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Overarching Framework for HCR

Five Core Elements of the MHSA should guide all work on MH

- Consumer and family oriented services
- Cultural competence
- Recovery/wellness/resilience orientation,
- Community collaboration
- Integrated service experiences for clients and families

Crosscutting issues

- Reducing disparities in mental health services
- Preserving meaningful stakeholder processes

ELEMENTS/ COMPONENTS	INFORMATION AND RELEVANT DOCUMENTS	WHAT WE'VE DONE SO FAR (ACTION TO DATE)	RELEVANCE TO CONSUMERS, FAMILY, STAKEHOLDER	POTENTIAL HCR/PLANNING COUNCIL ACTION IN FUTURE
Low income health program – Established a Medi-Cal funded program for most of California's uninsured by 2014, with phase in starting 2011 in certain counties	Counties' plans for mental health and substance abuse; State materials on LIHP; In 2012 review DHCS Transition to 2014 Plan	Reviewed San Bernardino summary and Blue Cross summary of county intent to provide mental health and substance abuse services Table summary now available Following/charting County contracts and depth of services for MH/SUD.	Avenue in for people who have existing or future conditions. They are now uninsured and will be Medi-Cal eligible under LIHP. Allows access to services without requiring SSI/SSDI and increases opportunity for employment, which supports recovery. May reduce disparities in access Insures TAY who do not have access through parents are still served. May stress system capacity. Concerns around equity of access to LIHP, ways implementation may foreshadow issues/success with larger expansion in 2012.	Ensure that constituents are aware of action in counties Track stress on MH system with new referrals *Determine HOW counties prioritize the enrollees they serve first.* Clarify whether 2014 enrollees will have same or better behavioral health services as existing medi-cal enrollees. Participate as a part of the CA Coalition for Whole Health in advocating for strong MH/SA benefit

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Exchanges and the Uninsured For those who are not eligible under the LIHP (due to income), they will be required to purchase insurance and will be able to do so through "Exchanges" – which have to offer BH services at some level. Some question as to whether new medi-cal enrolless will be going through exchanges.	IOM released its report and the minimum benefit for both health and mental health is very minimal. Papers from the CA on Whole Health including consensus principles and positions on Essential Health Benefits 2012 CA is considering Kaiser Small Group Business plan as the benchmark plan for the Essential Health Benefit	Reviewed material created by the Whole Health Coalition on minimum benefit. The Planning Council as a whole joined the Whole Health Coalition, which is an advocacy, group attempting to establish a decent minimum benefit for MH and SA services. *The Planning Council HCR staff person will attend the meetings. The Council will provide input to and support the CWHC through this committee*	Many people who do not have insurance wait to get BH care until it is very late in their illness, a good benefit for BH in this package could prevent that problem from occurring	Continue participation in the Whole Health Coalition Partner or influence state HBE, Board meetings are posted on web[1]. Sign on to new WH Coalition documents and confirm our endorsements of their efforts. At the point that the minimum benefit is established in CA, Planning Council should initiate or assist in ensuring that our population understands the changes
Dual Eligible demonstration projects Integrates Medi-Cal and Medicare funding for clients who are eligible for both and creates pilot projects to explore various configurations of services and systems. Will include at least one County Organized Health System	Dual Eligible State Summary July 2011 Proposals from counties and other entities are available to review; All documents provided to stakeholders from the MH/SA Workgroup for this process have been reviewed by committee chair	*Presentation from Sarah Arnquist on Dual-Eligible progress to date. Sent letter to project and others on stakeholder input and training of providers. Joined the mental health workgroup for dual Eligibles.* Participated in the CMHDA LIHP calls, advocated for active MH participation in this process; letter from Pat Ryan and CMHDA advocated for this participation Given input about beneficiary notification	How will pilots affect 1915b waiver, if at all? How will pilot programs provide behavioral health services? How will pilot programs work with county programs where clients and families could have significant input? What are the actual experiences of individuals who are in dual programs? What are the outcomes?	*Consult with CMHDA on feasibility of including medical case management as a reimbursable service.* Continue to advocate for adequate information for beneficiaries with SMI in the DHCS Transition process particularly through mental health community based providers HCR staff person will attend the MH/SA workgroup meetings

Deleted: *Eligibles*

		through Mental Health providers		Continue to track the evolution of these demonstrations
Health Homes Under HCR all clients will eventually have a health home, which will be responsible for the coordination of all their medical care. Individuals with SMI may be part of a health home. Where will these health homes be? IN primary care or in MH clinics	Materials to be provided for the October meeting (then they should be listed here	Scheduled presentation for October meeting	Clients who have serious mental illnesses may choose to have their health home be in a behavioral heath system, which would be responsible for coordinating all medical care for those clients. Is this feasible, has it been done well?	Ensure that clients with SMI are assigned to health homes that understand their unique needs October presentation will update HCR committee on SAMSHA models. Committee should extract critical issues for our clients and MHSA values
SPD enrollment All Medi-Cal eligible people who are seniors or have disabilities are being enrolled in managed care	State summary on SPD enrollment Are there any other documents available on this process?		Is there a disruption in patient/doctor relationships? Are hospitalizations increasing? SPD essential medical services like dialysis are requiring on-site case managers when our clients are given treatment	*Clients are reporting that their care is disrupted*. Not sure how we check the current status of this
Behavioral Health Needs Assessment	This Assessment has been done. CMHDA submitted a critique	*Contractor presented in October 2011.*		*Assessment completed in March 2012. Council supports CMHDA comments letter.*
Public Safety Realignment – newly eligible MC populations[2]	Telecare Analysis? LAO analysis? Rand Study on Public Health Implications of Prisoner Reentry in	Sent letter to Chief Probation Officers November 2011 Heard presentations at June	Affects access and potentially could reduce disparities in care (ethnic populations are overrepresented in the	Planning Council should complete the AB109 implementation report with recommendations and insure a wide distribution

	California	meeting about county AB109 implementation and recommended that the Planning Council develop a paper on the issues with implementation	criminal justice system – lack of preventive services.	

Develop a Matrix showing range and extent of services, funding source, proposed population served and number, and income eligibility.