the California Mental Health and Substance Use System Needs Assessment Final Report: February 2012 (CA Needs Assessment), the 2013 Behavioral Risk Factor Surveillance System (BRFSS), the 2012-13 National Survey on Drug Use and Health (NSDUH), and the 2011-13 California Healthy Kids Survey (CHKS). Smoking prevalence data are from California Department of Public Health (CDPH), California Tobacco Control Program. Table 3 reflects the findings from these needs assessments. Overall, these sources show that about 4% of California adults (18 +) have a SMI and about 8% of youth (0-17) have a SED. Both SED and SMI prevalence in California increases with age and as income level decreases, with SED/SMI most prevalent in lower income groups. Native American adults have the highest prevalence of SMI, while SED prevalence is higher in Native-American (8%), African-American (8%), and Hispanic (8%) youth. Younger adults (18-

[9] Title 42, USC §300x-21(b) authorizes the use of SAPT BG funds only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse, and for related activities contained in 42 USC §300x-24, which applies to tuberculosis and human immunodeficiency services.

25) have the highest rates of any mental illness (AMI[10]), serious thoughts of suicide, binge drinking, alcohol dependence, and illicit drug dependence, compared to other age groups. Substance use prevalence estimates by youth age group show that substance use increases with age. Eleventh graders (ages16-17) have the highest prevalence of alcohol use (33%), binge drinking (22%), and marijuana use (24%) compared to younger youth. Substance use in youth is also much more prevalent in youth who smoke. Research also shows that smoking prevalence is higher among those with behavioral health issues. Nearly half (49%) of the callers to the California Smoker's Helpline self-reported behavioral health issues.[17] Persons with serious psychological distress in California have a smoking prevalence of about 28%, compared to the overall California smoking prevalence rate of about 12%.

Table 3. Overview of California Behavioral Health and Smoking Prevalence Rates

Demographic/ Characteristic	Prevalence Estimates						
	SMI	SED	SUD or SMI	Substance Dependence or Abuse	Binge Drinking	Alcohol Use	Marijuana Use
Gender[11]							
Female	5%	8%			11%		
Male	4%	8%			23%		
Race/Ethnicity[12]							
Native American	7%	8%			-		
African American	6%	8%			15'%		
Hispanic	5%	8%			19%		
Caucasian	4%	7%			17%		
Age Group							
All Adults (18+)	4%[13]		22%[14]	9%[15]	23%[6]	54%[6]	9%[6]
Young Adults (18-25)	4%	-		19%[6]	36%[6]	58%[6]	22%[6]
Youth (12-17)		8%		9%[6]	6%[6]	12%[6]	8%[6]
Youth (12-13)				3%[16]	5%[7]	11%[7]	7%[7]
Youth (14-15)				8%[7]	11%[7]	20%[7]	15%[7]
Smoker					64%[7]		71%[7]
Non-Smoker					9%[7]		10%[7]
Youth (16-17)				14%[7]	22%[7]	33%[7]	24%[7]
Smoker					68%[7]		69%[7]
Non-Smoker					15%[7]		14%[7]
Other							
Veterans				3%[17]			
Smoker	28%[18]						

[10] NSDUH definition of AMI is any mental, behavioral, or emotional disorder that met DSM-IV criteria, excluding developmental and substance use disorders. SMI is a subset of the AMI population, including those with AMI, where the mental illness substantially interferes with or limits one or more major life activities.
[11] SMI/SED estimates by gender from CA Needs Assessment; binge drinking estimates by gender from BRFSS.
[12] Race/ethnicity estimates for SMI/SED from CA Needs Assessment and binge drinking estimates from BRFSS.
[13] CA Needs Assessment; NSDUH.
[14] CA Needs Assessment; SUD or SMI service utilization.
[15] NSDUH.
[16] CHKS; grade-level (7th, 9th, and 11th) used as proxy for age groups.
[17] Clients self-reported as veterans in publically-monitored SUD treatment in FY 2013-14.
[18] CDPH; California Tobacco Facts and Figures 2015; estimates for adults with serious psychological distress.

Section A-3 California's Medicaid State Plan

California's State Plan for Medicaid covers rehabilitative behavioral health services for beneficiaries as part of a comprehensive behavioral health program. These services are available to all beneficiaries who meet medical necessity criteria established by the State. As specified in the State Plan, services are to be provided consistent with wellness, recovery, and resiliency principles which align with the concept of person-centered care.

The State Plan covers each of the services listed in Appendix II's "*Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics (CCBHCs).* As indicated in Table 4, California's State Plan offers almost all of these benefits as specialty services, guaranteeing access to dedicated behavioral health providers. As such, California has the capacity to ensure through a certification process that sites identified and certified will provide those services identified in the California State Medicaid Plan and listed in Appendix II.

Table 4. Comparison of California's State Plan Covered Services to PAMA-Required Services

PAMA-Required Service	Medi-Cal Covered Benefit	Covered as a Specialty Service	
		MH	SUD
(i) Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.	✓	✓	✓
(ii) Screening, assessment, and diagnosis, including risk assessment.[19]	✓	✓	✓
(iii) Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.[20]	✓		
(iv) Outpatient mental health and substance use services.	✓	✓	✓
(v) Outpatient clinic primary care screening and monitoring of key health indicators and health risk.	✓	✓	
(vi) Targeted case management.	✓	✓	
(vii) Psychiatric rehabilitation services.	✓	✓	
(viii) Peer support and counselor services and family supports.[21]	✓		✓
(ix) Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration, including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration."	✓	✓[22]	

[19] Risk assessment is not specifically identified in the California's Medicaid State Plan; however, it is a required component of the assessment process pursuant to the MHP contract

[20] The State Plan does not specifically address patient-centered treatment planning as a distinct service type, although it does indicate that services are to be provided consistent with wellness, recovery, and resiliency principles which are consistent with the concept of patient-centered treatment. It also requires that a beneficiary client plan (treatment plan) include documentation that the beneficiary participated in the development of and is in agreement with the client plan

[21] Peer support services are not included as a distinct service type in the State Plan, but peers may provide some SMHS under the provider category "other qualified provider."

[22] The State Plan has no specific mandate for providers to offer various cultural competencies that target veterans and armed service members; however, veterans and armed service members who are Medi-Cal eligible and meet Medi-Cal SMHS medical necessity criteria may receive SMHS consistent with their mental health needs and treatment goals as documented in the beneficiary's client plan. Integrated providers, such as CCBHCs, would bridge these gaps directly and significantly *expand* the ability to connect medical necessity to specific outcomes.

Beyond the services offered in accordance with California's State Plan, unique to California are MHSA programs, which are patient-centered services available in every county that focus on wellness and recovery. The MHSA provides increased funding, personnel and other resources to support county mental health programs and emphasizes transformation of the mental health system with the intention of expanding services while improving the quality of life for Californians living with or at risk of serious mental illness. By addressing a broad continuum of prevention, early intervention, and other services, and supporting the development of the necessary infrastructure, technology and training elements needed to support these services, the MHSA has allowed local behavioral health departments to be well-poised to implement CCBHCs.

Section A-4 Nature of the Problem

While prevalence data are helpful for understanding the broader behavioral health needs in California, it does not necessarily allow for the identification of a specific target population that may best be served within the CCBHC structure. Given that the CCBHC concept focuses on intensive care coordination between physical and behavioral health systems, it is logical to surmise that a population that would benefit most would be comprised of individuals who have complex physical and behavioral health needs, as demonstrated by their health care utilization.

Recently, DHCS analyzed Calendar Year (CY) 2011 data from multiple sources in order to gain a fuller understanding of Medi-Cal spending. The focus of these analyses was on the Medi-Cal-only population, which reflects individuals served during CY 2011 only through the Fee-for-Service (FFS) system (FFS-only), both FFS and Managed Care (MC) (FFS/MC), and only the MC system (MC only). Individuals enrolled in both Medi-Cal and Medicare, also known as duals, were excluded.

Evident from the Medi-Cal spending analyses is a particular pattern that makes it clear that a small subset of the Medi-Cal population accounts for a large portion of the State's Medi-Cal expenditures. Specifically, the 1% most costly beneficiaries are responsible for 27% of the State's annual Medi-Cal costs. When expanded to the 5% most costly beneficiaries, this figure increases to 52%. Many of these individuals are adults with SMI (42 to 50%, depending on how the data are analyzed) who entered into the Medi-Cal system as a result of a disability. Further examination of the available data shows differences in health care utilization within the Medi-Cal sub-populations for emergency room (ER) visits, acute care hospital inpatient (ACHI) days, and average length of stay in ACHIs.

ER Visits

FFS-only and FFS/MC beneficiaries have high rates of ER visits, ranging from 119 to 200 visits per 1,000 member months for the top 1% and 5% most costly users. This is a notable difference from the MC-only population, whose ER use was 83 and 70 visits per 1,000 member months for the 1% and 5% most costly beneficiaries, respectively, and even more pronounced when compared to the remaining 95 to 99 % of the population of Medi-Cal eligibles who participated in FFS-only, FFS/MC and MC-only, whose emergency room use ranged from 31 to 45 visits per 1,000 member months.

ACHI Days

ACHI utilization is extremely high for FFS-only and FFS/MC beneficiaries, ranging from a low of 443 days to a high of 1,610 days per 1,000 member months for the top 1% and 5% most costly

users. Again, this is higher than the MC-only population, whose ACHI use was 265 and 94 days per 1,000 member months for the 1% and 5% most costly beneficiaries, respectively, and is in sharp contrast when compared to the remaining 95 to 99 % of the population of Medi-Cal eligibles who participated in FFS-only, FFS/MC and MC-only, whose ACHI use ranged from 14 to 65 days per 1,000 member months.

Average ACHI Length of Stay

The average length of stay at ACHIs ranged from 7-10 days for each of the Medi-Cal sub-populations that were analyzed by the 1% and 5% most costly groupings. The remaining 95 to 99% of the population of Medi-Cal eligibles who participated in FFS-only, FFS/MC and MC-only had an average length of stay of 4.5 days. Thus, not only do the 1% and 5% most costly beneficiaries utilize ACHIs more often than the overall Medi-Cal population, they also tend to have longer stays.

Clearly, the 1% and 5% most costly beneficiary population, often referred to as superutilizers, is a prime target population for the CCBHCs given their overuse of ER and ACHI services. As such, DHCS will continue to refine and use these data to prepare for the demonstration,[23] focusing on identifying "hot spots" (concentrations of beneficiaries in particular locations) in order to support the site selection process that will occur during the CCBHC Planning Phase. Although the current dataset does not contain specific identifiers that may be used to examine potential sub-populations, it is anticipated that there are a variety of different groups represented in these figures (e.g., veterans and their family members, individuals involved in the criminal justice system, foster care youth) that will benefit from CCBHC services. Essentially, California envisions that CCBHCs can offer a centralized location from which to provide direct behavioral health services, as well as to coordinate physical health care services, in order to stabilize and maintain the health and well-being of the identified high cost beneficiaries through a lower level of care, as appropriate, thereby preventing and reducing the need for emergency and inpatient (and likely other intensive/emergency) services.

Section B-1 Expansion of Current Capacity, Access and Availability

Acknowledging that California's population of focus, superutilizers (and those at risk of becoming high utilizers), have considerable health conditions that are caused and/or exacerbated by social circumstances and are challenged to receive services from a health care system that is all too often fragmented and uncoordinated, planning and developing CCBHCs in California will be undertaken with the following core objectives:

- Build capacity for individualized outreach and engagement that helps these individuals overcome existing access barriers to care and services as well as build their hope and belief in their own recovery and long-term health;
- Create and/or modify care settings to assure that they are welcoming, easily accessible and convenient (including evening and weekend hours, mobile field-based services and/or telecare), culturally sensitive and embracing;
- Develop sufficient capacity to assure individuals receive the care and supports they want and need when they want and need them;

[23] Comprehensive physical health and SUD data are not reflected in these results. DHCS anticipates such data will be available in the future, which could then be used during the CCBHC Planning Phase to better define the needs of this superutilizer population. That said, it is likely that examination of these data will further serve to demonstrate the high-needs of this population due to the co-morbid nature of physical and behavioral health disorders.

- Include crisis management that both reduces or prevents crises and then, when unavoidable, is timely, person-centered and the least restrictive possible; and,
- Coordinate care to enable all providers to work with these individuals in the context of their whole health needs and personal goals.

A central tenet of these approaches will be the development of behavioral health homes that do 'whatever it takes,' an orientation California specialty mental health systems have been applying for nearly 10 years in innovative, MHSA-funded programs known as Full Service Partnerships (FSPs). These programs are provided in every county in the state and target specific, high-need populations with Assertive Community Treatment (ACT)-model approaches, supplemented with additional services and supports to provide all of the behavioral health services and supports a person wants and needs to reach his or her goals. These programs have successfully reduced emergency department visits of individuals served.[24] The infrastructure California has built under the MHSA provides a solid foundation from which to build CCBHCs throughout the state.

Planning and development to effectively serve the population of focus in CCBCHs will include expanding current capacity and capability in, at minimum, the following areas:

- Care coordination model, infrastructure and supports that facilitate communication and collaboration between providers, transitions in care, and timely access to care in appropriate settings, and that is informed by what is needed to support individuals' health and wellness, including successful involvement in their community(s) of choice.
- Linkage with local crisis services, emergency departments and hospitals to enable rapid engagement of individuals into recovery-oriented services both during and after care in those settings.
- Outreach and engagement of these individuals in their communities, including using peer mentors who can effectively foster readiness to engage in services.
- Recovery-oriented services that include use of the evidence-based Strengths Model, which is a set of practices developed by Kansas University that focus on reducing functional impairments, guide shared decision-making, and increase independence and self-care. From initial intake and risk assessment through in-depth evaluation and treatment planning, there will be a focus on building hope, identifying strengths and meaningful goals, and helping individuals advance through their recovery journey.
- Access to primary care, medication and diagnostic services, dental care, specialty and other ancillary services, and a range of social services that fortify health and behavioral health outcomes and assure whole person care, including co-location and on-site integration of multidisciplinary care teams.

Once sites are selected, local and state planning activities will also address workforce development. These activities will leverage existing MHSA-funded workforce development infrastructure to support training and skill development in practices beneficial to this population. This formal training and skill development will be supplemented with strong clinical supervision and coaching throughout the life of the CCBHCs. These workforce development activities will be informed by the language and cultural sensitivities and other critical circumstances of the local

[24] Psychiatr Serv. 2012 Aug;63(8):802-7. doi: 10.1176/appi.ps.201100384. The impact of California's full-service partnership program on mental health-related emergency department visits. Brown TT[1], Chung J, Choi SS, Scheffler R, Adams N.

population to assure service delivery is highly individualized, culturally appropriate and consistently relevant. Further, during these development and expansion activities, CCBHCs will recruit/hire and train new staff (as needed) who are prepared to provide culturally sensitive services and supports. This staff development will be accomplished both through recruitment of individuals fully trained and ready, as well as via training up those who may have the proper foundation but not necessarily specific skills and/or cultural know-how.

Finally, with a long history of doing so, DHCS and individual sites will include both client and family representatives of the target population, including veterans' advocates, in all of the above proposed steps. Their involvement will inform the design and development of all aspects of the CCBHCs.

Section B-2 Input from Partners/Stakeholders

California envisions leveraging the DHCS Behavioral Health Forum as a venue from which to solicit meaningful input from consumers, family members, providers and other stakeholders. Implemented in 2014 as a result of recommendations from California behavioral health stakeholders in preparation for the transition of the former DMH and ADP into DHCS,[25] the Behavioral Health Forum meets on a quarterly basis. It is open to anyone who is interested in participating and is comprised of the following Forums, each of which would address a structural component of the CCBHCs:

- Client and Family Member "Open to All" Forum – provides Forum participants with "real life" stories from individuals who have lived experiences with mental health and/or substance use disorders, which are used to help inform and "bring to life" particular topics that will be discussed in the other Forums throughout the day.
- Strengthening Forum – focuses on improving or strengthening the existing delivery systems and benefits that are unique to specialty mental health and substance use disorders.
- Integration Forum – focuses on the new and expanded interaction between the county MHPs, county alcohol and other drug programs, other MH & SUD providers, and the MCPs in order to more effectively integrate the delivery of mental health, substance use and primary care services with the goal of developing a coordinated and integrated system between these delivery systems and benefits.
- Data Forum – focuses on developing and utilizing meaningful measures for performance/outcomes evaluation, with the goal of using appropriate and standard information to promote excellence in care and improve outcomes.
- Fiscal Forum – focuses on addressing key areas related to improving fiscal policy, reimbursement methodologies and billing processes for mental health and substance use disorder services, with the goal of streamlining program oversight and reducing administrative burdens that could detract from investing funds in direct services.

The CCBHC requirements span across each of these Forums. Specifically, the Client/Family Member Forum may help to inform the real-world operations of the CCBHCs, Strengthening and Integration may be used to develop the physical and behavioral health CCBHC coordinated systems, Data may be used to support the CCBHC evaluation, and Fiscal could be used to work

[25] The full "Stakeholder Recommendations for Mental Health and Substance Use Disorder Services" report, also commonly referred to as the "Business Plan," released in June 2013, may be downloaded online at: http://www.dhcs.ca.gov/Documents/StakeholderRecommen_forMHSUD.pdf

through CCBHC financing. Updates will be provided at the Behavioral Health Forum regarding the CCBHC Planning activities and decisions of the CCBHC Steering Committee, which is discussed in Section B-7 of this application. Behavioral Health Forum participants may provide their feedback regarding the development of the CCBHCs either at the Forum meetings or via email at the MHSUDS general email account (MHSUDStakeholderInput@dhcs.ca.gov).

Section B-3 CCBHC Selection

The selection process for California's CCBHCs will focus on identifying sites capable of implementing the array of services required to serve the target population, beneficiaries with co-morbid behavioral and physical health conditions utilizing high-cost ER and ACHI services. DHCS is currently underway with a data collection project to identify "hot spots" for these superutilizers throughout California. Although any MHP may submit a CCBHC Certification application, clinics located in these "hot spots" or concentrated geographic areas will be encouraged to apply. Interested MHPs will be vetted through an application process that ensures that CCBHC criteria are met.

DHCS has long-standing partnerships with the county MHPs through a formal contract between the department and each MHP. The department and the MHPs work closely together through a collaborative relationship with the County Behavioral Health Directors Association of California to identify best practices, performance measurement and reporting mechanisms, and areas for improvement. DHCS also has established relationships with provider organizations such as the California Council of Community Mental Health Agencies and the California Association of Alcohol and Drug Provider Executives. With input from the CCBHC Steering Committee, as well as stakeholders representing county MHPs, provider organizations, community based organizations, advocates, and persons with lived experience and their families, DHCS will develop and implement an application process whereby sites may apply to become a CCBHC. The selection process will incorporate the National Council's CCBHC Certification Criteria Readiness Tool to determine the prospective sites' readiness to participate in the demonstration project.

During the planning phase, DHCS will adapt the Institute for Healthcare Improvement's (IHI) Break Through Series learning collaborative model, to work with all prospective sites to prepare them to meet the CCBHC requirements. The IHI learning collaborative process is an excellent model for implementing systems change and improvement efforts. The learning collaborative model focuses on peer learning and collaboration to make system changes that will produce significant and sustainable results. By routinely measuring the impact of adopted innovations and shared learning amongst all participants, each prospective site will be able to accelerate their improvement process to achieve widespread implementation of the system change ideas.

Using this model, DHCS will adapt the Readiness Tool to develop a review protocol and work plan containing all CCBHC requirements to guide the learning and technical assistance of the prospective sites. Prospective sites will be engaged through a series of in-person and web-based learning sessions and regular technical assistance calls throughout the planning phase of the grant. At the conclusion of the learning collaborative process, prospective sites will be re-assessed using the adapted Readiness Tool to ensure readiness and compliance with CCBHC requirements before entering the demonstration phase of the project. All prospective sites, even those not selected to proceed with the CCBHC demonstration project, will benefit from the learning and change effort implemented in the selection process.

Section B-4 CCBHC Service Provision

Current California standards for behavioral health services are largely in alignment with core CCBHS requirements. That said, the gaps in services (intensity/volume and array) and care coordination resulting in avoidably high utilization by superutilizers will be identified and addressed during the CCBHC Planning Phase. DHCS, with input from the CCBHC Steering Committee and Behavioral Health Forum participants, will assess the needs of the target population and, based on those needs, develop programmatic standards that each CCBHS demonstration site is to meet. The local readiness assessments will include these programmatic standards, as well as those already delineated for CCBHS certification. Assessment findings will be reflected in workplans.

All program design and redesign efforts will be targeted to create behavioral health homes for individuals served, the foundation of which will be coordination of the full array of needed care, services and supports. The following describes current services associated with the five CCBHC program requirements, including the anticipated content of the workplans to directly address any gaps in services identified by the assessment and to provide services that advance recovery and improve overall consumer health and well-being.

PROGRAM REQUIREMENT 1: STAFFING

Using the Readiness Assessment, existing staffing will be evaluated to identify any gaps or shortfalls relative to the CCBHS and population requirements. Workforce shortages impacting staffing patterns in provider organizations are well known and being addressed through a variety of means, including using MHSA funds to expand the workforce. CCBHC candidate sites will look to more immediate means of assuring staffing size and scope meet the needs of the superutilizer population. Approaches will include increased use of telemedicine, primary care physicians, nurse practitioners, peers and other community supports to expand behavioral health capacity. The following briefly describes current staffing approaches and anticipated innovations to better serve superutilizers and others in the candidate site service areas.

General Staffing Requirements: Current MHP contracts specify the array of services required to meet Medicaid certification. The resulting mix and intensity of services is highly varied from county to county and site to site. Providers are required to have detailed job descriptions and written policies and procedures for assessing skills and providing evaluations to assure the adequacy of skills which may be reviewed as needed to ensure compliance with standards. During the planning and development phase, candidate sites will evaluate and, as needed, reformulate their staffing patterns to better serve superutilizers and to conform with CCBHC standards, if and when there are gaps. Given the centrality of care coordination for superutilizers, expanding the staffing and skill sets to effectively coordinate all aspects of care will be a high priority pursuit.

Management and Oversight: All local activities are overseen by the MHP Management team that includes the Chief Executive Officer (CEO) or Executive Director, and a Psychiatrist as Medical Director. The local CCBHC planning and development team will be guided by these individuals and prioritized to assure successful achievement of CCBHC standards.

Licensure and Credentialing of Providers: Currently, MHP staff comply with State licensure and accreditation requirements. This is assured through contract language and State oversight and monitoring. Any staffing changes associated with CCBHC development will conform to State requirements.

Linguistic Competence (and other training): California is a diverse state with multiple cultures and languages. The State requires counties to provide services in threshold languages, which are selected for each county depending on their population. Appropriate interpretation/translation services are required to be provided. Analysis of the superutilizers will include these individuals' language needs, with particular attention to whether these needs are outside of the threshold languages are potentially contributing to access barriers.

PROGRAM REQUIREMENT 2: AVAILABILITY/ACCESSIBILITY OF SERVICES

As with staffing, availability and accessibility of services will be evaluated with the Readiness Assessment Tool. Means to shorten access time and assure availability of needed services will be incorporated into workplans and addressed during planning and development. Given that superutilizers have not, and likely will not, use traditional means of accessing behavioral health services, CCBHC candidate sites will focus on deploying innovative ways to outreach and engage these individuals and design/redesign services so they are welcoming and comfortable for those in need.

General Requirements of Access and Availability: Counties currently provide services to all who seek it, including those with no ability to pay, to the extent resources are available. Candidate sites will evaluate whether their current scope meets the CCBHC standard and, as needed, develop means to assure required services are available to all.

Requirements for Timely Access to Services and Initial and Comprehensive Evaluation for New Consumers: Currently, all individuals calling or walking into a public behavioral health service site immediately receive a preliminary screening and risk assessment. If an emergency or crisis is identified, needed services and supports are immediately provided, and appropriate action is taken. This is followed up by an appointment for an initial evaluation and initiation of ongoing services and supports. State contract requires that initial visits are made available within seven calendar days for urgent needs (including those discharging from inpatient services) and 14 days for non-urgent. The CCBHC readiness assessment will include evaluation of current timeliness, as well as whether the 'super utilizers' would benefit from even shorter timeframes for access. Improving timeliness will include creating or expanding field-based initiation of services, same-day access, and expanded evening and weekend hours.

Currently providers are required to complete comprehensive initial assessments and treatment plans within 60 days of initial service. While treatment occurs during these 60 days, current approaches will be examined to find ways to shorten this duration and increase levels of engagement and therapeutically beneficial services during this critical initial window of service. This will include increased use of evidence-based patient activation and motivational interviewing techniques, introduction of and linkage to peers, and other activities that build individuals' belief and hope in their own recovery, and trust in the providers serving them. In addition, the CCBHC requirement to update the plan every ninety days will be implemented, if not already in place, since the current State requirement is annual review and revision. Finally, while formal guidelines will be in place to meet CCBHC requirements, processes will be designed to assure needed individual services and supports are provided when they are needed, regardless if these individualized timeframes exceed minimum, formal requirements.

Access to Crisis Management Services: All counties are required to have available 24-hour emergency services. To better support this requirement, two years ago the California Legislature passed a bill to increase access for crisis management. The bill allows counties to apply for funds

to create crisis management facilities and expand crisis management staff. In addition, providers currently work closely with local Emergency Departments to assure individual needs are met in a coordinated way, and services are based on a "system of care" approach. In light of the needs of superutilizers, these activities will be augmented during the development of CCHBCs.

Given that superutilizers and those likely to become high utilizers (like veterans and young adults) are not sufficiently benefiting from current crisis services, CCBHC candidate sites will be supported to expand their scope and size of crisis management, including development of services like Mental Health First Aid, respite centers, and other evidence-based approaches. In addition, analyses will be conducted to reveal what precipitates crisis to identify gaps in access and services that could have prevented crisis. Reducing crisis will be one of the core objectives of CCBHC development activities.

No Refusal of Services Due to Inability to Pay: No one is turned away due to inability to pay for services; to the extent resources are available. As indicated above, CCBHC candidate sites will work to eliminate any existing limitations that do not conform to CCBHC requirements.

Provision of Services Regardless of Residence: No individual is denied services due to place of residence or homelessness. MHPs have inter-county agreements for managing out-of-county residents, some of which is mandated and overseen by DHCS. To the extent that superutilizers are struggling with cross-county access and the existing agreements and relationships are not facilitating their timely access to services, CCHBC candidate sites will enhance their linkages with providers across counties and supports for individuals moving across county lines.

PROGRAM REQUIREMENT 3: CARE COORDINATION

Through DHCS-sponsored improvement projects, MHSA Innovation projects, and local initiatives, California has made great strides in the implementation of integrated care and the development of care coordination. The CCBHC Readiness Assessment will be used to understand each candidate site's progress in this area and identify shortfalls to be addressed via the workplans.

All CCBHC program requirements will be leveraged to assure successful development and delivery of care coordination. For example,

- Staffing requirements will include care coordination, both level of staffing and staff skills and abilities (per selected evidence-based care coordination model);
- Care coordination will drive timely access, reveal new problems in accessibility to be addressed, and generally drive resolution of barriers to access;
- Coordination will be designed to prevent crisis, assure its accessibility when unavoidable, assure post-crisis continuity of care, etc.;
- Individual care coordinators and care teams have access to the array of services needed, including the fostering of organizational relationships and communication methods that support person-centered care on a day-to-day basis; and,
- Quality improvement activities will be designed to support care coordination, including data collection and tracking to reveal when it is not sufficiently effective and where there are opportunities for improvement.

Over the last five years, DHCS funded three intensive learning collaboratives focused on care coordination for individuals with co-occurring behavioral health and chronic physical conditions. Each of these initiatives began with the convening of experts to share the most effective care

coordination methods in the field at the time. This allowed participants to benefit from models developed by University of Washington's AIMS Center, the MacColl Institute (Chronic Care and Care Coordination Models), American College of Physician (Patient Centered medical Homes) and others.

To participate in these initiatives, organizations were required to bring together mental health, substance use disorder, and primary care teams who were each committed to the ideal of integrated care. Improvement initiatives offered teams and health plans an opportunity to build more effective administrative and clinical communication processes and care coordination infrastructures. Health plans actively participated as collaborative partners, exploring the shared benefits of care coordination for complex target populations, as well as the potential role of Health Plans as "integrators" in California's health system reform. As such, these learning collaboratives have created a solid foundation for California to continue to increase the level of care integration into the CCBHCs. A document detailing lessons learned is available on the California Institute for Behavioral Health Solutions (CIBHS) website: www.CIBHS.org.

Another key area of care coordination experience that will inform candidate CCBHC's is the work of Cal MediConnect, a program that supported the creation of a structure to improve coordination of care for dually eligible beneficiaries with serious behavioral health conditions. DHCS has also just partnered with the Interagency Council on Veterans to participate in a SAMHSA-sponsored SUDs Virtual Implementation Academy with other states, which will begin in September 2015. The learning from this will be leveraged during CCBHC planning and development and beyond.

General Requirements of Care Coordination/Treatment Team, Treatment Planning and Care Coordination Activities: In light of the progress described above and the rapidly evolving practices in the area of care coordination, CCBHC development efforts will bring together what is already working in California with other and/or new evidence based practices (EBPs) (e.g. Pathways, BOOST) to identify care coordination standards and practices to be adopted – and then provide the technical support to adopt them in each candidate site. Care coordination will be designed for the deliberate organizing [of] patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. Candidate CCBHCs will coordinate care across the spectrum of health services, including access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities, as necessary, to facilitate wellness and recovery of the whole person.

Care Coordination Agreements: Pursuant to Title 9, California Code of Regulations, Chapter 11, Section 1810.370 and the DHCS/MHP contract, MHPs, including those participating in the learning collaboratives described above, are required to have written MOUs with all Medi-Cal MCPs that enroll beneficiaries covered by the MHP. The MOUs support care integration and care coordination and address referral protocols, clinical consultation, information exchange, and dispute resolution protocols. Agreements held by candidate CCBHC sites will be examined and amended, as needed, to support the care coordination standards discussed above. In addition, to the extent they are missing, partnerships or formal contracts will be developed with:

- Federally Qualified Health Centers and rural health clinics (as applicable);
- Inpatient psychiatric facilities and substance use detoxification, post-detoxification step-down services, and residential programs;

- Other community or regional services, supports, and providers, including schools, child welfare agencies, and juvenile and criminal justice agencies and facilities, Indian Health Service youth regional treatment centers, State licensed and nationally accredited child placing agencies for therapeutic foster care service, and other social and human services;
- Department of Veterans Affairs medical centers, independent outpatient clinics, drop-in centers, and other facilities of the Department;
- Inpatient acute care hospitals and hospital outpatient clinics; and,
- Other community regional services, supports, and providers who may enter into a care coordination agreement with the CCBHC (based on the population served)

Care Coordination and Other Health Information Systems: One of the difficulties partners often face in coordinating care is that they have different electronic health records that do not have interconnectivity, so timely sharing of information is insufficient. CIBHS has created a web-based clinical information system, eBHS, which has been programmed to address this gap. It is modeled after disease registries used in primary care settings and disease management, and has the necessary security and controls to meet HIPAA and CFR Part 2 requirements, as well as tracking of specific consents to release/share information. When partnering entities have the necessary Business Associate Agreements in place and individual releases of information executed, each entity may view and add to clinical information in one centralized location. Data can be uploaded from existing data sources to avoid data entry duplication, as well as entered directly into the web-tool to support data collection of clinical information that is not yet tracked in other systems. Reporting capability allows real-time tracking and identification of individual and population needs and, as such, will serve as a key care coordination tool.

eBHS is currently in the Beta stage of development. During the CCBHC Planning Phase, its testing and refinement will be completed. Some of the planned refinements include adding reminders and/or flags to date and value-sensitive items (e.g. incomplete referrals, lab results of concern).

PROGRAM REQUIREMENT 4: SCOPE OF SERVICES

Person-centered care will be a central tenet of planning and design of CCBHCs across the state. Recognizing that person-centeredness is a way of working, not separate work, it will be designed into all aspects of the programs, including outreach and engagement, assessment and planning, individual and group interventions, and care coordination. The Readiness Assessment will be designed to identify where person-centeredness is lacking and subsequent planning and design will include finding ways to expand it. A variety of supports will be provided to assure that candidate-CCBHC sites provide (directly or through appropriate contractors) all services needed by superutilizers. The learning community will also be designed to allow sites already strong in a given area to help those needing additional development.

Through the staffing, access and care coordination development described above, candidate CCBHCs will develop the infrastructure and capabilities necessary to monitor the needs, progress, utilization and outcomes of the population service, and to adjust the scope of services over time, as needed. This will include ensuring that the population can be stratified for risk, utilization, cost and other attributes on an ongoing basis. These adjustments will be at the individual, as well as program levels. The former so individuals receive what they need when they need it and the latter so programs can meet the evolving needs of the population – all the while assuring solvency of the CCBHC.

Below is a description of current service delivery in the nine key areas, as well as planned changes or advancements associated with becoming a CCBHC.

General Service Provisions: Entities working to become CCBHCs will be responsible for providing the required scope of services. Some services may be contracted by counties to providers other than CCBHCs to be part of an overall system. Services not available, but needed by the individual, will be available through referrals. Means to address identified gaps will be developed during the planning phase. Services will be integrated through care coordination and informed by recovery principles and approaches.

One of the most important roles that CCBHCs will be designed to fulfill is outreach and engagement to veterans not receiving services in any system and who may be at risk for suicide and/or significant deterioration of mental health. Rapidly engaging them in services and supports will be the first priority. Support will be provided to assist veterans who may be qualified to access Veteran's Affairs (VA) benefits, but are not yet enrolled. When they are not qualified or the services are not accessible (e.g., too far away), the CCBHCs will meet their needs.

Requirement of Person-Centered and Family-Centered Care: Services for adults are person- and family-centered and recovery-oriented. California has been working on this for the last eleven years under the MHSA. Services for children and families are family-centered, youth-guided, and developmentally appropriate. As California is very diverse, cultural competence is important. Any entity working to become a CCBHC will be required to assure that these standards are met. To build on this foundation, CIBHS will provide guidance on person-centered treatment planning via an existing practice improvement program known as Transformational Care Planning (TCP), as well as and the Kansas University Strengths Model.

Crisis Mental Health Services and Crisis Stabilization: CCBHCs' approach to crisis health services will be three-fold: 1) prevention of crisis via improved access to services; 2) crisis stabilization via recovery-oriented services; and, 3) timely follow-up care to assure continued improvement.

As described earlier, superutilizers and those likely to become high utilizers (like veterans and young adults) are not sufficiently benefiting from current crisis services. Therefore, CCBHC candidate sites will be supported to expand their scope and size of community-based crisis management services, including development of services like Mental Health First Aid, respite centers, and other evidence-based approaches, thus reducing emergency room visits.

Currently as part of California's Medicaid rehabilitation option, counties coordinate with social services, housing, educational systems and employment systems. This effort has been reinforced by MHSA, which provides funding for activities such as outreach, "whatever it takes" services for FSPs, and housing. Most counties and providers provide access to and education about Psychiatric Advance Directives. Suicide prevention, crisis hotlines and warm-lines are available around the State, which is another benefit of MHSA funds through the work of the county California Mental Health Services Authority (CalMHSA), a Joint Powers Authority. The Suicide Prevention Initiative uses a full range of strategies from Prevention to Early Intervention across the lifespan and across diverse backgrounds to prevent suicide. There are four program areas: 1) Statewide Suicide Prevention Network; 2) Regional and Local Suicide Prevention Capacity Building Program; 3) Social Marketing; and 4) Training and Workforce Enhancement. Other CalMHSA statewide programs are elimination of stigma and discrimination and expansion of

school mental health. This existing capability will be brought into the collaborative learning community to help address identified gaps in services.

CIBHS has developed consensus guidelines for involuntary care assessment and is preparing to provide training on them for providers, hospital emergency departments, and law enforcement. Also, Crisis Intervention Training has been provided or is in planning for law enforcement in most areas of the state, including the California Highway Patrol. Many counties in California received funds to develop and implement mental health triage teams and funding for the physical plant development of crisis residential and Mental Health Urgent Care Centers. Collectively, these investments will substantially increase a county's ability to manage individuals in crisis at the least restrictive, lowest level of care possible.

Screening, assessment, and diagnosis, including risk assessment: Comprehensive assessment services are currently required to be provided. These assessments include identification of risks, cultural factors, tobacco and other substance use, physical health concerns, and many other individual needs and circumstances. Through the CCBHC development activities, existing screening and assessment services will be modified to assure the following for individuals initiating services:

- Identification of Veteran status, including potential to gain VA benefits (e.g., asking the question "Have you or a member of your family ever served in the military?");
- Exploration of access barriers to services needed and methods to overcome them;
- Introduction of peer supports and stories of recovery to promote hope and belief in their own possible improved future:
- Measurement of stage of change and stage of treatment;
- Patient activation and engagement; and,
- Linkage to a care coordinator to assure follow-up services are supported and whole person care is underway.

Person-Centered and Family-Centered Treatment Planning: The same principles and practices discussed above under "*Requirement of Person-Centered and Family-Centered Care*" will also be applied to treatment planning.

Outpatient Mental Health and Substance Use Services: Providers working to become CCBHCs currently provide many of the required behavioral health services. Some services are provided directly while others are delivered by contracted community-based providers. Services not available, but needed by the individual, are available through referrals. In California, most county agencies serving as MHPs have fully integrated substance use services within their administrative structure. To varying degrees, these sets of services are clinically integrated. Smoking cessation is also often supported by these providers. Many link individuals to free services like those provided by the University of California, San Francisco, Smoking Cessation Leadership program designed for individuals with mental illness. These smoking cessation programs can be replicated and expanded to other CCBHCs through the planning that this grant makes possible.

In 2002, California established the Assisted Outpatient Treatment Demonstration Project Act of 2002, known as Laura's Law, which authorizes court-ordered involuntary assisted outpatient treatment (AOT), for individuals that, due to the symptoms of their mental illness, do not voluntarily access local mental health services. This Act allows individual counties to determine whether to offer these services. Since 2013, counties have been able to utilize various specified funding including Mental Health Services Act (MHSA) funds for AOT services. The decision to

implement AOT is made by county boards of supervisors (BOS). It is not a decision made by the MHP. While only a very small number of county BOS have elected to develop and offer these services to date, it will be included in the potential service array to be developed during the planning, depending on the identified needs of the superutilizers in each location, and whether or not a county offers AOT services. Several counties have recently established AOT programs on a pilot basis and CCBHC funding may lead to these counties expanding such programs. California's AOT model is an augmentation of the Assertive Community Treatment model for FSPs, as only individuals who have been offered and refused such services are eligible for the AOT services.

Outpatient Clinic Primary Care Screening and Monitoring: During the Planning Phase, candidate-CCBHC sites will be responsible for creating and/or expanding outpatient clinic primary care screening and monitoring of key physical health indicators and health risk. Many providers already do this, either directly or through an arrangement with a health clinic. No site will be certified as a CCBHC unless this requirement is met.

Targeted Case Management Services: Several years ago, California obtained federal CMS approval to develop targeted case management (TCM). As a result, it is currently available in all counties. Candidate CCBHCs will work to enhance these case management services, especially during times of transition between providers and care settings like emergency departments and inpatient services. As the awareness of individuals' barriers to access deepens and their triggers for crisis become clearer, the deployment of TCM will become increasingly focused and provided within the context of the whole person, their goals, their community and natural supports.

Psychiatric Rehabilitation Services: California has the Medicaid Rehabilitation Option for its Medi-Cal (Medicaid) program. Rehabilitation services are available in all counties. Counties frequently contract for these services, including with social rehabilitation programs. As with other services, gaps in services that are needed by the population of focus will be identified and addressed during the planning phase. Given the robust nature of psychiatric rehabilitation services, they represent an important area. CCBHC development will support diversifying the existing array of these services to meet the specific needs of the target population.

Peer Supports, Peer Counseling and Family/Caregiver Supports: Most providers currently provide some degree and range of peer specialists and recovery coaches, peer counseling, and family/caregiver supports. One of the most prominent and common peer supports is peer-guided Wellness and Recovery Action Planning (WRAP). Given the proven benefit of peer supports, the planning phase will include developing methods to better link them to peers and these existing services, as well as development of new services specifically suited to the population of focus (e.g., specialized peer supports for veterans). The CCBHC focus on this should by substantially fortified by the County Behavioral Health Directors Association of California-sponsored bill currently in the legislature to develop a certification process for peers.

Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans: In California, although there are many military bases and VA health facilities (including hospitals), State-supported behavioral health providers do provide services for military members. This is true especially if there are no military services in the area. These services must be provided consistent with the Uniform Mental Health Services Handbook (UMHSH). Consistency with the UMHSH will need to be explored and enforced, if needed. Active Duty Service Members and Activated Reserve Component (Guard/Reserve) must use their servicing

Military Treatment Facility (MTF) and their MTF Primary Care Managers, who are contracted by the MHP. Members of the Selected Reserves who are not on active duty are eligible for TRICARE insurance, which can pay for services.

Every veteran seen for behavioral health services will be assigned a "Principal Behavioral Health Provider" (PBHP). The PBHP is responsible for assuring a treatment plan in consultation with the military person (or whomever the military person authorizes) and all appropriate services are provided. The PBHP is also responsible to assure all requirements for services to military personnel, including cultural competence, are met. No entity will be certified as a CCBHC if this is not done.

PROGRAM REQUIREMENT 5: QUALITY AND OTHER REPORTING

As previously described, DHCS will work with CIBHS to form a learning community that will facilitate participating entities to regularly convene in-person and/or via the web to share what is and is not working and why. Counties in California have a strong tradition of working together and learning from each other. DHCS and CIBHS will also form work groups, including a data and evaluation work group to develop a continuous quality improvement (CQI) model and infrastructure, as well as to identify and define data sources, elements, and indicators to monitor and evaluate program performance. In addition, specific technical assistance or training may be requested by a county or group of counties to address a single problem or issue and the learning community creates an efficient means to provide it.

Additional technical supports will be provided, as needed, regarding rapid cycle testing, data gathering and measurement, use of data for improvement, and other useful quality improvement techniques. These supports will be applied during the CCBHC development activities and provided to site staff so they can be used in their continuous quality improvement efforts.

Data Collection, Reporting and Tracking / Continuous Quality Improvement (CQI) Plan: Several approaches will be applied to assure data capabilities, from collection to reporting and tracking to use for routine management and continuous quality improvement. The CIBHS web-based clinical information system, known as eBHS, will be used for the following:

- Integrating and making accessible clinical data for care coordination and whole person care and that would otherwise remain in separate medical records.
- Organizing this clinical data so it supports chronic condition management (e.g., a disease registry).
- Providing clinical alerts and other forms of communication between treatment teams and to support care coordination
- Querying and reporting of this data at the individual patient, provider panel, and whole program levels, as well as around a variety of population variables (e.g., age, language, location, treatment needs, utilization) for stratification of the target population and support of population management activities.
- Tracking of process and outcomes to evaluate progress and quality, including on-line assessment scales like Milestones of Recovery, GAD-7, PQ-9, etc.

CIBHS' eBHS system has the following design features:

- Web-based - no hardware or software installation or maintenance
- Accessed by individually licensed users
- Adaptable to meet both State and local data tracking, sharing and reporting needs

- Flexible, real-time reporting and querying capability to support individual, population and system improvement
- Secure data storage and access: HIPAA and CFR42 compliant
- Accessibility to and use of both new and existing clinical data

Since eBHS can upload electronic data from external sources, data from existing collection systems will be leveraged to minimize double data entry and maximize clinical and demographic information available to providers and for care coordination activities. In addition, DHCS will work with CIBHS and other forums to identify the data necessary for annual reporting, as well as for CQI. This will include specifying goals and objectives, defining metrics, determining data analysis methods, progress tracking and reporting, and applying findings toward training and technical assistance to improve achievements.

Section B-5 *Evidence-based Practices*

DHCS will be working closely with CIBHS and the California Department of Public Health's Office of Health Equity (OHE) to offer an array or palette of EBPs and community defined practices (CDPs) to support effective delivery of the service array required of selected CCBHCs. Practices ***required*** of the CCBHCs to support and improve treatment outcomes for the target population will be:

- Patient Activation and Engagement: Recognizing that a lack of engagement and activation around their health status and needs often contributes to this population's high utilization of urgent, emergent and acute services, an evidence-based patient activation and engagement practice, such as Insignia's "Patient Activation Management," will be selected with the guidance from key stakeholders. Candidate sites will be provided the change management support to successfully deliver the practice.
- Motivational Interviewing (MI): A client-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment, MI also frequently includes other problem-solving or solution-focused strategies that build on clients' past successes. Use of this evidence-based practice will be critical to improving outcomes for the population of focus.
- Cognitive-Behavioral Therapy (CBT): CBT is based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned. Supporting this kind of change will be central to effectively changing individuals' patterns of health care utilization, lifestyle choices, etc.
- Care Coordination: Similarly, candidate CCBHCs will be supported to adopt an evidence-based approach care coordination. Selection of the particular approach will be based on what is already working in California and what will best fill the gaps or shortfalls in the candidate sites.

These practices are expected to have broad applicability to superutilizers. Patient activation and engagement will improve linkage to services and adherence to treatment and self-care. MI will be critical in engaging these individuals in services and developing their readiness to benefit from subsequent services and supports. CBT will also be a key intervention to support changes related to accessing care, as well as self-care, community engagement, and other recovery-oriented activities. Finally, care coordination will be the foundation for person-centered, whole person care.

Leveraging California's existing expertise, training capacity, and technical assistance infrastructure for EBP adoption will ensure the ongoing successful implementation and evaluation of the identified EBPs in the selected CCBHCs. For a full listing of EBPs and CDPs currently identified by CIBHS and implemented in MHPs throughout California, see Table 5.

Table 5. Evidence-Based Practices Currently Used in California

Aggression Replacement Training®	Cognitive Behavioral Therapy for Psychosis CBTp	Depression Treatment Quality Improvement (DTQI)
Functional Family Therapy (FFT)	Trauma-Focused Cognitive Behavioral Therapy (TF CBT)	Triple P Project
Motivational Interviewing	Brief Parent Enhancement Strategies (BPES)	Kansas University Strengths Model
Supported Employment	Supported Education	Crisis Residential
Transitional Residential	WRAP	Supported Housing
Medication Optimization	PIER Model: Early Detection and Intervention for the Prevention of Psychosis	

Section B-6 *CCBHC Certification*

DHCS is already responsible for the certification of county owned and operated outpatient mental health clinics and for provider enrollment and certification of DMC providers, and will develop similar processes for the certification and re-certification of CCBHCs. The department will be responsible for the initial certification of each CCBHC and for re-certification every three (3) years. However, for the 2-year demonstration pilot, the two selected CCBHCs will be certified annually during the 2-year period.

Certification will be done onsite utilizing a state developed certification protocol that contains all the CCBHC requirements. The site review will include a review of the physical environment and will require the CCBHC to show documented evidence of compliance with each requirement. For any items found to be out of compliance, the CCBHC will be required to submit a Plan of Correction (POC) within 30 days and follow-up will be conducted to verify the effectiveness of the POCs.

In addition, the department will encourage CCBHCs to be accredited by an appropriate nationally-recognized organization (e.g., the Joint Commission, the Commission on Accreditation Rehabilitation Facilities, the Council on Accreditation, or the Accreditation Association for Ambulatory Health Care), which will be verified during the re-certification process.

Section B-7 *Transition to Implementation*

At the onset of the CCBHC Planning Phase, DHCS will form a CCBHC Steering Committee that will be comprised of key partners/stakeholders such as participating state agencies, CCBHC counties and their contracted providers, as well as others who have the subject matter expertise necessary to ensure both successful planning and implementation of the project. DHCS will also form workgroups that will inform the Steering Committee, as well as the Behavioral Health Forum. Potential workgroups will focus on rate-setting, application development, certification standards, care coordination, and data and reporting. Steps to be directed by the Steering Committee and workgroups include:

- Statewide analysis of service history to identify "hot spots" of high utilization (e.g., via GIS mapping) and to discover drivers of this utilization (e.g., insufficient pathways to timely and

appropriate care, physical and behavioral health concerns, social conditions, cultural characteristics).

- Application by interested MHPs/providers to become a CCHBC that serves superutilizers and addresses these drivers of high utilization.
- Assessment of level of readiness in each applicant and selection of project sites in urban, rural and possibly frontier counties with the following attributes: critical mass of existing capacity that can be expanded to meet the needs of the population of focus, strong local leadership commitment and support, and engagement of local hospitals and social/community-based services.
- Development of rates.
- Organization of selected MHPs/providers into a learning community to enable shared support and learning throughout the planning stage.
- Support for each site to use their completed Readiness Assessment Tool to create a work plan for their individual CCBHC development.
- In-person and web-based technical assistance and training to provide guidance and expertise that supports activities in the workplans.
- Local completion of workplans with DHCS support and cross-agency shared learning to include training and technical assistance with select EBPs, development and/or expansion of care coordination, quality improvement and other uses of clinical and utilization data.
- Support for development of workplans in each site to transition from planning to implementation. Plans will include steps to initiate and continue staff training and development; outreach to and engagement of the population of focus; coordination of each individual's care; and provision of timely, welcoming and recovery-oriented services.

The Planning Phase will result in the development of a California CCBHC Project Plan. The Plan will provide a framework and outline of DHCS one-year planning phase activities, goals and objectives, roles and responsibilities, and projected timelines to complete the project. At a minimum, the Plan will:

- Memorializes the CCBHC application and expectations.
- Identify and describe California proposed CCBHCs.
- Describe the CCBHC structure and infrastructure.
- Describe the target population to be served.
- Review certification processes.
- Review and describe billing processes.
- Detail data submission requirements and deadlines.
- Provide an overview of available training and technical assistance.
- Describe oversight and compliance monitoring activities, program integrity and required data reporting.
- Describe local governance requirements.
- Establish timeframes and information for engaging in ongoing state-level stakeholder and feedback/input.
- Identify relevant partnerships and specify MOUs, where applicable.
- Identify the supports and services the sites will provide.

This planning and development will be informed by the needs of special populations, such as veterans who have behavioral health concerns and who may be at risk for suicide. For example,

themes could include the identification of these veterans and their families who are not currently accessing United States Department of Veterans Affairs (USDVA) benefits, connecting them with the California Department of Veterans Affairs and their local County Veteran Service Officer to determine their eligibility for USDVA benefits, and then filling the gaps in benefits and services not available to them.

Section B-8 *PPS Rate Selection and Justification*

California is planning to use the Certified Clinic Prospective Payment System Alternative (CC PPS-2) rate-setting methodology because it is designed to prioritize quality of care over quantity of care, and it includes mechanisms to mitigate risks associated with monthly payments. By reimbursing CCBHCs for monthly contacts rather than daily contacts, the CC PPS-2 rate setting methodology incentivizes CCBHCs to manage the care provided during the month. The CC PPS – 2 rate methodology mitigates the risk of providers limiting care to too few encounters per month by including a quality bonus payment, which will incentivize providers to render services sufficient to meet the quality measures. The CC PPS – 2 reduces the incentive for providers to not serve high cost beneficiaries to ensure costs remain within the base PPS rate by allowing providers to be paid multiple PPS rates for high cost beneficiaries with specified conditions. Finally, the CC PPS - 2 mitigates the risk of one or two high cost utilizers from pushing costs beyond the PPS rates by including an outlier payment for each PPS rate. California is planning to develop a monthly PPS rate to encourage CCBHCs to render high quality care.

California is planning to collect base cost with supporting data from CCBHCs through a standardized cost report that determines costs in a manner that is consistent with the standards described in Appendix III of the RFA. California has substantial experience collecting cost reports from providers of Medi-Cal SMHS and SUD services as these providers are currently required to file cost reports annually. California will be able to build upon its existing infrastructure to collect base cost and supporting data from CCBHCs for the purpose of developing PPS rates.

Section B-9 *Establishment of CCBHC PPS Rates*

During the planning phase, California will work with an expert actuarial consultant to develop monthly PPS rates, quality bonus payments and outlier payments for each CCBHC utilizing the CC PPS-2 rate setting methodology. California will work with the consultant to specify the base cost information and supporting data that will be needed for the actuarial to calculate a base PPS rate for each CCBHC, PPS rates for high cost utilizers, and outlier payments. The impacts of the forthcoming CMS rule on mental health and substance use disorder parity and changes in utilization due to the provision of services that are not currently covered under California's Medicaid State Plan will be considered in calculating the PPS rates.

California will work with stakeholders to identify quality measures in addition to the six measures required in Appendix III that will be designed to incentivize CCBHCs to provide services in an amount sufficient to produce desired outcomes for the target population. California is currently working with MHPs to design a set of quality measures for the Medi-Cal 1915(b) SMHS waiver. These quality measures will be considered during the CCBHC Planning Phase as additional measures for the quality bonus payment. Once the quality measures have been defined, California will also develop mechanisms to capture the quality measures (if not already captured), establish standards to determine when a quality measure has been met, define the payment amount when quality measures are met, and a mechanism to make the payments to the CCBHCs

that meet the quality measures. If additional quality measures are identified, California will collaborate with SAMHSA and CMS on the selection of those measures.

During the CCBHC Planning Phase, California will also develop a reimbursement mechanism for CCBHCs that is consistent with its current financial and reimbursement structure for Medi-Cal SMHS and SUD services. California currently utilizes certified public expenditures as the basis to make federal reimbursement to county mental health and county behavioral health departments for Medi-Cal SMHS and SUD services. These certified public expenditures are made with state funds that are continuously appropriated and distributed to counties on a monthly basis from dedicated income tax revenue, sales tax revenue, and vehicle license fee revenue, as well as county general funds. California is planning to design a reimbursement process for CCBHC's that utilizes intergovernmental transfers (IGTs) so as to preserve the existing financial structure for the provision of Medi-Cal SMHS and SUD services.

Section B-10 *Participation from Other Organizations*

During the Planning Phase, and eventual Demonstration Phase, of the project, DHCS will work with core organizations that represent local mental health plans and substance use treatment providers, as well as organizations that provide statewide technical assistance and training. As local mental health plans and their organizational contract providers are vital to the success of planning and the implementation of the demonstration program, the County Behavioral Directors of Association of California (CBHDA) will be a core organization that will work with DHCS to develop the California CCBHC concept. CBHDA is an advocacy association representing the behavioral health directors from each of California's 58 counties, as well as two cities (Berkeley and Tri-City). CBHDA provides policy, program, and information support and advocacy for MHPs. CBHDA will play a critical role in helping to identify CCBHC sites in the State, and ensuring the certification, funding and service delivery processes developed during the Planning Grant Phase will be successfully implemented and evaluated.

Additionally, a significant function will be to support the CCBHC implementation with the appropriate technical assistance and training. Consequently, DHCS will work with the University of California, Los Angeles (UCLA), and the California Institute for Behavioral Health Services (CIBHS) and others as core partners during both the Planning and Demonstration Phases. UCLA provides technical assistance to help improve the performance of local substance use treatment delivery, while CIBHS is a non-profit agency that provides health professionals, agencies, MHPs and DHCS with technical assistance and training to address behavioral health challenges through policy, training, evaluation, technical assistance, and research.

Lastly, DHCS, CBHDA and CIBHS will be working closely with provider organizations and stakeholders through outreach opportunities offered by the Behavioral Health Forum to ensure feedback and input on a continuous basis during both the Planning and Demonstration Phases.

Section B-11 *CCBHC Board Governance*

DHCS will be maximizing California's current process for local board governance of mental health service delivery provided by a statewide network of Local Mental Health Boards and Commissions (LMHB/C). LMHB/Cs are in each of California's 58 counties, pursuant to California Welfare and Institutions Code (WIC), which requires MHPs to establish a LMHB/C. Members are appointed by the local MHPs and are individuals who have experience and

knowledge of the mental health and substance use treatment system.[26] Additionally, WIC Section 5604(a) (2) requires that half of board membership be consumers or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services. At least 20 percent of the total membership is consumers, or individuals with lived experience. An important function and requirement of LMHB/Cs is to review and evaluate the community's mental health needs, services, facilities and special problems. This function will be leveraged to meet the purpose of planning and implementation of CCBHCs and the related evaluation processes. The current duties of LMHB/Cs to advise the local Board of Supervisors and the county behavioral health director regarding aspects of the local mental health program will be leveraged to provide input and review of CCBHC services, especially with regard to the identified target populations. Consequently, LMHB/C participation will ensure informed community participation in the planning process, provide significant governance and oversight of the CCBHC services provided to the target population, and will be an invaluable partner in the planning and implementation of CCBHCs.

Section C-1 DHCS Capability and Experience with Similar Projects and Populations

DHCS has had extensive experience administering primary care and community-based behavioral health services through its managed care delivery system, 1915(b) SMHS waiver, MHSA, DMC system and SAMHSA Block Grants (SAPT, Mental Health and PATH), with a focus on recovery-oriented and culturally appropriate/competent services through partnerships with county MHPs. For well over a decade, these principles/services have been evident in both State statute and regulations, most recently with the passage of the MHSA. For years, counties have developed and submitted to the State Cultural Competence Plans, in which the MHPs is required to develop a plan that includes strategies for improvement, a population assessment and provider assessment, a listing of specialty mental health services available in primary languages, and a plan for cultural competency training for MHP staff and provider. Furthermore, DHCS has invested resources into ongoing culturally competent and recovery-oriented trainings and technical assistance through a contract with CIBHS. CIBHS' Center for Multicultural Development is designed to promote the cultural competence of publicly funded behavioral health systems and ensure the integration of cultural competence into policy development, research, training, technical assistance, and other activities and products of CIBHS. Other CIBHS trainings and technical assistance topics include EBPs (a wide array of practices in dozens of counties over the last 10 years), Care Coordination Collaboratives (four multi-county initiatives), Advancing Recovery Collaboratives (three multi-county projects), person-centered treatment planning (Transformational Care Planning in two large counties) and many others. Finally, the MHSA has expanded these principles through such initiatives as Wellness and Recovery Centers and the Reducing Disparities Project, which is managed by CDPH.

Section C-2 AND Section C-3 *List of Staff Positions and their Demonstrated Experience*

Karen Baylor, Deputy Director, MHSUDS: Provides strategic and political vision and is ultimately responsible for delivering project. Dr. Baylor has over 20 years of experience working in the field of behavioral health as both a clinician and an administrator, and has worked at both the State and local levels.

[26] Some mental health boards that oversee blended behavioral health departments have over-see and monitor both mental health and substance use treatment services.

Brenda Grealish, Assistant Deputy Director, DHCS MHSUDS: To provide daily oversight and will be the primary contact at DHCS for all activities related to the administration of the grant. Ms. Grealish has worked for the State of California for 20 years, primarily in the field of behavioral health research and evaluation, but more recently in the administration of California's public specialty mental health services system.

Rachelle Weiss, Assistant Division Chief, DHCS MHSD: To lead the data and reporting workgroup, establish data standards and data reporting capacities for CCBHC clinics. Ms. Weiss has over thirteen years of professional experience in California State Government, most of which was at the former Department of Alcohol and Drug Programs.

Chuck Anders, Branch Chief, MHSD: To lead the rate setting workgroup and work with a PPS rate consultant to establish a PPS rate following the guidelines developed by CMS/SAMHSA. For almost 20 years, Mr. Anders has worked in behavioral health, and is a subject matter expert regarding behavioral health fiscal policy development and implementation.

Lanette Castleman, Branch Chief, MHSD: To oversee all activities related to the certification of clinics, and coordinate the implementation of all quality assurance criteria. Ms. Castleman has 30 years experience in the mental health field, including project management for monitoring and oversight of MHPs, certification of county owned/operated mental health clinics; licensing and certification of mental health facilities/programs; and directing quality improvement projects to obtain and maintain facility licensure and accreditation.

Henry Omoregie, Section Chief, MHSD: Responsible for the successful completion of all clinic certifications, and oversee the implementation of all quality assurance criteria. Mr. Omoregie has 22 years of experience working in both private and public mental health settings and oversight of licensure and certification of statewide 24-hour psychiatric community facilities

Kimberly Wimberly, Unit Chief, MHSD: To oversee the technical and complex administrative support work for the CCBHC Planning Grant application process. 15 years experience working in mental health programs, including project management and monitoring of a variety of state and federal programs. Her qualifications also include providing consultation and guidance in the administrative processing of contracts, federal grants, interagency agreements and cooperative agreements to ensure adherence to both federal and state guidelines.

Section D-1 Section I-2.2 Performance Measure Data Collection and Reporting

The data collection and reporting requirements specified in Section H-2.2 of the CCBHC RFA will be fulfilled through eBHS, which is a web-based data platform developed by eCenter Research, Inc. through a partnership with CIBHS. DHCS will work with CIBHS and eCenter Research to make modifications to eBHS to capture the 8 required performance measures on a quarterly basis. The organizations selected to participate in this grant will report data for the performance measures into eBHS through the web-based platform. DHCS will compile and analyze the data reported by participating organizations and submit the information through SAMHSA's Common Data Platform (CDP) for the required quarterly reporting. Given the comprehensive data collection and reporting required for the CCBHCs, the State currently has no plans to require additional measures for the grant project. This may change, however, during the planning phase if additional reporting is deemed necessary in order to meet the objectives of the project.

Section D-2 State Support for CCBHC Performance Measurement Infrastructure

DHCS will appoint a CCBHC Data and Evaluation Work Group comprised of DHCS staff and stakeholder representatives at the beginning of the planning year to develop the continuous quality improvement (CQI) infrastructure and plan in accordance with Program Requirement 5: Quality and Other Reporting Requirements specified in Appendix II, and those specified in Appendix A of the RFA. The CQI Plan will include monitoring suicide deaths/attempts, consumer 30 day hospital readmissions for psychiatric or SUD reasons, and other events, pursuant to Criteria 5.B. The CCBHC Data and Evaluation Work Group will specify goals and objectives, define metrics, determine data analysis methods, progress tracking and reporting, and apply findings in order to develop training and technical assistance to improve achievements. Data sources, measures, and CQI infrastructure will be addressed continuously and in detail throughout the planning year.

Section D-3 Section H Performance Measure Data Collection and Reporting

DHCS will collect, gather, and analyze the performance data required in Section H-2.2 and other information necessary to conduct the performance assessment specified in Section H-2.3 on a quarterly basis. The data will be used to assess performance of grant projects and identify areas in need of improvement. DHCS will provide technical assistance to the CCBHCs in assessing performance data and using the information to determine progress toward goals, objectives, and outcomes and whether adjustments are needed to improve achievements. DHCS will document progress achieved, barriers encountered, and strategies used to overcome barriers in its quarterly performance assessment report. DHCS will submit quarterly performance reports to SAMHSA within 15 days of the end of each reporting quarter.

DHCS will collaborate with CIBHS to utilize eBHS for purposes of meeting the data collection and reporting requirements of this grant. The eBHS is capable of flexible, real-time reporting and querying to support individual, population, and system improvement and outcome tracking. This can be accomplished in a variety of ways through eBHS. First, the system can be modified so necessary data elements can be added and participating CCBHCs can enter data directly into the eBHS through a graphical user interface. Second, a module for CCBHC required data collection could be built for direct data entry by participating CCBHCs. Third, existing data systems (specified in Appendix III) can be leveraged, so that data from these systems can be uploaded to and processed by eBHS. Finally, there is the possibility to meet all the reporting requirements through a combination of pulling data from existing systems as well as modifying the eBHS. The Data and Evaluation Work Group will analyze each of these possible approaches during the planning phase and identify an approach that most efficiently and effectively captures the data required for the demonstration and progress reporting.

Section D-4 Data Collection and Reporting Challenges

Challenge #1: Reaching agreement and consensus among DHCS and the CCBHCs on measure definitions and data elements can be sensitive and take several months, which could delay initiation of data collection. In addition, issues may arise with data elements or measures once operationalized that may require changes mid-stream, thereby affecting the analysis of the data over the course of the project. To help mitigate this, DHCS will collaborate and communicate closely with national evaluators (e.g. ASPE) and SAMHSA regarding such challenges and strategize resolution.

Challenge #2: Not all of the data required for this grant are currently collected through a single data system within DHCS. Therefore, DHCS will establish a Data and Evaluation Work Group to

assess capacity within existing data systems and the eBHS against the data collection requirements of the CCBHC demonstration and develop a plan for fulfilling the requirements. DHCS will include CIBHS in this Work Group and collaborate with them closely to modify the eBHS as necessary to address data gaps and ensure all data collection needs are met. In developing and implementing these new measures, unexpected challenges may arise that could limit DHCS' ability to gather all the data required for the reporting requirements of this grant. To help mitigate this, DHCS will collaborate and communicate closely with national evaluators (e.g. ASPE) and SAMHSA regarding such challenges and strategize to resolve.

Challenge #3: It is unknown at this time what specific challenges may be encountered with data linkage or information sharing within the eBHS or across other existing data systems. For example, regardless of the specific technology platform used, there may be challenges in establishing data usage agreements (DUAs), business associate agreements (BAAs), or other data exchange mechanisms between DHCS and the CCBHCs and/or between the CCBHCs and DCOs. To mitigate this, DHCS will engage its Office of Legal Services, Information Security Office, Privacy Office, and Information Management Division early to develop a strategy and clear processes for establishing all necessary, appropriate agreements. DHCS will also provide technical assistance to CCBHCs and DCOs in establishing such agreements at the local level as well. In addition, any technical platform(s) and mechanism(s) selected to fulfill reporting requirements will be built to ensure compliance with all applicable privacy laws and regulations.

Challenge #4: Since data reports will be public, meeting such requirements may pose a challenge due to DHCS policies regarding public data reporting. DHCS has implemented Public Aggregate Reporting (PAR) Guidelines to ensure compliance with HIPAA and other privacy laws in public reports. Since DHCS will be required to submit quarterly reports as well as participate in the national evaluation for this grant, all data reports will be subject to the PAR Guidelines and the corresponding review process. This may affect the level of detail DHCS is able to report, particularly for information at the CCBHC-level of reporting.

In order to prevent some of the issues described above and address challenges that may arise, DHCS will collaborate and work closely with CCBHCs, CIBHS, and eCenter Research, Inc. DHCS will utilize standard measures and reporting requirements, such as those available through the National Quality Forum, wherever available. For measures that are not already defined or standardized, DHCS will work closely with participating CCBHCs to develop standard definitions and reach consensus on data elements, and communicate these to SAMHSA for their feedback to ensure consistency with grant reporting requirements. DHCS will regularly monitor and provide technical assistance to CCBHCs to ensure data quality, completeness, and integrity.

In addition, DHCS will identify or develop standard templates for DUAs and BAAs as well as provide technical assistance to assist CCBHCs and DCOs in establishing the necessary mechanisms for data sharing and health information exchange. DHCS will also assess the eBHS database and work closely with eCenter Research, Inc. and CIBHS to ensure compliance with all relevant privacy laws and regulations and the protection of all data collected. This will also include taking steps to ensure reports generated are compliant with the previously mentioned PAR Guidelines.

Section D-5 Preliminary Plan to Construct a Comparison Group

The preliminary plan for selection of a comparison group is to use a variety of information, including the prevalence estimates in Section A.2, provider data, and other data to select

comparison sites that are most closely aligned with the demonstration sites based on SED/SMI and SUD population needs, region, and provider characteristics/service types. DHCS will first examine "hot spots" in the state where there are concentrations of Medi-Cal high-utilizer populations with any mental health condition or SMI, and/or SUD, as described in Section A.4 of this application. Regions or counties where these populations are currently being served by mental health and SUD providers will inform selection of providers that will not be CCBHC certified to participate as comparison sites. DHCS will work with demonstration and comparison site directors to reach agreement regarding data collection and reporting, and execute the appropriate agreements to clarify requirements and agreements.

In addition, DHCS will work closely with counties and providers in planning and designing the demonstration program. This will help ensure DHCS achieves a demonstration design that enables assessment of access, quality, and scope of services in a manner that ensures sound comparisons of CCBHCs and comparison sites.

Section D-6 Data Collection Capacity

As mentioned in response to Section D-1, DHCS will use the eBHS to collect and report data that will inform the national evaluation of the demonstration program. The eBHS is a web-based data platform developed by eCenter Research, Inc. through partnership with CIBHS. DHCS will collaborate with CIBHS to utilize eBHS for purposes of meeting all data collection and reporting requirements of this grant.

All graphs and charts programmed in eBHS have 'filter' functions. The data can be filtered by any number of characteristics, including client demographics (i.e., age, gender, ethnicity), date range, and practitioner/therapist/case manager, to name a few (anything can be programmed as a filter, depending on the needs of the practice or treatment strategy or project). All graphs and charts in eBHS also have a 'drill-down' function, which allows a user to delve deeper into any segment of data to identify the clients that are contributing to that sub-group. These two functions provide powerful support for quality improvement activities at the click of a button, as well as increasing the understanding of services provided and outcomes achieved, in ways that are not possible with static reports.

The eBHS is capable of flexible, real-time reporting and querying to support individual, population, and system improvement and outcome tracking. The eBHS is capable of collecting and storing all types of data required for the national evaluation. The eBHS can also support analysis and data sharing that enables assessment of the extent to which clients are progressing in their recovery and improving in their health status. The database can also support cross-system care coordination, and collection and reporting of standardized measures for purposes of program evaluation and outcome assessment. However, there are also a variety of local data systems in place that are used to fulfill state reporting requirements. Therefore, the planning phase will include collaboration with stakeholders to ensure a data collection plan, and strategy, and technical solution are developed that meet the grant reporting requirements, without creating data collection duplication or additional data burden.

DHCS will work with CIBHS and eCenter Research to make the modifications to eBHS to fulfill all of the reporting requirements specified in Appendix A, Tables 1 and 2 of the RFA. The organizations selected to participate in this grant will report data to meet these requirements to the eBHS through the web-based platform.

Section E *Biographical Sketches and Job Descriptions*

See Pages to Follow.

KAREN BAYLOR
Curricula Vitae

Educational Background

- Ph.D. Clinical Psychology (July 1986), International College, Los Angeles, California
- Masters of Arts in Psychology (April 1982), Pepperdine University, Malibu, California
- Bachelor of Science in Psychology (May 1977), Illinois State University, Normal, Illinois
- California Licensed Marriage & Family Therapist

Professional Experience

CALIFORNIA MENTAL HEALTH DIRECTORS ASSOCIATION

- o President 10/11 – 9/2012
- o Co-Chair, Mental Health Services Committee 10/10 – 7/2013
- o Chair, Psychiatric Health Facility Sub-committee 01/07 – 7/2013

CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY (Joint Powers Authority)

- o Board Officer 07/10 – 06/2013

COUNCIL ON ACCREDITATION FOR CHILDREN AND FAMILIES

- o Peer Reviewer 11/03 – Current

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES - Sacramento, CA

- o Deputy Director of Mental Health and Substance Use Disorders, 08/13–Current

COUNTY OF SAN LUIS OBISPO - San Luis Obispo, CA

- o Behavioral Health Administrator 09/05 – 08/13

FAMILIESFIRST, INC - Davis, CA

- o Director of Clinical Services and 02/05 – 08/05
- o Program Development
- o Director of Program Integrity 08/03 – 02/05
- o Service Director, Community Based Services 10/02 – 07/03

MENTAL HEALTH MENTAL RETARDATION AUTHORITY OF HARRIS COUNTY - Houston, TX

- o Program Director: Clinical Services (Core Site Director) 02/96 – 11/96
- o Department Head – Children and Adolescent Services 11/92 – 01/96
- o Program Manager – Children's Intake and Referral Center 03/91 – 10/92

THE OAKS AT HYDE PARK - Austin, TX

- Director 02/90 – 02/91

COMMUNITY SERVICS PROGRAM, Inc. - Laguna Beach, CA

- Youth Shelter Program Director 10/86 – 12/89

PRIVATE PRACTICE - Huntington Beach, CA

- Therapist 01/84 – 12/89

FAMILY SERVICE ASSOCIATION - Costa Mesa, CA

- Contract Therapist 10/85 – 10/86

LONG TERM RESIDENTIAL TREATMENT - Anaheim, CA

- Senior Social Worker

Honors Received – N/A

Recent Relevant Publications – N/A

Other sources of support in direct support to their activities through grants, cooperative agreements, contracts, fellowships, gifts, prizes and other means – N/A

Karen Baylor
Job Description

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, Deputy Director, Mental Health & Substance Use Disorder Services

- Oversees three new departmental divisions: Mental Health Services and Substance Use Disorders;
- Provides leadership in the formulation and administration of policy to achieve the mission of the Department, and serves as liaison to federal and state partner agencies in the areas of mental health and substance use disorders;
- Develops and oversees a strategic plan for assessment, service delivery, coordination and integration of mental health and substance use disorders;
- Directs and coordinates the mental health and substance use disorder programs with one another and with primary care to ensure uniform program direction and maximum efficiency of program delivery in accordance with state and federal requirements and standards; and
- Directs and evaluates the policy, planning, fiscal and ongoing performance management activities necessary to respond to federal requirements and to improve operations within the programs of the Mental Health and Substance Use Disorders Divisions.

Qualifications for position: Ph.D. in Clinical Psychology; knowledge of substance use disorders and specialty mental health services.

Supervisory relationships:

As the Deputy Director, Dr. Baylor reports directly to the Director of CDHCS. The Chiefs from each of the three new divisions, Mental Health Services, SUD Compliance and SUD Prevention Treatment and Recovery Services report directly to Dr. Baylor, as does the Assistant Deputy Director, MHSUDS. There is approximately 300 staff in the MHSUD division.

Skills and knowledge required: Able to administer a large and diverse system, knowledge of mental health and substance use disorders financing, and all laws and regulations pertaining to mental illness and substance use disorders. Able to provide leadership and vision for statewide behavioral health delivery system.

Personal qualities: Integrity, responsible, conscientious, reliable, have passion for the work and compassion for those that suffer from serious mental illness and substance use disorders.

Amount of travel and any other special conditions or requirements: Approximately once a month to speak and/or attend numerous Mental Health and SUD conferences both within the state of California as well as throughout the country.

Salary: Exempt

Hours per week: 60 hours per week +/-.

BRENDA GREALISH
Curricula Vitae

SUMMARY: Over twenty years of professional experience in California State Government, primarily in the field of research and evaluation, which began at the former California Department of Mental Health, gaining progressive responsibility that subsequently led to a governor's appointed position as the Deputy Director of the Office of Research at the California Department of Corrections and Rehabilitation (CDCR). Thereafter, transferred to the Department of Health Care Services (DHCS) to serve as the Mental Health Services Division Chief, and recently promoted to become the Assistant Deputy Director of Mental Health and Substance Use Disorder Services (MHSUDS).

EDUCATION:

Master of Arts, Psychology, California State University, Sacramento, August 2009
Bachelor of Arts, Psychology, University of California, Davis, June 1999
Associate of Arts, Psychology, Sacramento City College, May 1996

PROFESSIONAL EXPERIENCE:

Assistant Deputy Director, November 2015 – Present, DHCS, MHSUDS

- Assistant to the Deputy Director to oversee three Divisions.
- Develops and directs implementation of policy specific to the addition of mental health and substance use disorder benefits for newly eligible populations under Medi-Cal expansion and the Affordable Care Act, the integration of physical and behavioral health services, current and future federal and state-enacted health care reform legislation specific to mental health and substance use disorder services, operational policies that cross all three MHSUDS divisions, and direction for the review of all current mental health and substance use disorder services policies to ensure uniformity, accuracy and accountability.

Division Chief, July 2013 – November 2015, DHCS, Mental Health Services Division

- Responsible for managing a team of 150 staff to oversee the California public mental health system.
- Plan, organize, supervise, and direct program operations and policy formulation for all Medi-Cal and non-Medi-Cal community mental health services, as well as administration of the Specialty Mental Health Services 1915(b) waiver, Mental Health Services Act and the federal Substance Abuse and Mental Health Services Administration (SAMHSA) mental health block grant.

Deputy Director, July 2012 – June 2013 (acting from January 2012 to July 2012), CDCR, Office of Research

- Responsible for managing a team of 70 staff within a budget of approximately $7.2 million.
- Oversee all CDCR research activities, including those conducted by both internal/external entities.
- Establish, interpret, and implement research projects and assist CDCR stakeholders in their development of criminal justice policies and practices by providing sound, data-based decision support.
- Work closely, and productively, with a variety of stakeholders on multiple major projects, including the "Study of the CDCR Inmate Classification Score System," using project

management skills, under the guidance of a panel of University of California correctional scholars and key CDCR Division of Adult Institutions staff.

- Represent CDCR's research and evaluation interests at the local and national levels to ensure that CDCR's accomplishments are shared with other correctional entities that may benefit, and to ensure that CDCR remains current in its own correctional programs and practices, particularly those which are evidence-based.

Research Manager III, September 2011 – June 2012 (acting from August 2010 to August 2011), CDCR Office of Research, Research and Evaluation Branch

- Responsible for supervising management staff who, in turn, manage staff who perform duties related to budget and contract management, coordination and processing of external research requests
- Management of major projections including the CDCR Classification Study, Annual Outcome Evaluation reporting, New Parole Model programing, the CDCR Rehabilitative Program Evaluation Plan Using the CPC, and other similar large-scale projects.
- Subject matter expert for designing research and evaluation methodologies, including methodology development, data collection, analysis and reporting.

Research Manager II, April 2009 – August 2011, CDCR, Juvenile and Adult Research and Evaluation Branches

- Coordinate staff workload for short- and long-term projects that primarily focus on meeting the objectives set forth in the CDCR Office of Research plan for a "Comprehensive System of Program Evaluation," as well as supporting CDCR reform efforts.
- Interact with Departmental executive staff and other relevant stakeholders to identify and establish research and evaluation priorities and resources.
- Utilize my project management and oversight skills to guide team toward developing and providing accurate, mission-critical research and evaluation products to stakeholders in a timely manner.

Research Analyst I, II and Research Program Specialist I, August 1999 – April 2009, California Department of Mental Health, Performance Outcomes and Quality Improvement Unit

- Key DMH staff person responsible for the development and deployment of the methodology used to collect performance outcomes data for mental health consumers.
- Created training materials and continuously conduct trainings, either in-person or via conference calls, for county staff responsible for collecting and reporting data at the local level.
- Assisted with the design, development, and deployment of the multiple DMH databases.

ACHIEVEMENTS:

- Completion of DHCS Leadership Development Academy, 2014
- Received the DMH Award for Superior Accomplishment of a Non-Recurring Nature , 2006
- Recipient of the 1998-99 UC Davis Community Service Award

Recent Relevant Publications – N/A

Other sources of support in direct support to their activities through grants, cooperative agreements, contracts, fellowships, gifts, prizes and other means. N/A

Brenda Grealish
Job Description

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, Assistant Deputy Director, Mental Health & Substance Use Disorder Services

Job Summary: Under the general direction of the Deputy Director, Mental Health and Substance Use Disorder Services (MHSUDS), the Assistant Deputy Director assists in overseeing the planning, implementation, coordination, evaluation, and management of the Department of Health Care Services mental health and substance use disorder services, programs, and policies. In addition to serving as a member of the Directorate, the Assistant Deputy Director will help provide direction to the three MHSUDS divisions: Mental Health Services Division; Substance Use Disorder Compliance Division; and Substance Use Disorder Prevention, Treatment and Recovery Services Division. The Assistant Deputy Director serves as a backup to the MHSUDS Deputy Director on all issues associated with the field of responsibility, and may work directly with the Health and Human Services Agency, legislative representatives, other state, local and federal representatives, members of the public, and the media. Under the general direction of the MHSUDS Deputy Director, the Assistant Deputy Director serves as an integral component in the formulation of policy to achieve the mission of the Department.

Qualifications for position: M.A. in Psychology, over 20 years experience in government administration, with the majority of these years spent working on and leading complex research and evaluation projects.

Supervision Received: General direction of the MHSUDS Deputy Director

Supervision Exercised: Direct and indirect supervision of MHSUDS Deputy Director's Office and Division level staff.

Skills and knowledge required: Able to administer a large and diverse system, knowledge of mental health and substance use disorders financing, and all laws and regulations pertaining to mental illness and substance use disorders. Able to provide leadership and vision for statewide behavioral health delivery system.

Personal qualities: Integrity, dependable, personable, and dedicated to enhancing the quality of lives for Californians who suffer from mental health and substance used disorders.

Amount of travel and any other special conditions or requirements: Approximately once a month to speak and/or attend numerous behavioral health conferences within California.

Salary: $8,594.00 - $11,000.00

Hours per week: 60 hours per week +/-.

RACHELLE WEISS
Curricula Vitae

SUMMARY: Over thirteen years of professional experience in California State Government, most of which was at the former Department of Alcohol and Drug Programs (ADP), and, now the Substance Use Disorder Services Prevention, Treatment, and Recovery Services Division (PTRSD) of Department of Health Care Services (DHCS). In addition, experience at former Healthy Families Program (HFP) and California Department of Public Health (CDPH).

EDUCATION:

Master of Public Health, Executive Leadership, Drexel University, June 2011
Bachelor of Arts, Psychology, California State University, Sacramento, May 2007
Associate of Arts, Social Science, Sacramento City College, June 2000

PROFESSIONAL EXPERIENCE:

Staff Services Manager III, May 2015 – Present, DHCS, Mental Health Services Division (MHSD)

- Assist the Division Chief in oversight of three branches.
- In partnership with Division Chief, plan, organize, and direct the development, review, analysis and implementation of all Medi-Cal and non-Medi-Cal community mental health services.
- Oversee day-to-day operations and ensure assignments and projects are completed accurately, within specified timeframes, and respond to internal/external inquiries.
- Provide leadership for development and implementation of the MHSD Performance Outcomes System.
- Participate in annual budgeting process, strategic planning activities, and assist in resolution of complex, controversial, or sensitive issues.
- Represent DHCS in meetings with a variety of high-level officials.

Research Manager II, June 2013 – April 2015, DHCS, SUD-PTRSD-OARA

- Manage, plan, direct, and oversee all proposed and established research operations.
- Ensure compliance with 42CFR2 and HIPAA.
- Manage all administrative functions, including hiring and developing staff, and budgets and contracts.
- Advise upper management and executives regarding statewide research-to-service strategies.
- Serve as liaison to all segments of applied SUD research community.
- Collaborate with internal/external partners on research projects, compliance with privacy laws, data analysis, and/or development of data standards or indicators.
- Participate and represent DHCS in various conferences, forums, committees, and work groups related to behavioral health service and data integration, or research and evaluation methods.

Health Program Specialist II, May 2012 – May 2013, CDPH, Center for Chronic Disease Prevention and Health Promotion, Chronic Disease and Injury Control Branch, Coordinated Chronic Disease Prevention Program

- Plan, manage, and lead all activities related to development of a state plan for chronic disease prevention and health promotion, and evaluation projects and activities.

- Lead policy and evaluation work groups related to chronic disease programs.
- Collaborate with internal program staff, other State agencies, and local health offices.
- Develop evaluation plans, program logic models, and evaluation plans.
- Prepare and submit deliverables and reports to Centers for Disease Control and Prevention (CDC).

Research Program Specialist I (RPSI), April 2010 – April 2012, Managed Risk Medical Insurance Board (MRMIB), Benefits and Quality Monitoring Division, Research Unit

- Conduct evaluation projects related to the HFP using HEDIS and dental quality data from plans.
- Lead, design, and prepare annual HFP plan performance profiles and reports.
- Lead, design, and develop pay-for-performance models based on HEDIS and CAHPS measures.
- Prepare Federal Annual Report sections on plan performance in HEDIS and dental measures.

RPS I, April 2009 – March 2010, ADP, Information Management Services Division (IMSD), OARA

- Lead and conduct research activities on SUD program performance and client outcomes.
- Lead efforts to assess data quality and reliability and identify and resolve issues.
- Manage contracts for research and evaluation of substance use treatment services.
- Provide consultation to a variety of staff and external stakeholders related to data analysis.
- Develop written policies and guidelines to clarify requirements and standards.
- Perform annual validation analysis of client treatment data and create a static annual reporting dataset.

Research Analyst II (RA II) August 2007 – April 2009, ADP, IMSD, OARA

- Prepare caseload projections for Drug Medi-Cal (DMC) funding estimates.
- Provide consultation related to methodologies for DMC caseload estimates.
- Develop and deliver presentations of research findings to a wide variety of audiences.
- Lead and conduct research activities on SUD program performance and client outcomes.
- Lead efforts to assess data quality and reliability and identify and resolve issues.
- Monitor contracts for research and evaluation of substance use treatment data.
- Prepare annual research reports and fact sheets.
- Perform annual validation analysis of client treatment data to create annual reporting dataset.

ACHIEVEMENTS:

- Completion of DHCS Leadership Academy, 2014
- County Alcohol and Drug Program Administrators' Association of California Award for Outstanding work in Research/Evaluation Related to Alcohol & Programs, 2010
- Superior Accomplishment Award, CalOMS Tx Team, 2006
- Superior Accomplishment Award, Health and Safety Code, 2003

Recent Relevant Publications – N/A

Other sources of support in direct support to their activities through grants, cooperative agreements, contracts, fellowships, gifts, prizes and other means. N/A

Rachelle Weiss
Job Description

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, Assistant Division Chief, Mental Health Services Division

Job Summary: The Staff Services Manager III, Assistant Division Chief, of the Mental Health Services Division (MHSD) reports directly to the MHSD Division Chief. The Assistant Division Chief assists the Division Chief in meeting the mission of the Department to preserve and improve the health of all Californians' by adopting policies to assure the availability of, and equal access to comprehensive health services, and ensuring appropriate expenditure of public funds to serve those persons with the greatest health care needs. MHSD serves as the central point for policy development and interpretation for mental health services for the Department of Health Care Services (DHCS).

The Assistant Division Chief consults with, makes recommendations to, and/or represents the Division Chief and other DHCS executive staff, Health and Human Services Agency, and Cabinet level officials on mental health services-related policies and procedures. The Assistant Division Chief assists the Division Chief in the oversight of three branches (Program Policy and Quality Assurance Branch, Program Oversight and Compliance Branch, and Fiscal Management and Outcomes Reporting Branch) through three subordinate Branch Chiefs.

The Assistant Division Chief also provides leadership for the development and implementation of the MHSD Performance Outcomes System using a variety of analytical research/evaluation methodologies to solve complex problems; ensures timely and quality data collection; analyze/interpret results and review reports regarding public mental health services; ensure effective communication and collaboration with multiple partners/stakeholders; explore opportunities to integrate data captured in disparate internal and external data systems; and lead efforts to modernize legacy data systems

Qualifications for position: M.P.H. in Executive Leadership, over thirteen years of professional experience in California State Government, most of which was at the former Department of Alcohol and Drug Programs focusing on research and evaluation.

Supervision Received: General direction of the MHSD Chief

Supervision Exercised: Direct and indirect supervision of MHSD Division Office and Branch level staff.

Skills and knowledge required: Knowledge of federal waivers; state laws and regulations; SAMHSA block grants; research and evaluation methods; budgeting process; contracts; and strategic planning.

Personal qualities: Hardworking, honest, good communicator, creative, thorough, innovative thinker, analytical, diplomatic.

Amount of travel and any other special conditions or requirements: Minimal travel (approximately once per quarter).

Salary: $7,088 - $8,048

Hours per week: 50 hours per week +/-.

CHARLES ANDERS
Curricula Vitae

EDUCATION

California State University, Sacramento

- Master of Public Policy and Administration, 1998

University of California, Irvine

- Bachelor of Arts in Political Science, 1994

Los Rios Community College District

- Twenty-three semester units in Accounting

EMPLOYMENT HISTORY

July 1, 2012 – Present: California Department of Health Care Services

Chief, Fiscal Management and Outcomes Reporting Branch (February 2015 – Present)

- Plan, organize, supervise and direct program operations within the Fiscal Management and Outcomes Reporting Branch (FMORB). FMORB administers the federal reimbursement process for the Medi-Cal Specialty Mental Health Services (SMHS) waiver program, the Mental Health Block Grant and Projects for Assistance in Transition from Homelessness grant programs, and the State's fiscal and outcome responsibilities for the Mental Health Services Act (MHSA)
- Represent the Department in meetings with representatives from various internal and external State agencies, county associations, consumer advocates, and others regarding issues, requirements, and other aspects of the Medi-Cal SMHS waiver program and the MHSA.
- Respond to inquiries from the Legislature, control agencies, and others for information on policies related to the Medi-Cal SMHS waiver program and the MHSA.

Chief, Fiscal Policy Section (July 2012 – January 2015)

- Planned, organized, and directed program operations within the Fiscal Policy Section. The Fiscal Policy Section administers the MHBG and the PATH grant programs, the interim cost settlement process for the SMHS waiver program, and recommends and administers fiscal policies for the SMHS waiver program.
- Represented the Department in meetings with various internal and external State agencies, county associations, consumer advocates, and others regarding issues related to the interim cost settlement process for the SMHS waiver program, fiscal policies for the SMHS waiver program, and the MHBG and PATH grant programs.

May 2007 – June 2012: California Department of Mental Health

Chief, Local Program Financial Support (July 2010 – June 2012)

- Planned, organized, and directed program operations within the Local Program Financial Support unit. The Local Program Financial Support unit administered the financial component of the MHBG and the PATH grant programs, the interim cost settlement process for the SMHS waiver program, and set rates for the SMHS waiver program.

Staff Mental Health Specialist, Local Program Financial Support (January 2009 – June 2010)

- Lead staff responsible for the interim cost settlement process for the Medi-Cal SMHS waiver program.
- Lead staff responsible for the Mental Health Medi-Cal Administrative Activities Claiming process.

Staff Mental Health Specialist, California Mental Health Planning Council (May 2007 – December 2009)

- Provided staff support to the Planning Council's Adult System of Care Committee and Policy Committee
- Authored a policy brief recommending changes in policy to improve services for transition age youth.

November 2001 – April 2007: United Advocates for Children and Families

Director of Program Evaluation

- The lead staff in developing and implementing a training and technical assistance model for Statewide Family Networks with a grant from the Substance Abuse and Mental Health Services Administration.
- Provided training and technical assistance to Statewide Family Network grantees in areas such as grant writing, program evaluation, and roles and responsibilities of boards of directors.

July 1998 – October 2001: California Institute for Mental Health

Policy Associate

- Coordinated the preparation and provision of training and technical assistance to strengthen county development and implementation of a Children's System of Care model.
- Authored several newsletters on mental health policy and fiscal issues for statewide dissemination
- In consultation with stakeholders, prepared a review of the academic literature addressing the effectiveness of assisted outpatient treatment (AOT).

Honors Received – N/A

Recent Relevant Publications – N/A

Other sources of support in direct support to their activities through grants, cooperative agreements, contracts, fellowships, gifts, prizes and other means – N/A

Charles Anders
Job Description

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, Fiscal Management and Outcomes Reporting Branch Chief, Mental Health Services Division

Existing Duties

- Plan, organize, supervise and direct program operations within the Fiscal Management and Outcomes Reporting Branch (FMORB). Program operations include administering the federal reimbursement processes for the Medi-Cal Specialty Mental Health Services waiver program, administering the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant and Projects for Assistance in Transition from Homelessness (PATH) grant programs, and administering the State's fiscal and outcome responsibilities for the Mental Health Services Act program.
- Represent the Department in meetings with representatives from various internal and external State agencies, county associations, consumer advocates, and others regarding issues, requirements, and other aspects of the Medi-Cal Specialty Mental Health Services waiver program and the Mental Health Services Act.
- Respond to inquiries from the Legislature, control agencies, and others for information on policies related to the Medi-Cal Specialty Mental Health Services waiver program and the Mental Health Services Act.

Qualifications for Position

- Master in Public Policy and Administration with a focus on public finance
- Over 15 years of experience in the public mental health system

Supervisory Relationships

- Directly Supervisors three Staff Services Manager IIs and one Research Manager II.
- Indirectly supervisors six Staff Services Manager Is, one Research Manager I and 42 analytical staff.
- Reports to the Chief of the Mental Health Services Division

Skills and Knowledge Required

- Knowledge of federal waivers; state laws and regulations; SAMHSA block grants; research and evaluation methods; budgeting process; contracts; and strategic planning.

Personal qualities:

- Hardworking, honest, good communicator, creative, thorough, innovative thinker, analytical, diplomatic.

Amount of Travel and Other Special Conditions and Requirements

- None

Salary Range

- $7,088 - $8,048

Hours Per Day or Week

- 40 hours/Week

LANETTE CASTLEMAN
Curricula Vitae

INTRODUCTION

- Member of the Executive and/or Senior Management Team in all positions since 1989
- 24+ years exceedingly responsible administrative / supervisory experience (16*+ years as a supervisor*)
- 27+ years working with regulatory/accreditation standards (Title 9, 15, & 22, JCAHO, HIPAA, OSHA, CFR)
- Experience working and preparing facilities for licensing, CMS, and JCAHO surveys as well as experience as a licensing and certification surveyor
- 6 years at CDCR working closely with Special Master of the Federal Court and court appointed experts
- Extensive knowledge and expertise in Quality / Performance Improvement and Risk Management
- Experience working collaboratively with numerous State Departments and stakeholders on various issues
- Extensive Public Relations experience, e.g., media relations, marketing, speaker presentations
- Numerous years' experience in Staff Education and Training, and the development of policies & procedures

EDUCATION: **Bachelor of Arts Degree in Recreation Administration (1979), Emphasis in Therapeutic Recreation working with Special Populations, San Diego State University, San Diego, California**

Associate of Arts Degree: Psychology, Music, General (1977), West Hills Jr. College, Coalinga, California

WORK HISTORY / EDUCATION SUMMARY

July 2012 – Present **MENTAL HEALTH PROGRAM ADMINISTRATOR / Branch Chief**

Program Oversight & Compliance Branch / Mental Health Services Division, Department of Health Care Services (DHCS), 1500 Capitol Avenue, Sacramento, Ca 95814

Feb 2012 – July 2012 **MENTAL HEALTH PROGRAM ADMINISTRATOR / Section Chief Medi-Cal Oversight (MCO)**

MEDICAL REVIEW BRANCH (MRB) / AUDITS & INVESTIGATIONS (A&I) / DHCS 1500 Capitol Avenue, Sacramento, CA 95814

Nov. 2009 – Feb. 2012 **MENTAL HEALTH PROGRAM ADMINISTRATOR**

PROGRAM COMPLIANCE DIVISION Department of Mental Health (DMH), 1600 9th St., Sacramento, CA

June 2009 – Nov. 2009	**CHIEF, LICENSING & CERTIFICATION, PROGRAM COMPLIANCE DIVISION,** DMH, 1600 9th St., Sacramento, CA
June 2008 – June 2009	**ACTING MENTAL HEALTH PROGRAM ADMINISTRATOR, PROGRAM COMPLIANCE DIVISION** DMH, 1600 9th St., Sacramento, CA
April 2007 – June 2008	**CHIEF, LICENSING & CERTIFICATION, PROGRAM COMPLIANCE DIVISION** DMH, 1600 9th Street, Sacramento, CA 95814
Feb. 2002 – April 2007	**DIRECTOR OF PERFORMANCE IMPROVEMENT & REGULATORY COMPLIANCE/ RISK MANAGER / HIPAA & PRIVACY OFFICER, Sierra Vista Acute Psychiatric Hospital, Sacramento, California**
Dec. 2000 – Nov. 2001	**CORRECTIONAL HEALTH SERVICES ADMINISTRATOR II, Pelican Bay State Prison (PBSP)**
Dec. 1995 – Dec. 2000	**STANDARDS COMPLIANCE COORDINATOR, Pelican Bay State Prison – Madrid Compliance Unit**
April – Sept. 1999	**STANDARDS COMPLIANCE COORDINATOR (Special Assignment), Short-Term Special Assignment at Corcoran State Prison**
Jan. 1993 – Dec. 1995	**ASSISTANT TO THE EXECUTIVE DIRECTOR, Camarillo State Hospital & Developmental Center (CSH/DC)**
Dec. 1989 – Jan. 1993	**FACILITY-WIDE QUALITY ASSURANCE COORDINATOR – CSH/DC (Special Assignment while in Rehabilitation Therapy Classification)**
July 1985 – Dec. 1989	**DAY TREATMENT CENTER (DTAC) COORDINATOR – CSH/DC, (Special Assignment while in Rehabilitation Therapy Classification)**
Oct. 1982 – July 1985	**REHABILITATION THERAPIST (Recreation) – CSH/DC**
March 19890 – Oct. 1982	**REHABILITATION THERAPIST (Recreation) – Patton State Hospital**

Recent Relevant Publications – N/A

Other sources of support in direct support to their activities through grants, cooperative agreements, contracts, fellowships, gifts, prizes and other means. N/A

Lanette Castleman
Job Description

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, Program Oversight and Compliance Branch (POCB) Chief, Mental Health Services Division

Overall responsibility for staff supervision, day-to-day program operations, policy development, and monitoring of all aspects of the POC Branch. Oversight of the mental health system and facility or provider activities described in statute, regulations, contract, or memoranda of understanding. Maintains systems to monitor and ensure compliance with state and federal requirements and the Mental Health Plan (MHP) contract. Ensures the recoupment of funds when overpayments are identified. Statewide travel is required. Branch functions include triennial system and outpatient chart reviews of the County MHPs, triennial Short Doyle/Medi-Cal Hospital chart reviews; certification of county outpatient clinics; second level Treatment Authorization Request Appeals; Questionable Medi-Cal Billings; licensing Mental Health Rehabilitation Centers and Psychiatric Health Facilities; certification of mental health programs within Skilled Nursing Facilities with Special Treatment Programs; Social Rehabilitation Programs; and Community Treatment Facilities; approval of 5150 designated facilities; investigation of unusual occurrences; Criminal Background Clearances; Level I PASRR Screen and ensuring Level II PASRR Evaluations for all persons positive for significant mental illness; Clinical Review of Level II PASRR Evaluations. Responsibility for program operations and hiring practices. Direct and indirect supervision of all branch staff.

Qualifications for position:

Supervisory Relationships

- Directly Supervisors 4 Staff Services Manager IIs, 1 Consulting Psychologist and 1 Staff Services Analyst
- Indirectly supervisors 4 Staff Services Manager Is, 9.5 Consulting Psychologists, 5 Health Facility Evaluator Nurses, and 27 analytical staff.
- Reports to the Chief of the Mental Health Services Division

Skills and Knowledge Required: Principles, practices, programs, problems, and trends in mental health administration; policies, standards, and functions; organization and administration of mental health facilities and systems. Principles of community organization and functions of public and private agencies concerned with mental health; principles and practices of organization, fiscal management, personnel administration, and supervision; community and/or forensic mental health services, and operation of private institutions for the mentally disabled or judicially committed; the organization and function of the California Mental Health Directors Association and the California Mental Health Planning Council; understanding and implementation of the Department's Equal Employment Opportunity Program objectives.

Personal qualities: An objective and sympathetic understanding of the mentally and emotionally disturbed; tolerance and tact.

Amount of travel: 30%

Salary range: $7,088.00 - $8,048.00

Hours: Minimum of 40 hours per week

HENRY OMOREGIE
Curricula Vitae

Twenty two (22) years of experience working in both private and public mental health settings and oversight of licensure and certification of statewide 24-hour psychiatric community facilities such as Mental Health Rehabilitation Centers, Psychiatric Health Facilities, Skilled Nursing with Special Treatment Programs, Social Rehabilitation Programs and Community Treatment Facilities for compliance with relevant statutes and regulations.

EDUCATION

- San Francisco State University
  Bachelor of Science in Health Science, 1996
- California State University, Hayward
  MPA: Health Care Administration, 1998
- San Francisco City College
  AS Criminal Justice, 1992

EMPLOYMENT HISTORY

Chief of Licensing and Certification Section, July 2013-Present, California Department of Health Care Services (DHCS)

- Plans, organizes, and directs the DHCS program for facility licensure of 24- hour facilities. This includes overseeing the development of legislation, policies and procedures and management reports. Establishes Licensing and Certification Section (LCS) priorities and goals, and monitors the workload for the LCS staff. Provides the necessary resources, support and training required to complete assignments regarding facility licensure, program certifications, unusual occurrences, legislative bill analysis, criminal background clearances and Lanterman-Petris-Short Act. Directs staff in liaison responsibilities of DHCS with the Department of Public Health and the Department of Social Services with respect to mental health services provided in 24-hour care facilities. Participates in licensing surveys, certification reviews, and onsite reviews of serious facility events, as part of maintaining a visible presence, observing processes and staff performance in the field, and providing hands-on training to staff.

Chief of Mental Health Licensing Bureau, July 2012- July 2013, California Department of Social Services

- Directed, supervised and coordinated the California Department of Social Services (CDSS) planning/implementation of oversight responsibilities and the licensure of Mental Health Rehabilitation Centers and Psychiatric Health Facilities. Responsible for monitoring CDSS process for approving WIC 5150-designated facilities throughout the state and the development of goals, objectives and milestones for implementing the criminal background check processes within the Mental Health Treatment Licensing Bureau (MHTLB). Responsible for the supervision of Staff Services Manager I, Staff Mental Health Specialist, Associate Mental Health Specialist, Staff Services Analyst and Office Technician. Established the MHTLB priorities and goals, and monitors the workload for the MHTLB staff. Provided the necessary resources, support and training

required to complete assignments regarding facility licensure, unusual occurrences, legislative bill analysis, and Lanterman-Petris-Short and criminal background clearances.

Chief of Licensing and Certification Section, May 2010-July 2012, Department of Mental Health

- Planed, organized, and directed the Department of Mental Health's (DMH) program for facility licensure of 24-hour facilities. This includes overseeing the development of legislation, policies and procedures and management reports. Responsible for the supervision of Staff Services Manager I, Staff Mental Health Specialist, Associate Mental Health Specialist, Staff Services Analyst and Office Technician. Established Licensing and Certification Section (LCS) priorities and goals, and monitors the workload for the LCS staff. Provided the necessary resources, support and training required to complete assignments regarding facility licensure, program certifications, unusual occurrences, legislative bill analysis, Lanterman-Petris-Short and criminal background clearances. Directed staff in liaison responsibilities of the DMH with the Department of Public Health and the Department of Social Services with respect to mental health services provided in 24-hour care facilities. Periodically participates in licensing surveys, certification reviews, and onsite review of serious facility events, as part of maintaining a visible presence, observing processes and staff performance in the field, and providing hands-on training to staff.

Licensing Manager, April 2008 May 2010, Department of Mental Health

- Responsible for the Licensing Unit planning regarding the oversight and licensure of Psychiatric Health Facility and Mental Health Rehabilitation Center under the jurisdiction of the DMH. This includes overseeing the development of legislation, policies and procedures and management reports. Responsible for the supervision of Associate Mental Health Specialist and Staff Services Analyst. Established licensing Unit priorities and goals, and monitors the workload for the Licensing Unit staff. Provided the necessary resources, support and training required to complete assignments regarding facility licensure, legislative bill analysis and Public Record Act.

AWARDS AND RECOGNITIONS

- *Recognition for Contribution to Improving the Health of the Patients of Alameda County Medical Center, 1998*
- Awarded by Alameda County Medical Center-1998.
- *Sustained Superior Accomplishment:* Awarded by the California Department of Mental Health-2004.
- *Superior Accomplishment:* Awarded by the California Department of Mental Health-2008.

Recent Relevant Publications – N/A

Other sources of support in direct support to their activities through grants, cooperative agreements, contracts, fellowships, gifts, prizes and other means – N/A

Henry Omoregie
Job Description

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, Program Oversight and Compliance Branch (POCB), Licensing and Certification Section Chief, Mental Health Services Division

Position: Staff Services Manager II (SSMII)

- Plans, organizes, and directs the DHCS' program for Facility Licensure of 24-hour facilities, specifically, Mental Health Rehabilitation Centers and Psychiatric Health Facilities, and Program Certifications for Special Treatment Programs within Skilled Nursing Facilities and Community Residential Treatment Systems also known as Social Rehabilitation Programs.
- Directs staff in liaison responsibilities of DHCS with the Department of Public Health, and the Department of Social Services with respect to mental health services provided in 24-hour care facilities.
- Consults with the County Behavioral Health Directors Association, the California Association of Health Facilities, and other departments and organizations to explain and interpret the Department's policy on licensing and certification.
- Liaison to various advisory groups/other stakeholders related to 24-hour care facilities.
- Develops organizational assignments; selects, and provides oversight, training, and technical assistance to all L&C staff regarding facility licensure, Program Certifications, unusual occurrences, Criminal Background Clearances (CBC), legislative bill analysis, Public Records Act (PRA) requests, 5150 facility designation approvals, and interpretation/application of relevant laws, regulations, and policies and procedures.

Qualifications for position: B.S. in Health Science, extensive experience working in both private and public mental health settings and oversight of licensure and certification of statewide 24-hour psychiatric community facilities

Supervisory Relationships: Reports to the Mental Health Program Administrator (MHPA)

- Directly supervises two Staff Services Manager ls, Staff Mental Health Specialist, two Registered Nurses and Office Technician.
- Indirectly supervises seven Associate Governmental Program Analysts, three Staff Services Analysts and fifteen (15) staff within the Licensing and Certification (L&C) Section including two (2) Staff Services Managers and provides oversight, training, and technical assistance to all staff regarding L&C Section responsibilities and assignments.
- Reports to the Chief of Program Oversight and Compliance Branch

Skills and knowledge: Experience in community program that serve clients who have a mental illness, and leadership roles in the area of mental health program, development, management evaluation and ability to complete reports that are very complex and politically sensitive

Personal Qualities: Punctual, conscientious, helpful, independent, productive, honest and good management and organizational skills.

Travel: 20% statewide travel is required

Salary Range: $6453.00 - $7331.00

Hours: 40 per week

KIMBERLY WIMBERLY
Curricula Vitae

Education - University of California, Davis, September 1987 – June 1992, Bachelor of Science Degree, Human Development

Professional Experience

Staff Services Manger I – July 2012 – present;
Grants Management Unit, California Department of Health Care Services

- Provide direction to staff, setting goals and objectives and general management of the unit. Participates in the state-level process for the design, planning, and implementation of federal grants
- Implement and direct in research and analysis necessary for the development of program policy. Prepare oral and written presentations for approval by division management. Finalize procurement of application documents, contracts/contract amendments and grants. Provide consultation and recommendations to Division Management regarding the development of policies and procedures, and operation and implementation strategies.

Staff Services Analyst – July 2005 – November 2006
Associate Mental Health Specialist – December 2006 – June 2012
Grants Management Unit, California Department of Mental Health

- Reviewed and approved county program applications for funding by federal programs, program budgets and budget revisions to ensure compliance with Federal, and departmental policies, regulations, and laws.
- Reviewed total county costs to ensure that funds are being expended as budgeted, expenditures are within approved allocations, and payments reported were correct. Conduct review and provide payment authorizations for counties funded by the PATH and MHBG grant program.
- Monitored claimed expenditures, total program support and direct services expenditures against Federal funding sources and revenue development where applicable. Provided training to counties on the requirements of federal programs and conducted site reviews to ensure compliance with Federal and State mandates

Office Technician – May 2001 – June 2005
Administrative Services, California Department of Mental Health

- Responsible for developing the Office Technician Desk Manual for the County Financial Program Support Branch
- Typed county allocation worksheets, legislative reports, Cost & Financial Reporting System Manuals and policy letters. Type controlled correspondence for the Director or Agency Director's signature. Maintain project, cost report, computer and correspondence files and directories. Arranged meetings, made necessary travel arrangements, ordered supplies and maintained timekeeping records of section staff. Received, assisted and/or made referrals of telephone calls and personal inquiries from the public, State and local agencies.

Office Assistant (Typing)/Program Technician – January 2000 – April 2001
Forensic Services, California Department of Mental Health

- Coordinated the timely evaluation of California Department of Corrections inmates by Department of Mental Health evaluators to determine if inmates met criteria for treatment in a state hospital as a condition of parole. Reviewed Mentally Disordered Offender evaluation reports received from the clinicians to ensure report contents met statutory requirements.
- Distributed reports to a variety of recipients in multi-medium formats.
- Responded independently to public and other agencies' inquiries regarding program information, policies, and/or regulations. Independently created and compiled data in the form of ad hoc reports and excel spreadsheets.

Elementary Teacher/Assistant Director – June 1993 – June 1999
St. John Christian School, Sacramento, CA

- Hired, supervised, coached, and disciplined staff of 10 teachers
  - Conducted staff quarterly and yearly performance evaluations
- Consulted preschool staff on a vast number of policies and procedures for work flow efficiency and improved program planning
- Formulated with School Administration, procedures, policies and program alternatives and made recommendations on a wide spectrum of program related concerns
- Provided parents with vital information to ensure open communication
- Coordinated, developed and facilitated teacher in-service training for the personal and professional development of staff
  - Taught multiple subjects to 7 and 8 year old students to develop academic, social and cognitive skills.

Honors Received – N/A

Recent Relevant Publications – N/A

Other sources of support in direct support to their activities through grants, cooperative agreements, contracts, fellowships, gifts, prizes and other means. N/A

Kimberly Wimberly
Job Description

Title of Position - Staff Services Manager I (SSMI)

Description of Duties and Responsibilities - Provides direction to staff, setting goals and objectives and general management of the unit. Participates in the state-level process for the design, planning, and implementation of federal grants, specifically the Mental Health Block Grant (MHBG), Projects for Assistance in Transition from Homelessness Formula Grant (PATH) and the Behavioral Health Services Information System (BHSIS) Funding awarded by the Substance Abuse and Mental Health Services Administration (SAMHSA). Supervises, coaches, directs, selects, and evaluates GMU staff in federal grant activities. Implements and directs in research and analysis necessary for the development of program policy and documents (e.g., guidelines, strategic plans, proposals, etc.), budget change proposals, and other administrative materials (e.g., proposal reviews, audit findings). Prepare oral and written presentations for approval by Division Management. Summarize program and fiscal data for inclusion in written reports, presentations, etc.

Qualifications for position – At the SSMI level supervise a small group of analysts performing journeyperson level work and personally perform the most difficult or sensitive work; may direct a function such as management analysis, budgeting, or personnel and to serve as a project leader, coordinating the work of others through task force type organizations

Supervisory Relationships

- Directly supervises 5 analytical staff
- Reports to the Section Chief, Fiscal Policy Section

Skills and knowledge required –
Knowledge of principles, practices, and trends of public and business administration, including management and supportive staff services such as budget, personnel, management analysis, planning, program management and evaluation, or related areas; principles and practices of employee supervision, development, and training; formal and informal aspects of the legislative process; the administration and department's goals and policies; governmental functions and organization at the State and local level; department's Affirmative Action Program objectives; and a manager's role in the Affirmative Action Program and the processes available to meet affirmative action objectives.

Personal qualities - able to act independently, with open-mindedness, flexibility, and tact.

Amount of travel - 10% travel to conduct site reviews of federal programs.

Salary range - $5,181 - $6,437

Hours per day or week – 40 hours per week

Section F Confidentiality and SAMHSA Participant Protection/Human Subjects

1. Protect Clients and Staff from Potential Risks

All information about mental health or SUD clients are protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule[27] and the federal Confidentiality of Alcohol and Drug Abuse Patient Records regulations.[28] These, as well as applicable state laws[29], place strict limits on the use and disclosure of any information that can be used to identify clients in mental health or SUD treatment programs. DHCS has policies and procedures in place that ensure privacy and security, including ensuring counties, plans, and providers comply with these policies and procedures. All personally identifiable information and protected health information is protected through various administrative, physical, and technical procedures, pursuant to federal law and state privacy laws. DHCS will utilize the required safeguards and assure, through Business Associate Agreements, Data Use Agreements, and other necessary mechanisms that CCBHCs and DCOs have appropriate privacy and security protections in place.

The decision to participate in the CCBHC program is completely voluntary. If an individual chooses not to participate, the decision will not affect any aspect of future services or benefits with the social service system. For those who choose to participate, there is the possibility of minimal risk. A client could experience some emotional anxiety or upset as a result of discussing personal topics when answering questions during interviews related to mental health, substance abuse, treatment history, criminal history, and family/social support.

Upon interviewing a participant, the collection of personal data brings about the potential risk to privacy. The procedures to ensure confidentiality of personal data and to minimize the risk associated with privacy are covered in the sections to follow.

In the event of adverse effects to the participants, all participants will be informed that they can withdraw from participation in the CCBHC program at any given time. All participants in treatment will have individual treatment plan monitoring as well as professional intervention and enhanced support. If deemed necessary, arrangements with medical care facilities for the provision of detoxification services, pharmacologic interventions, and medical emergencies will be arranged.

The privacy and confidentiality of participant information will be protected at each point where information is collected, stored, or transmitted. All confidential information will be handled according to the requirements stated above. Adherence to federal and state laws will ensure the privacy of all clients throughout and following their participation in the program. Please refer to the heading "Privacy and Confidentiality" below for further detailed procedures.

[27] Title 45 Code of Federal Regulations (CFR), Parts 160 and 164.
[28] Title 42 CFR, Part 2.
[29] Family Code, Section 6929(b); Welfare and Institutions Code, Section 14100.2; and the Information Practices Act, CA Civil Code Section 1798, et.seq.

2. Fair Selection Process

Final decisions about target populations and selection criteria will be further defined through the planning phase of the program. However, the program will focus on Medi-Cal high-utilizers as described in Section A.4 of this application; the 5% most costly Medi-Cal eligible FFS participants who also had any mental health condition or SMI. Other proposed eligible populations include: substance- abusing youth ages 12 through 21; youth with SED, up to age 21; substance-abusing military service members or veterans ages 18 through 25; military service members or veterans ages 18-25 with SMI; homeless persons with SUD or SMI/SED; criminal justice populations, such as AB 109-referred; and/or individuals with co-occurring SUD and SMI/SED. Recruitment strategies will occur through existing local referral agencies and established processes as well as by the DHCS marketing and outreach efforts of the CCBHC Outreach and Training Coordinator.

Final selection of target populations and specification of eligibility criteria will be determined by DHCS and stakeholders during the planning phase. These criteria will be used to determine participant eligibility and appropriate services. Any individual who meets the CCBHC eligibility criteria may choose to participate. The only exclusion criteria for an otherwise eligible individual will be if he/she is unwilling to participate or the program does not have sufficient capacity. Referral to alternative services in this case will be offered.

3. Absence or Coercion

No individual will be forced to participate in the CCBHC program. Participation is voluntary and no type of incentive will be awarded to those individuals who choose to participate. Members will be informed prior to the assessment that participation in CCBHC services is voluntary. Individuals who choose to receive CCBHC services but do not want to participate in or complete the SAMHSA-mandated data collection component of the program will be informed of their option to receive intervention services even if they do not wish to participate in data collection, and they will be referred to and connected with appropriate programs.

The program will utilize outreach methods to educate potential program participants on the CCBHC services available as well as alternative services. Strategies shown to be effective will be used to encourage participation. The specific strategies will be determined through the planning phase of the program, which will include collaboration with counties, plans, providers, and other eligibility and enrollment staff within DHCS.

4. Data Collection

The details of the data collection methodology, instruments, and interview protocols are to be determined during the planning phase. Individuals who consent to participate in the SAMHSA-mandated data collection will be asked to sign a consent form prior to their enrollment in the CCBHC program. Data will be collected from all clients consenting to participate in the project through various data systems, tools, and personal interviews and surveys.

CCBHC and DCO provider staff will also provide data by maintaining a participants' records and reporting required data on clients and services. Data will be collected from EHRs, cost reporting systems, Medi-Cal billing systems, SUD and mental health service

information systems, and other electronic data systems, as defined and specified in the planning phase. Examples of the types of data collection tools to be used are included in Attachment 2: Data Collection Instruments/Interview Protocols.

5. Privacy and Confidentiality

The details of the data collection and instruments and corresponding processes for ensuring privacy and confidentiality are maintained will be completely defined during the planning phase. DHCS will work closely with CCBHCs and DCOs to develop protocols, policies, and administrative, physical, and technical controls that ensure adherence to federal and state laws to protect privacy and confidentiality of all CCBHC participants. This will include ensuring only the minimum data and information necessary for performing the functions of a specific role will be provided. Policies and protocols will include such things as non-intelligent identifiers for data records, limited access to data records, and separating identifiers from the data as appropriate. Data will only be accessible to those individuals who have a business need pursuant to the administration of the CCBHC program. DHCS will also use its Public Aggregate Reporting Guidelines to ensure protection of participant identity in any required public reporting.

Data submitted to DHCS will be stored in accordance with DHCS information confidentiality and security requirements. The time period for maintaining CCBHC data will be specified during the planning phase and incorporated into all related agreements (e.g. MOUs, BAAs, DUAs). Safeguards are in place to protect personal information, protected health information, confidential information and sensitive information with the focus on administrative, physical and technical controls.

Administrative Controls

This includes ensuring proper employee privacy and security training, employee discipline for those who fail to comply with privacy policies and procedures, signing of confidentiality statements, and background checks.

Technical Security Controls

This includes ensuring proper workstation/laptop encryption, sever security, minimum protected health information or private information necessary, removable media devices, antivirus software, patch management, user IDs and password controls, data destruction, system timeout, warning banners, system logging, access controls, transmission encryption, and intrusion detection.

Physical Controls

This includes ensuring audit controls (system security review, log reviews, change control procedures), business continuity/disaster recovery controls (emergency mode operation plan, data backup plan), and paper document controls (supervision of data, escorting visitors, confidential destruction, removal of data, faxing, and mailing).

6. Adequate Consent Procedures

The details of the consent procedures are to be determined in the planning phase. Participants will give their informed consent to the goals of the program, the specific activities involved in their participation, and the benefits and risks of their participation.

Because some participants will be minors, parental consent will be obtained when appropriate.

Parental consent to program participation will be pursued even in cases when it is not legally required. Minors (and their parent(s) or legal guardian as appropriate) who agree to participate will then be asked to sign a consent/assent form from minors after they have had ample time to read and understand it. Copies of all signed consent/assent forms will be given to the participants.

The consent form for prospective participants in CCBHCs will contain the following information regarding participation:

- A statement that CCBHC ensures the client a genuine and independent choice among participating providers, including a provider to which the client has no religious objection.
- A description of the data that will be collected, how it will be used, and how it will be kept confidential.
- A list of participating agencies and a statement giving the client's consent to all the agencies to communicate as necessary about their treatment.
- The type of information to be released, such as intake/assessment information, program participation and services, urine test results, and discharge status.
- A statement that all participating agencies will use procedures for release of information in accordance with all relevant state and federal privacy laws.
- Information on individual rights and remedies, such as access to health information and accounting of disclosures, under the HIPAA Privacy Rule.
- A statement of understanding by the client that participation in CCBHC is voluntary and that if he/she chooses not to participate, he/she will be referred to another treatment program.
- A statement of any risks or discomforts that may be experienced as a result of participating.
- A statement that the participant may withdraw from the program at any time without prejudice.
- A statement that if the client divulges certain information, all participating agencies have a legal responsibility to report it to the appropriate authorities. Information to be reported includes child physical or sexual abuse, elder or dependent abuse, threat of physical harm to an identifiable victim, and immediate threat of physical harm to the client.
- A statement indicating that information about the client may be released under limited conditions by court order.

Program personnel will be available to answer any questions potential participants may have prior to their agreement to participate. Those who do not consent to the collection of data will be referred to another treatment program.

The assessor will be responsible for obtaining the consent to participate in CCBHC and original consent to release information, as appropriate. All this information will be provided to the participant verbally as well as in writing. Consent forms will be written in clear, non-technical terms and in a language that the participant understands. For

those who speak languages other than English, consent forms in those languages will be provided as well as a verbal translation.

7. Risk/Benefit Discussion

More details about potential project risks will be determined during the planning phase. The ethical, privacy, and confidentiality provisions in the program should protect clients from all possible risks. The preventive measures described in this section are designed to protect all participants from adverse effects, and provisions have been made for intervention, if necessary, to diminish any detrimental impact that may occur.

The anticipated benefit to participants of comprehensive treatment and recovery support services designed to meet their individual development and psychological and treatment needs is expected to outweigh any potential risk the individual may face by participating in CCBHC services.

The information obtained about the systems that monitor the effectiveness of CCBHCs will be used to improve the way services are provided in California. The feedback of treatment experience and provider input will be an important source of information that can be used to make decisions about improving behavioral health services.

Protection of Human Subjects Regulations

The project details have not been finalized and the need for an Institutional Review Board approval is to be determined through the planning phase. Protecting confidentiality is critical in mental health and substance abuse treatment. In addition HIPAA, alcohol and other drug abuse patient records are governed by 42 Code of Federal Regulations (CRF) Part 2. These provisions limit the circumstances information about a patient's treatment may be disclosed without the patient's consent. With some exceptions, patient consent is required for disclosure of protected health information even for the purpose of treatment, payment, or health care operations. Consequently the integration of physical health, mental health, and substance use disorder services could present some challenges of sharing patient information across the various systems. During the CCBHC Planning Phase, efforts will be made to address some of these issues.

Attachment 1
Single Entity SSA/SMHA Confirmation

The California Department of Health Care Services (DHCS) is the Single State Agency that is responsible for the administration of the federal Medicaid program, called Medi-Cal. Prior to July 2012, California delegated the administration of the behavioral health components of the Medi-Cal program to other departments, including the former California Departments of Mental Health (DMH) and Alcohol and Drug Programs (ADP), which administered the Medi-Cal specialty mental health services (SMHS) and Drug Medi-Cal (DMC) / Substance Abuse Prevention and Treatment (SAPT) Block Grant (BG) programs, respectively.

As part of the Fiscal Year 2011-12 budget process, beginning on July 1, 2012, Governor Brown signed Assembly Bill (AB) 102 (Chapter 29, Statutes of 2011), which enacted law to transfer the administrative responsibilities from the former DMH and ADP to DHCS, and DMH and ADP were dissolved. As such, DHCS serves as the State Medicaid Agency, State Mental Health Authority, as well as the Single Sate Agency for Substance Abuse Services.

Included in this Attachment are Letters of Commitment from State-level organizations who will participate in California CCBHC Planning Grant. Letters have been provided by the California Department of Education, California Department of Public Health, California Department of Social Services, and California Interagency Council on Veterans.

CALIFORNIA
DEPARTMENT OF
EDUCATION

TOM TORLAKSON
STATE SUPERINTENDENT OF PUBLIC INSTRUCTION

July 29, 2015

Substance Abuse and Mental Health Services Administration
Division of Grants Management
1 Choke Cherry Road
Rockville, MD 20857

RE: California's SAMHSA's Certified Community Behavioral Health Clinics Planning Grant Application RFA No. SM-16-001

On behalf of the California Department of Education, we are writing to express our commitment to participate in the California Department of Health Care Services (DHCS) Certified Community Behavioral Health Clinic (CCBHC) Planning Grant and a CDE representative will readily serve as a member of their CCBHC Steering Committee.

The CDE is committed to engaging in all positive efforts to address student mental health and well-being throughout the State of California. With a student population of 6.2 million, it is both appropriate and necessary to collaborate at every opportunity. The CDE was awarded a Project NITT-AWARE grant in the fall of 2014 and is committed to enthusiastically collaborating with DHCS to meet the identified behavioral health needs of our students and achieve our goals of providing quality care.

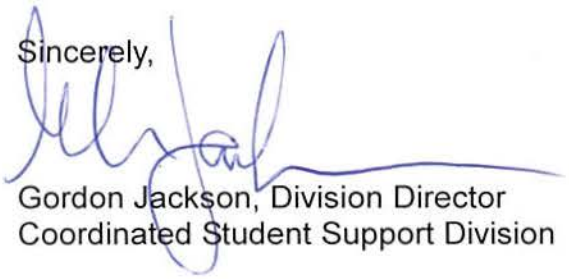
Should California be awarded a CCBHC Planning Grant, it would readily advance our states efforts to improve mental wellness and deliver person-centered care to those with behavioral health needs. Our current efforts in CDE are very much aligned with our commitment to work closely with local mental health plans, providers, and stakeholders to make the difference in California.

Our two departments currently engage in collaborative work associated with CDE's Student Mental Health Policy Workgroup (SMPHW) and DHCS's Garrett Lee Smith Memorial Suicide Prevention Project (GLS). It is of high value to the CDE to have representatives of DHCS in the SMPHW where there is a focus on policy development needs to address student mental health. It is of equal high value for the CDE to be engaged in GLS so that the Department is involved in this comprehensive effort to establish suicide prevention programs in our schools.

We very much look forward to DHCS being awarded a CCBHC Planning Grant and the subsequent collaborative work that will be generated by this award.

If you have any questions regarding this subject, please contact Gordon Jackson, Division Director, Coordinated Student Support Division, by phone at 916-319-0911 or by e-mail at GJackson@cde.ca.gov.

Sincerely,



Gordon Jackson, Division Director
Coordinated Student Support Division

GJ:dr

cc: Brenda Grealish, Assistant Deputy Director
Mental Health and Substance Use Disorder Services
California Department of Health Care Services
1501 Capitol Avenue, MS 4000
P.O. Box 997413
Sacramento, CA 95899-7413

State of California—Health and Human Services Agency
California Department of Public Health

KAREN L. SMITH, MD, MPH
Director and State Health Officer

EDMUND G. BROWN JR.
Governor

July 30, 2015

Substance Abuse and Mental Health Services Administration
Division of Grants Management
1 Choke Cherry Road
Rockville, MD 20857

RE: California's SAMHSA's Certified Community Behavioral Health Clinics Planning Grant Application RFA No. SM-16-001

On behalf of the California Department of Public Health, Office of Health Equity (OHE) I am writing to express our commitment to participating with the California Department of Health Care Services Certified Community Behavioral Health Clinic (CCBHC) Planning Grant as a member of their CCBHC Steering Committee.

The OHE was established, as authorized by Section 131019.5 of the California Health and Safety Code, to provide a key leadership role to reduce health and mental health disparities to vulnerable communities. A priority of this groundbreaking office is the building of cross-sectoral partnerships. The work of OHE is informed, in part, by their advisory committee and stakeholder meetings. The office consults with community-based organizations and local governmental agencies to ensure that community perspectives and input are included in policies and any strategic plans, recommendations, and implementation activities. An existing interagency agreement between OHE and the Department of Health Care Services outlines the process by which the departments will jointly work to advance the mission of the OHE.

The proposed CCBHC Steering Committee builds on this interagency collaboration, and its work aligns with the OHE's charge to advise and assist other state departments in their efforts to accommodate and respond to the needs of all communities, especially vulnerable populations and culturally, linguistically and geographically isolated groups.

Along with its focus on cultural competency and health equity, the OHE can contribute to the Steering Committee its technical assistance through its Health Research and Statistics Unit. California's application will advance our state's efforts to improve quality of services

and deliver person-centered care to those with behavioral health needs, and it closely partners with local mental health plans, providers, and stakeholders.

Sincerely,

Wm. Jahmal Miller, MHA
Deputy Director – Office of Health Equity
California Department of Public Health

cc: Brenda Grealish, Assistant Deputy Director
Mental Health and Substance Use Disorder Services
California Department of Health Care Services
1501 Capitol Avenue, MS 4000
P.O. Box 997413
Sacramento, CA 95899-7413

CDSS
WILL LIGHTBOURNE
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • *www.cdss.ca.gov*

EDMUND G. BROWN JR.
GOVERNOR

July 31, 2015

David Morissette, Ph.D.
Substance Abuse and Mental Health Services Administration
Division of Grants Management
1 Choke Cherry Road
Rockville, MD 20857

Dear Dr. Morissette:

SUBJECT: CALIFORNIA'S SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION'S CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC'S (CCBHC'S) PLANNING GRANT APPLICATION RFA NO. SM-16-001

The California Department of Social Services (CDSS) is writing to express our commitment to partner with the California Department of Health Care Services (DHCS) CCBHC Planning Grant as a member of their CCBHC Steering Committee. We support the application for the CCBHC Planning Grant which would result in services that are consistent with the mission of the CDSS which is to serve, aid, and protect the needy, vulnerable children and adults in ways that strengthen and preserve families, encourage personal responsibility and foster independence.

The services that the clinics will be certified to provide are for adults with serious mental illness, children with serious emotional disturbance, and those with long term and serious substance use disorders, as well as others with mental illness and substance use disorders. The CCBHC and the expanded services would benefit the consumers served by both departments.

The CDSS has successfully partnered with the DHCS to improve the delivery of mental health services to children, youth and their families. We further support our state's efforts to improve both the quality of care and delivery of person-centered care to those with behavioral health needs while closely partnering with local mental health providers and stakeholders.

Sincerely,

KEVIN GAINES, Chief
Child Protection and Family Support Branch
Children and Family Services Division

c: Brenda Grealish, Assistant Deputy Director
Mental Health and Substance Use Disorder Services

THE GOVERNOR'S CALIFORNIA
INTERAGENCY COUNCIL
ON VETERANS

July 31, 2015

Substance Abuse and Mental Health Services Administration
Division of Grants Management
1 Choke Cherry Road
Rockville, MD 20857

RE: California's SAMHSA's Certified Community Behavioral Health Clinics Planning Grant Application RFA No. SM-16-001

On behalf of The California Interagency Council on Veterans (ICV) workgroups, I am writing to express our commitment to participate with the California Department of Health Care Services Certified Community Behavioral Health Clinic (CCBHC) Planning Grant as a member of their CCBHC Steering Committee.

The ICV was established By Governor Edmund G. Brown Jr. via Executive Order in August of 2011. The purpose of the ICV is to "identify and prioritize the needs of Califonrnia's veterans and to coordinate activities at all levels of Government in addressing those needs." The California Health and Human Services Agency Secretary is an appointee to the ICV. Participation of the ICV Administrative Officer on the DHCS Steering Committee provides an opportunity to partner with one of our member entities to in a way that serves to fulfill our purpose by sharing information learned within the ICV workgroups and through direct connections to relevant subject matter experts. The ICV Administrative Officer also serves as the Team Lead for the SAMHSA Service Members, Veterans, and their Families (SMVF) Policy Academy process.

California's application advances our states efforts to improve quality and deliver person-centered care to those with behavioral health needs, closely partners with local mental health plans, providers, and stakeholders. Recent shifts in policy at the national level have increased the potential for veterans and their families to seek services from non-VA providers if they live farther than 40 miles from a VA facility. Integrating veteran-centric modalities into the process will enhance the ability of community behavioral health clinics to meaningfully serve SMVF.

Sincerely,

Pamela Rasada
Administrative Officer, California Interagency Council on Veterans

cc: Brenda Grealish, Assistant Deputy Director
Mental Health and Substance Use Disorder Services
California Department of Health Care Services
1501 Capitol Avenue, MS 4000
P.O. Box 997413
Sacramento, CA 95899-7413

Attachment 2
Data Collection Instruments/Interview protocols

Given that this application is for the CCBHC Planning Phase, the evaluation instruments/protocols have yet to be developed. Accordingly, to provide grant reviewers with an idea of California's plan to capture the required data for the CCBHC Demonstration Project evaluation, below is a description of the Department of Health Care Services' (DHCS') behavioral health data systems, as well as a sample of the California Institute for Behavioral Health Solutions' eBHS Care Coordination Tracker Data Elements and Data Capture Design.

DHCS Behavioral Health Data Systems

Short Doyle/Medi-Cal System

The Short-Doyle/Medi-Cal (SD/MC) system enables California MHPs to obtain reimbursement of Federal funds for medically necessary specialty mental health services provided to Medi-Cal-eligible beneficiaries diagnosed as seriously mentally ill or seriously emotionally disturbed. The SD/MC system provides information about who is receiving services, how often the services are received, and the cost of services for Medi-Cal consumers. DHCS receives this data monthly. The types of data that are captured in this system include client demographics, service types, dates of services, and approved claim amounts.

Client and Services Information System

The Client and Services Information (CSI) System collects data pertaining to mental health clients and the services they receive at the county level. The CSI system provides information about who is receiving mental health and specialty mental health services and the types and numbers of those services. DHCS receives this data monthly. The types of data that are captured in this system include client demographics, dates and types of services, diagnoses and periodic data.

Web-Based Data Collection Reporting System - Consumer Perception Surveys

The Web-Based Data Collection Reporting System (WBDRS) collects data reported from the Consumer Perception Surveys. The WBDRS system provides information about the client's/family member's perception of satisfaction with regards to services and also provides information about perceived impacts to quality of life. The surveys are administered once annually during a two-week sampling period and the client is not required to complete the survey. DHCS receives this data annually. The types of data that are captured in this system include consumer satisfaction with services across seven domains; general satisfaction, access, quality/appropriateness of care, social connectedness, client functioning, criminal justice, and quality of life. Other data include perceived impacts to quality of life across these seven domains; general life satisfaction, living situation, daily activities and functioning, family and social relations, finances, legal and safety, and health.

Data Collection and Reporting System

The Data Collection and Reporting (DCR) System collects data pertaining to any client enrolled in a Mental Health Services Act funded Full Service Partnership program. The DCR system provides the primary source of outcomes data for Full Service Partnership programs. The information is collected at the client's intake, as key events occur, and some data elements are collected on a quarterly basis. DHCS receives this data within sixty days post intake. The types of data that are captured in this system relate to the eight domains: residential status, education, criminal justice, legal designations, co-occurring disorders, source of financial support, and emergency intervention.

Management Information System/Decision Support System

The Management Information System/Decision Support System (MIS/DSS) is a subsystem of the California Medicaid Management Information System (CA-MMIS) and serves as the DHCS' Medi-Cal Data Warehouse. The MIS/DSS system provides data pertaining to eligibility, provider, and claims information for the Medi-Cal Program. The MIS/DSS is the largest Medicaid data warehouse in the nation and the data are integrated from many different sources (i.e., Medi-Cal (Medical and Dental) Fiscal Intermediaries, County Organized Health Systems, Department of Social Services, Mental Health, Substance Use Disorder Services, and Department of Developmental Services). DHCS refreshes the system every month. The types of data that are captured in this system are claims and encounter data, eligibility data, provider data, and other reference data such as National External Norms and Benchmarks.

California Outcome Measurement System-Treatment

The California Outcome Measurement System-Treatment (CalOMS –Tx) collects data from clients receiving substance use disorder (SUD) treatment services in publicly funded treatment programs and all narcotic replacement treatment programs, regardless of funding source. CalOMS- Tx captures data on client demographics and other client characteristics including life experiences prior to treatment admission and discharge. Information on alcohol and other drug use, criminal involvement, employment and education, family and social structure, and mental and physical health are used to describe the SUD treatment population and their outcomes.

Drug and Alcohol Treatment Access Report

The Drug and Alcohol Treatment Access Report (DATAR) system collects data on treatment capacity and waiting lists from treatment providers. DATAR has information on a provider's monthly capacity to provide different types of treatment services to clients and how much of that capacity is utilized. Specific categories of individuals awaiting treatment are identified (e.g., injecting drug users, pregnant women) to assist in identifying appropriate treatment facilities for these clients as they become available. All providers that submit CalOMS -Tx data are also required to submit DATAR.

SAMPLE FORM: eBHS Care Coordination Tracker Data Elements and Data Capture Design

Name of Person (Auto Pop)	**Name of Agency** (Auto Pop)	**Visit Date**	**Date Entered** (Auto Pop)

Last Name:	Place Holder	First Name:	Place Holder	Unique Identifier:	Free text		
Clinician:	Dropdown list (editable)	DOB:	Place Holder	Age:	Place Holder		
Address:	Free text	Sex:	Place Holder	Phone number	Free Text	Lang:	(Drop Down, e-Center get state list)
Living Situation:	(Drop Down)	Date Started in Living Situation:	Click here to enter a date.	Ethnicity:	Place Holder		
Originating Agency	Free Text	First Contact Date:	Click here to enter a date.	Emergency Contact	Free Text	Free Text	

Screening and Other Frequent Data				**Diagnoses**		
Type	Date Taken	Agency	Value	Type	Check as appropriate	Source of Info
BP (Diastolic)	Click here to enter a date.	Dropdown list (editable)	Enforced range	Medical	☐ DM ☐ HTN ☐ Dyslipidemia	Free text
BP (Systolic)	Click here to enter a date.	Dropdown list (editable)	Enforced range			Free text
Weight	Click here to enter a date.	Dropdown list (editable)	Enforced range			Free text
Height	Click here to enter a date.	Dropdown list (editable)	Enforced range	Psychiatric	☐ Bipolar ☐ Schizophrenia ☐ Depression ☐ Anxiety ☐ PTSD ☐ Psychosis	Free text
BMI	Click here to enter a date.	Dropdown list (editable)	Calculated			Free text
PHQ-2	Click here to enter a date.	Dropdown list (editable)	Enforced range			Free text
PHQ-9	Click here to enter a date.	Dropdown list (editable)	Enforced range			Free text
SIA	Click here to enter a date.	Dropdown list (editable)	Need Dropdown List			Free text
SID	Click here to enter a date.	Dropdown list (editable)	Need Dropdown List			Free text
GAD-2	Click here to enter a date.	Dropdown list (editable)	Need Dropdown List	Substance Use Disorder	☐ Alcohol Use ☐ Opiate Use ☐ Stimulant Use ☐ Tobacco Use ☐ Sedative Use ☐ Others	Free text
A1c	Click here to enter a date.	Dropdown list (editable)	Enforced range			Free text
LDL	Click here to enter a date.	Dropdown list (editable)	Enforced range			Free text
Experience of Care	Click here to enter a date.	Dropdown list (editable)	Enforced range			Free text
Confidence	Click here to enter a date.	Dropdown list (editable)	Enforced range			Free text
Coordination	Click here to enter a date.	Dropdown list (editable)	Enforced range	Other	Free text	Free text

Care Coordination Team

Type	Name	Agency Name	Phone	Email	Unique Identifier	ROI Date
Care Coordinator	Dropdown list (editable)	Dynamic based on name	Dynamic based on name	Dynamic based on name	Free text	Calendar Select
Clinical Care Manager	Dropdown list (editable)	Dynamic based on name	Dynamic based on name	Dynamic based on name	Free text	Calendar Select

Primary Care	Dropdown list (editable)	Dynamic based on name	Dynamic based on name	Dynamic based on name	Free text	Calendar Select
Mental Health	Dropdown list (editable)	Dynamic based on name	Dynamic based on name	Dynamic based on name	Free text	Calendar Select
Substance Use	Dropdown list (editable)	Dynamic based on name	Dynamic based on name	Dynamic based on name	Free text	Calendar Select
Peer and/or Family Member Provider	Dropdown list (editable)	Dynamic based on name	Dynamic based on name	Dynamic based on name	Free text	Calendar Select
Health Plan	Dropdown list (editable)	Dynamic based on name	Dynamic based on name	Dynamic based on name	Free text	Calendar Select
Other 2	Dropdown list (editable)	Dynamic based on name	Dynamic based on name	Dynamic based on name	Free text	Calendar Select

RRAL(S) STATUS

Agency Referred to:	Contact Name:	Phone number	Date of Referral	Current Status	Completed Date	Summary Report Received Date
1. Dropdown list (editable)	List dynamic based on Organization	Dynamic based on Contact Name	Click here to enter a date.	Choose an item.	Click here to enter a date.	Click here to enter a date.
2. Dropdown list (editable)	List dynamic based on Organization	Dynamic based on Contact Name	Click here to enter a date.	Choose an item.	Click here to enter a date.	Click here to enter a date.
3. Dropdown list (editable)	List dynamic based on Organization	Dynamic based on Contact Name	Click here to enter a date.	Choose an item.	Click here to enter a date.	Click here to enter a date.
4. Dropdown list (editable)	List dynamic based on Organization	Dynamic based on Contact Name	Click here to enter a date.	Choose an item.	Click here to enter a date.	Click here to enter a date.
5. Dropdown list (editable)	List dynamic based on Organization	Dynamic based on Contact Name	Click here to enter a date.	Choose an item.	Click here to enter a date.	Click here to enter a date.
6. Dropdown list (editable)	List dynamic based on Organization	Dynamic based on Contact Name	Click here to enter a date.	Choose an item.	Click here to enter a date.	Click here to enter a date.
7. Dropdown list (editable)	List dynamic based on Organization	Dynamic based on Contact Name	Click here to enter a date.	Choose an item.	Click here to enter a date.	Click here to enter a date.
8. Dropdown list (editable)	List dynamic based on Organization	Dynamic based on Contact Name	Click here to enter a date.	Choose an item.	Click here to enter a date.	Click here to enter a date.

Planning and Care	Date	Shared Care Objectives	Notes
Shared Medication Reconciliation	Click here to enter a date.		
Treatment/Shared Care Objectives	Click here to enter a date.		

Most Recent ER Visit	Click here to enter a date.		
Most Recent Hospitalization	Click here to enter a date.		

Organization	Date Updated	List of Medications
Medication from Primary Care	Date picker	Text entry
Medication from Mental Health		
Medication from Substance Use		
Health Plan		

Attachment 3
Sample Consent Forms

For an example of a comprehensive consent form that may be used to provide intensive case coordination, as envisioned for California's CCBHCs, please see the attached policy and procedure regarding "Confidentiality and the Release of Protected Health Information of Community Behavioral Health Services Behavioral Health Clients" and accompanying consent forms, that is currently used by the City and County of San Francisco Department of Public Health.

City and County of San Francisco
Department of Public Health
Community Programs
COMMUNITY BEHAVIORAL HEALTH SERVICES

1380 Howard Street, 5th Floor
San Francisco, CA 94103
415.255-3400
FAX 415.255-3567

POLICY/PROCEDURE REGARDING: **Confidentiality and the Release of Protected Health Information of CBHS Behavioral Health Clients**

Issued By: Jo Robinson, MFT
Director of Community Behavioral Health Services

Date: September 26, 2011

Manual Number: 3.06-01
References: California Welfare & Institutions Code Section 5328; 42 C.F.R. part 2; 45 C.F.R. part 164; DPH HIPAA Privacy and Data Security Policies

Technical Revision. Replaces 3.06-01 of March 17, 2011

Purpose

DPH HIPAA Privacy Policies cover all relevant local, federal and state confidentiality laws (available at www.sfdph.org). This policy provides further guidance to staff on how to protect the confidentiality of protected health information of DPH behavioral health clients.

Scope

This CBHS policy applies to all staff in mental health civil service programs, affiliates, and contract programs, substance abuse treatment programs, and Private Providers Network who provide services for Community Behavioral Health Services (CBHS).

Policy

It is the policy of CBHS to comply with the confidentiality of client health information governed by the following laws, regulations, and codes:

1. Lanterman-Petris-Short Act [California Welfare and Institutions Code Section 5328]
2. Federal Regulations [Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. part 2]
3. Health Insurance Portability and Accountability Act (HIPAA); [45 C.F.R. part 164]
4. DPH HIPAA Privacy and Data Security Policies

In situations where there is a conflict or overlapping of the laws, the provider must comply with the law that has a more stringent provision. "More Stringent" means whichever law that provides the greater protection to the confidentiality of the client's health information.

When allowed by law, protected health information (PHI) may be shared for treatment purposes across disciplines and programs on a "need-to-know" basis and for the purposes of improving health outcomes.

The determination of which law applies can be complex. For assistance, call the Privacy Officer for Community Programs.

I. Definitions

"Protected Health Information (PHI)" means individually identifiable health information known, maintained or transmitted in any medium. PHI includes case management/coordination communication, medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment, results of clinical tests, and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

"Mental Health Records" means client records, or discrete portions thereof, specifically relating to evaluation or treatment of a mental disorder, and may include knowledge of the client's general health, substance use, HIV/AIDS status, and/or STD conditions.

Treatment, Payment, and Healthcare Operations (TPO)

- **Treatment** - PHI obtained in the course of treatment by a mental health provider may be disclosed to any healthcare provider (any discipline) "who has medical or psychological responsibility for the patient" without the client's written authorization for treatment purposes."[1] PHI may be disclosed across disciplines and programs on a "need-to-know and minimum necessary" basis for the purposes of improving health outcomes.
- **Payment** - means activities related to being paid for services rendered. These activities include eligibility determinations, billing, claims management, utilization review and debt collection.
- **Health Care Operations** – means a broad range of activities such as quality assessment, student training, contracting for health care services, medical review, legal services, auditing functions, business planning and development, licensing and accreditation, business management and general administrative activities.

"Psychotherapy Notes" The use and maintenance of psychotherapy notes is prohibited at CBHS. For detailed information, refer to *CBHS Policy 3.06-05: Maintenance and Use of Psychotherapy Notes and Informal Memory Prompts.*

"Alcohol and drug abuse records" means client records created by substance abuse treatment programs.

"Client's representative" means a parent or the guardian of a client who is a minor, or the guardian or conservator of an adult client, or an executor or the beneficiary of a deceased client.

II. Electronic Health Records

Providers who maintain, store and transmit client health information electronically must comply with regulations governing the safety, integrity, and confidentiality of the electronic health records. For detailed information, refer to the *DPH HIPAA Data Security Policy Brief.*

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[1] Reference: W&I Code 5328(a); DPH Privacy Policy Matrix

III. User Confidentiality, Security and Electronic Signature Agreement Form

All individuals who work for CBHS and individuals who need access to DPH patient information systems must sign the "User Confidentiality, Security and Electronic Signature Agreement Form" (Attachment 1). This signed form serves to verify that an individual has been informed of the statutory obligation to maintain confidentiality and the consequence of violations.

Return the original signed form to CBHS Information Systems Access Manager: 1380 Howard Street, 3rd Floor, San Francisco, CA 94103 via interoffice or US mail. A copy is kept in the individual's personnel file. For detailed information, refer to *CBHS Policy: 6.00-01 CBHS Electronic Signatures* and *CBHS Policy: 2.06-03 Confidentiality & Security Agreement.*

IV. Secured Delivery of Protected Health Information

Any protected health information that needs to be sent through interoffice mail, US mail, other mail, and by fax transmission must be protected with appropriate measures. For detailed information, refer to *DPH HIPAA Policy: Secured Delivery of Protected Health Information through Interoffice Mail, US Mail, Other Mail, and by Fax Transmission.*

V. Releasing Mental Health PHI for Treatment, Payment, and Health Care Operations

Authorizations are Not Needed for:

- **Treatment** - PHI obtained in the course of treatment by a mental health provider may be disclosed to any healthcare provider (any discipline) "who has medical or psychological responsibility for the patient" without the client's written authorization for treatment purposes."[2] PHI may be disclosed across disciplines and programs on a "need-to-know and minimum necessary" basis for the purposes of improving health outcomes.
- **Payment** - means activities related to being paid for services rendered. These activities include eligibility determinations, billing, claims management, utilization review and debt collection.
- **Health Care Operations** – means a broad range of activities such as quality assessment, student training, contracting for health care services, medical review, legal services, auditing functions, business planning and development, licensing and accreditation, business management and general administrative activities.

For detailed information, refer to *DPH HIPAA Compliance: Authorization for Use and the DPH Privacy Policy Matrix – Sharing Protected Health Information for Treatment Purposes*

VI. Releasing Mental Health PHI for Reasons Other than Treatment/ Payment/ Health Care Operations

Authorizations are needed for:
A signed HIPAA-compliant authorization form must be obtained from the client for each separate PHI disclosure for non-treatment purposes.

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[2] Reference: W&I Code 5328(a); DPH Privacy Policy Matrix

Examples of non-treatment providers:

- Parole Officers
- Property managers
- Tenant's advocates
- Benefits advocates
- HSA Employment Specialists

(See Attachment 2 – Authorization for Use or Disclosure of Protected Health Information Form, MRD 04) For detailed information, *refer to DPH HIPAA Compliance: Authorization for Use or Disclosure of Protected Health Information*

Note:

A. Prior to the release, the clinician must review and determine what information may not be released:
   1. Any PHI about the client that was given in confidence by a family member or someone else other than another provider may be removed from the medical record before copying.
   2. If PHI has references of another client's name, the information must be redacted from the medical record before copying.

B. Follow the procedure for releasing mental health records (See Attachment 3).

Research

Researchers must comply with the *DPH HIPAA Compliance: Privacy and the Conduct of Research*.

Courts

For detailed information, refer to *CBHS Policy 3.06-04: Release of Information Pursuant to a Subpoena/Court Order*.

Government Law Enforcement

For detailed information, refer to *DPH Privacy Policy: Law Enforcement Requests for Immediate Entry to DPH Community-Based Programs*.

Child Protective Service/Child Abuse Investigators

If a clinician has information that leads the clinician to suspect child abuse, the clinician must report the information. For detailed information, refer to *CBHS Policy 3.06-11: Special Situations Governing Release of Information: Child Abuse Reporting Act-Disclosure Requirements*.

Elder/Dependent Adult Abuse

If a clinician has information that leads the clinician to suspect elder or dependent adult abuse, the clinician must report the information. For detailed information, refer to *CBHS Policy 3.06-13: Special Situations Governing the Release of Information: Elder Abuse Report Requirements*.

"Tarasoff" Warnings

When the mental health client, in the opinion of the mental health clinician, presents a serious danger of violence to such person or persons, the clinician must warn the person or persons and may notify law enforcement agencies. The information released should be limited to the minimum necessary deemed to protect the person or persons. Program director/program manager should also be notified immediately. For detailed information, refer to *CBHS Policy 3.06-09: Special Situations Government Release of Information: Duty to Warn (Tarasoff Decision)*.

VII. Releasing Substance Abuse Treatment Program PHI for Any Purpose

Programs That Fall Under These Regulations[3]

- Substance abuse regulations apply to substance abuse treatment programs that provide alcohol or drug abuse diagnosis, treatment, or referral for treatment; e.g., methadone programs, Ward 93 at SFGH, etc.
- Regulations do not apply to all other general medical and mental health programs that serve clients with substance abuse issues.

Authorization Needed

A signed HIPAA-compliant authorization form must be obtained from the client of a substance abuse treatment program before the substance abuse treatment program may disclose PHI to any third party. Refer to *DPH HIPAA Compliance: Authorization for Use and the DPH Privacy Policy Matrix – Sharing Protected Health Information for Treatment Purposes*. If the provider has any questions regarding the validity of the authorization, call Health Information Management (HIM) for technical assistance.

Follow the procedure for releasing substance abuse records (See Attachment 4).

Prohibition of Re-disclosure

Federal regulations require that PHI documents disclosed with the client's authorization must be accompanied by a notice (Attachment 5 – Substance Abuse Cover Letter-Notice of Prohibition of Redisclosure Form) that states further disclosure of the documents is prohibited unless the disclosure is otherwise permitted by law[4].

VIII. Responding to Telephone Inquiries

- If the inquiry is not for treatment purposes, explain to the caller that CBHS provides mental health and substance abuse services and client information is protected by laws. Client identification information (even the fact that the client is or is not known to the program) is considered confidential and may not be disclosed.

Mental Health Treatment

- If the inquiry is made or received for coordination of treatment purposes, mental health staff may respond. It is the duty of the program staff to verify that the caller is a treatment provider (or a member of the treatment provider's team).

Substance Abuse Treatment

- PHI cannot be released without the client's authorization unless otherwise permitted by law; e.g., Medical emergencies.

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[3] PHI created by alcohol and drug abuse treatment programs are governed by federal statute, 42 U.S.C. Section 290dd-2, and federal regulations, "Confidentiality of Alcohol and Drug Abuse Patient Records – 42 C.F.R. part 2. California Health and Safety Code Section 11845.5 also provides special protections to information of certain drug abuse programs.

[4] 42 C.F.R. Section 2.32

IX. Clients' Right to Access Their PHI

Any client or any client's representative has the right to inspect or obtain a copy of his or her paper and/or electronic medical records with limited exceptions as noted below. A provider must provide access to all documents in the medical record, even if the provider did not create the document. Refer to *DPH Policy: HIPAA Compliance: Patient/Client/Resident Rights Regarding Protected Health Information, Section II.*

Denial of Right to Access
Under HIPAA, the provider may deny access if the provider determines that the disclosure to the individual 1) is reasonably likely to endanger the life or physical safety of the individual or another person, or 2) is reasonably likely to cause harm to another person referenced in the information[5].

If access is denied, the provider must inform the client of the denial. The client may request a review by the "reviewing official" at Community Behavioral Health Services.

- If the "reviewing official" agrees with the denial, the client may request a third party professional review. At this point, the "reviewing official" will notify the Privacy Officer for Community Programs.
- The reason for the denial must be documented in the progress notes.

Access of PHI through Inspection
Access must be provided within 5 working days of receiving the written request for inspection of records. Access may only be provided during business hours by appointment. The provider should accompany the client during the inspection process[6].

Access of PHI by obtaining a copy of medical record
Copies of the requested parts of the medical record (and that have been authorized by clinician) must be handed to the client or mailed within 15 calendar days after receiving the written request[7].

Summary in lieu of record
If the provider wishes to provide a summary of PHI, the client must agree in advance. If the client does not agree, the provider must furnish the actual records requested. The summary must be provided within 10 working days of receiving a written request[8].

Time period may be extended to 30 calendar days if information being summarized is lengthy[9].

Minors
If the parent or legal guardian consents for the treatment of a minor, the parent or legal guardian has the right to access the medical record. If the minor consents for treatment, (e.g., emancipated minor, self-sufficient minor, minor seeking sensitive services), only the minor has the right to access the medical record. For detailed information, refer to *CBHS policy 3.06-03: Minor Access to Medical Records.*

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[5] 45 C.F.R. § 164.524(a)(3)(i); Cal. Health & Safety Code §123115(b)
[6] 45 C.F.R. § 164.524 (c) (3); Cal. Health & Safety Code § 123110(a)

[7] 45 C.F.R. § 164.524 (c) (3); Cal. Health & Safety Code § 123110(b)
[8] 45 C.F.R. § 164.524 (c) (3); Cal Health & Safety Code § 123130 (a)
[9] 45 C.F.R. § 164.524(b) (2), (c) (3); Cal. Health & Safety Code § 123130(a)

X. Restriction on Use of Substance Abuse Information

Any substance abuse treatment program documents obtained through the client's own access may not be used by others to criminally investigate or prosecute the client[10].

XI. Client Requests for an "Accounting of Disclosures"

Accounting of Disclosures is a log maintained in each client's medical records for logging PHI that has been disclosed for reasons OTHER than treatment, payment, or operations. Also excluded are mandatory CPS/APS reportings. *For detailed information, refer to HIPAA Compliance Patient/Client/Resident Rights Regarding Protected health Information*

- Accountings must be provided to clients within 60 calendar days of the client's request. HIM staff will assist program staff in how to respond to such request.
- The client may not be charged for the first request within any 12-month period, but may be charged a cost-based fee for subsequent requests within that 12-month period, provided the client has been advised of the fee and has the opportunity to withdraw the request to avoid the fee. For more information, refer to *DPH Policy: HIPAA Compliance: Patient/Client/Resident Rights Regarding Protected Health Information, Section IV.*

XII. Sanctions

Violations of HIPAA privacy and security standards may result in:

- Disciplinary action;
- Disciplinary action/revocation by licensing boards;
- Fines; $1000 for each violation due to "reasonable cause and not to willful neglect" (with a maximum penalty of $100,000); $10,000 for each violation due to willful neglect that is corrected (with a maximum penalty of $250,000).
- Criminal prosecution; and/or
- Termination

Attachments:

Attachment 1 - User Confidentiality, Security and Electronic Signature Agreement Form
Attachment 2 - Authorization for Use or Disclosure of Protected Health Information Form, MRD 04
Attachment 3 - Procedure for Releasing Mental Health Medical Records
Attachment 4 - Procedure for Releasing Substance Abuse Medical Records
Attachment 5 - Substance Abuse Cover Letter-Notice of Prohibition of Redisclosure
Attachment 6 - Request for Access to Medical Record Form, MRD 01
Attachment 7 - Request for the Release of Information Log, MRD 13
Attachment 8 - Response to Request for Confidential Information

Related Policies:

CBHS Policy 2.06-03: Confidentiality & Security Agreement
CBHS policy 3.06-03: Minor Access to Medical Records
CBHS Policy 3.06-04: Release of Information Pursuant to a Subpoena/Court Order
CBHS Policy 3.06-05: Maintenance and Use of Psychotherapy Notes and Informal Memory Prompts

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[10] 42 C.F.R. Section 2.23

CBHS Policy 3.06-09: Special Situations Government Release of Information: Duty to Warn (Tarasoff Decision)
CBHS Policy 3.06-11: Special Situations Governing Release of Information: Child Abuse Reporting Act-Disclosure Requirements

CBHS Policy 3.06-13: Special Situations Governing the Release of Information: Elder Abuse Report Requirements
CBHS Policy 6.00-01: CBHS Electronic Signatures
DPH HIPAA Compliance: Privacy and the Conduct of Research
DPH HIPAA Compliance: Authorization for Use and the DPH Privacy Policy Matrix – Sharing Protected Health Information for Treatment Purposes
DPH HIPAA Compliance: Authorization for Use or Disclosure of Protected Health Information
DPH HIPAA Compliance: Patient/Client/Resident Rights Regarding Protected Health Information
DPH HIPAA Policy: Data Security Policy Brief
DPH HIPAA Policy: Secured Delivery of Protected Health Information through Interoffice Mail, US Mail, Other Mail, and by Fax Transmission
DPH HIPAA Privacy Policy: Law Enforcement Requests for Immediate Entry to DPH Community-Based Programs

Contact Person: Manager, Health Information Management, 255-3488

Distribution:
CBHS Policies and Procedures are distributed by the Office of Quality Management for Community Programs
Administrative Manual Holders
CBHS Programs
SOC Managers
BOCC Program Managers
CDTA Program Managers
HIM Staff

City and County of San Francisco – Department of Public Health

User Confidentiality, Security and Electronic Signature Agreement Form

Revised 062510 DPH Privacy Board – 415-255-3708

Individuals with access to confidential information and information systems (PCs, network, internet, e-mail, telephones, pagers, fax machines, etc.) of the San Francisco Department of Public Health have a legal and ethical responsibility to protect the confidentiality of personal, medical, financial, personnel, and protected health information, and to use that information and those systems only in the performance of their jobs. When my signature or co-signature is required for "a financial, program, or medical record" under California or Federal law, California or Federal regulation, or organizational policy or procedure," my user ID and password together shall constitute an electronic signature. The following applies to confidential DPH information accessed, received or sent in any format, including digital, paper, voice, facsimile, electronic signatures, etc.

I understand and agree to the following terms and conditions:

1. **I will only access, discuss, or divulge confidential DPH information as required for the performance of my job duties.** Providers may need to use all of an individual's health information in the provision of patient care. However, access to protected health information for other purposes must be limited based on job scope and the need for the information.
2. **I will not download or maintain patient information on my privately-owned portable devices.** If using a DPH- or UCSF-provided and password-protected device, I will delete patient information (and empty it from my computer's recycle bin) promptly when it is no longer needed to fulfill my job responsibilities.
3. DPH information systems maintain internal logs of applications and data accessed, indicating who viewed, added, edited, printed or deleted information. **I may be asked to justify my use of specific information contained in or managed by DPH information systems.**
4. Individuals requiring access to DPH information systems will be given a user ID and password. It is my responsibility to maintain the confidentiality of patient and other information to which I have access. **I agree to keep my user IDs and passwords secret and secure** by taking reasonable security measures to prevent them from being lost or inappropriately acquired, modified or otherwise compromised, and to prevent unauthorized disclosure of, access to, or use of them, or of any media on which information about them are stored. If I suspect that my user ID or password has been stolen or inappropriately acquired, lost, used by an unauthorized party, or otherwise compromised, **I will immediately notify the appropriate Information Systems Help Desk and request that my electronic signature be revoked.**
5. The hardware, software, data, and outputs of DPH information systems are the property of the DPH and must be appropriately licensed for installation on a DPH computer. **I will obtain prior authorization from a DPH information systems administrator before installing personal software on a DPH computer.** DPH has the right to review and remove personal or unlicensed software and data on any DPH computer or information system.
6. **Non-adherence** to this Agreement **may result in disciplinary action up to and including termination** of employment or contractual relationship with DPH.
7. **Violation of state and federal laws regarding patient privacy may subject me to substantial monetary penalties and/or make me the subject of a civil or criminal action** pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the California Medical Information Act, the Welfare and Institutions Code, and other federal and state privacy laws.
8. NOTE for individuals whose entries are "signed" electronically: For the purposes of authorizing and authenticating electronic health records, **my electronic signature (my user-ID plus my password) has the full force, effect, and responsibility of a signature affixed by hand to a paper document. My electronic signature establishes me as the signer or co-signer of electronic documents.** My electronic signature will be valid for the length of time specified in the DPH Password Security Policy (or the database administrator, whichever is shorter) from date of issuance, or earlier if it is revoked or terminated per the terms of the user agreement. Prior to the expiration date, I will receive a system alert when my password is due to expire and be given the opportunity to renew it. Setting a new password related to user's-ID (electronic signature) renews the terms of this agreement.

USER NAME (PRINT)	USER SIGNATURE	
USER DEPARTMENT/PROGRAM		DATE SIGNED
APPROVER NAME (PRINT)	APPROVER SIGNATURE/TITLE	DATE SIGNED

Return completed, signed forms to CBHS Information Systems Access Manager: 1380 Howard Street, 7th Floor, San Francisco, CA 94103 via interoffice or US mail.

Attachment 1

City and County of San Francisco
Department of Public Health
COMMUNITY BEHAVIORAL HEALTH SERVICES

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and federal law concerning the privacy of such information. **Failure to provide all information marked with an asterisk(*) may invalidate this authorization.**

Name of Client*:_____ **Date of Birth*:**_____

I authorize* _____ to disclose health
(Name, title, & address of person or organization)*
information obtained in the course of my diagnosis and treatment for the **purpose of:*** _____
and shall be limited to the following types of information – I recognize that if I am disclosing my health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law requires that recipients refrain from redisclosing such information except with my written authorization or as specifically required by law.

- o Discharge Summary
- o Assessment
- o Treatment Plan of Care
- o Physician's Orders
- o Progress Notes
- o Results of Lab Tests
- o Results of Psychological or Vocational Testing
- o Educational Assessment and Behavioral Reports (including school observation & educational testing)
- o Substance Abuse Treatment
- o Other (Specify)_____

Send to*:_____
(Name, title, & address of person or organization authorized to *receive* the information)

My Rights: I understand that authorizing the disclosure of this health information is voluntary. I may refuse to sign this authorization. I may revoke this authorization at any time. Revocation must be in writing, signed by me or on my behalf by someone with the legal authority to do so and delivered to CBHS or other facility. My revocation will be effective upon receipt, but will not be effective to the extent that CBHS may have acted in reliance upon this authorization prior to revocation. I have a right to obtain a copy of this authorization. I may not be denied treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

Expiration*: This authorization will automatically expire in 90 days from the date of execution unless a different end date or event is specified: _____ **or immediately upon fulfillment.**
(date/event)

*_____ *_____ _____
Date **Signature (Client/Patient/Parent/Guardian/Conservator)** Relationship if not Client/Patient

_____ o Interpreter used _____
Witness (Required if Client/Patient unable to sign)

Notes:
* A separate authorization is required to authorize the disclosure or use of **psychotherapy notes**.
If this authorization is for the disclosure of **substance abuse** information, the recipient may be prohibited from disclosing the information under 42 C.F.R. part 2.

MRD04 Rev 01/2/06 Confidential Patient/Client Information: see W & I Code 5328

White for the Requestor **Yellow** for Client/Patient/Parent/Guardian/Conservator **Pink** for Chart

Attachment 2

Attachment 3

Procedure for Releasing Mental Health Medical Records

Requests for Mental Health Medical Records

A. Upon receipt of the request, the program/provider/HIM staff will log the request and determine the validity of the authorization (Attachment 7 – Release of Information Log). If the program/provider has any questions regarding the validity of the authorization, contact HIM staff for technical assistance.
   1. Invalid authorization – The program/provider/HIM staff will prepare the reply to the requestor (See attachment 8 – Response Letter).
   2. Valid authorization – The program/provider/HIM staff will search Avatar and Insyst to see if client is known to CBHS.

B. Prior to the release, the clinician/provider must review and approve documents and notes in Avatar (if applicable), Clinician Gateway (CG) (if applicable), and the paper medical record (if applicable) to determine what information may <u>not</u> be released.
   Examples:
   1. Any PHI about the client that was given in confidence by a family member or someone else other than another provider may be removed from the medical record before copying.
   2. If PHI has references of another client's name, the information must be redacted from the medical record before copying.

C. The clinician/provider prints the information in CG and Avatar.

D. If the release involves any copying of the paper medical record, the clinician/provider must instruct the administrative/designated staff as to what information is to be copied by clipping or removing information that may <u>not</u> be released.

E. The clinician/provider must document the release on the progress note by indicating the date of the disclosure, the purpose of disclosure, the type of information disclosed, and the name of the entity/ person who received the information.

F. The administrative/designated staff is responsible for compiling copies, placing the authorization in the client's medical record, mailing, and completing the Request for Information Log (Attachment 7). A COPY OF THE INFORMATION THAT IS SENT TO THE REQUESTOR SHOULD NOT BE IN THE MEDICAL RECORD.

G. If the clinician/provider is no longer working at the program, the program director or the designee is responsible for reviewing the documents and notes in Avatar (if applicable), Clinician Gateway (if applicable), and the paper medical record (if applicable) before disclosing the information to the requestor.

Time Required for Processing Written Requests

Requests for medical records should be responded to promptly whether the request can be complied with or not.

Attachment 3

Fees

- $15.00 clerical cost incurred in locating and preparing the medical records.
- Actual copying costs, not to exceed 10 cents per page.
- Actual postage charges.

Professional Photocopy Services

The professional copy service is acting as the agent of the attorney and is subject to all confidentiality laws. A valid authorization must be obtained from the client before the copy service is allowed to come to the facility. Prior to copying, the clinician/provider must review and determine what information can/cannot be released.

Attachment 4

Procedure for Releasing Substance Abuse Medical Records

Requests for Substance Abuse Medical Records

A. Upon receipt of the request, the program/provider will log the request and determine the validity of the authorization (Attachment 7 – Release of Information Log). If the program/provider has any questions regarding the validity of the authorization, contact HIM staff for technical assistance.
   1. Invalid authorization – The program/provider will prepare the reply to the requestor (Attachment 8 – Response Letter).
   2. Valid authorization – The program/provider will search Avatar and Insyst to see if client is known to CBHS.

B. Prior to the release, the provider must review notes in Avatar (if applicable) and the paper medical record (if applicable) to determine what information may not be released.
   Example:
   If PHI has references of another client's name, the information must be redacted from the medical record before copying.

C. The provider must document the release on the progress note by indicating the date of the disclosure, the purpose of disclosure, the type of information disclosed, and the name of the entity/ person who received the information.

D. The provider/designee is responsible for compiling copies, placing the authorization in the client's medical record, mailing, and completing the request log (Attachment 7).
   Note: A COPY OF THE INFORMATION THAT IS SENT TO THE REQUESTOR SHOULD NOT BE IN THE MEDICAL RECORD.

E. If the provider is no longer working at the program, the program director or the designee is responsible for the release of information and documents the release on the progress note with the required information as listed above in B.

Time Required for Processing Written Requests

Requests for medical records should be responded to promptly whether the request can be complied with or not.

Fees

- $15.00 clerical cost incurred in locating and preparing the medical records.
- Actual copying costs, not to exceed 10 cents per page.
- Actual postage charges.

City and County of San Francisco
Department of Public Health
Community Programs
Office of Quality Management

Health Information Management
1380 Howard Street, Room 436
San Francisco, CA 94103
(415) 255-3488 Fax(415) 252-3001

Substance Abuse Treatment Program
Notice of Prohibition of Redisclosure

Date:_____

Name of Client:_____

Name of Counselor/Clinician:_____

The information has been disclosed to you from records protected by federal confidentiality rules (42C.F.R. part 2) per client's authorization form signed and dated, _____.

The federal rules prohibit you from making any further disclosure of the information/documents unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 C.F.R. part 2.

Thank you.

City and County of San Francisco
Department of Public Health
Community Programs
Office of Quality Management

Health Information Management
1380 Howard Street, Room 427
San Francisco, CA 94103
(415) 255-3488 Fax(415) 252-3001

REQUEST FOR ACCESS TO MEDICAL RECORD

Client Name:

Date of Birth:

I hereby request that _____ to
(name and address of program/provider)

provide access to my paper and/or electronic health record.

I request this access: (check one)

- ☐ Self
- ☐ Parent of the minor client
- ☐ Guardian of the minor client*
- ☐ Conservator of the person
- ☐ Attorney-in-fact under durable power of attorney for health care law*
- ☐ Beneficiary/personal representative of deceased client*
- ☐ Other: (specify) _____

Type of access requested is: (check one)

- ☐ Personal inspection of the record
- ☐ Copies of the record, as follows: (check one)
  - ☐ Entire record
  - ☐ Part of the record (describe): _____

Name (please print): _____

Address: _____ Phone: _____

Signature: _____ Date: _____

*Please furnish a copy of your appointment papers with this request.

MRD 01 rev. 3-8-11

City and County of San Francisco
Department of Public Health
Community Programs
COMMUNITY BEHAVIORAL HEALTH SERVICES

Request for the Release of Information Log

Date of the Request	Client Name	Date of Birth	BIS Number	Purpose	Requestor & Address	Date Sent	Type of Information Disclosed	Disclosed by

City and County of San Francisco
Department of Public Health
Community Programs
Office of Quality Management

Health Information Management
1380 Howard Street, Room 436
San Francisco, CA 94103
(415) 255-3488 Fax(415) 252-3001

DATE:

RE:

DOB:

Dear

A request to release information regarding the above-named individual has been received. We can neither confirm nor deny that the above-named person has been a client in our facility.

WE ARE UNABLE TO COMPLY WITH THIS REQUEST BECAUSE:

____ We are unable to find a record on this client. Please provide more information.

____ Pursuant to state and federal law, records which contain information pertaining to the diagnosis or treatment of psychiatric, alcohol or drug related disorders are subject to strict confidentiality. The records you seek may contain information which falls within this category, and we cannot release the records to you without specific written authorization by the client. Enclosed is an authorization which may be completed by the client to authorize release of any such records.

____ Other:

If we can be of further assistance, please call me at (415) 255-3488. Thank you.

Sincerely,

Alice Lee, MPH
Manager, Health Information Management

Enclosure

Attachment 4
Statement of Assurance

Appendix IV – Statement of Assurance

If selected, as the Authorized Representative of the CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, I agree to pay for services at the rate established under the prospective payment system during the demonstration program. I agree that no payments will be made for inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services, or to satellite facilities of CCBHCs if such facilities were established after April 1, 2014.

Signature of Authorized Representative

8/3/15
Date