



December 22, 2014

To: California Mental Health Planning Council

From: Jane Adcock
Executive Officer

Subject: January 2015 Planning Council Meeting

CHAIRPERSON
Monica Wilson PhD

EXECUTIVE OFFICER
Jane Adcock

Enclosed is the packet for the January 14-16, 2015 Planning Council meeting at the Crowne Plaza Hotel in San Diego, CA. The hotel is located at 2270 Hotel Circle North, San Diego, CA 92108. The hotel offers \$12 per day self-parking.

Issue Request Form

You have several copies of Issue Request Forms provided in this packet. We are enabling Planning Council members to request that committees on which they are not members address issues that are of concern to them. We have set aside the first five minutes of each committee meeting for Planning Council members to attend other committee meetings and briefly submit their issue requests. You will find Issue Request Forms in the front of this packet for your use. Please promptly return them to your committee after presenting your issue request so the regular agenda items can be handled.

➤ **Advocacy**

➤ **Evaluation**

➤ **Inclusion**

Mentorship Forum

A Mentorship Forum will be held the evening of **Thursday, January 15**, immediately following the general session. Planning Council officers and all committee chairs and vice-chairs are specifically requested to attend. Other Planning Council members who wish to benefit from the discussion are welcome to attend.

The purpose of this forum is to discuss the process issues involved in chairing the committees and the Planning Council. For example, experienced chairs can explain the techniques they use during the meetings to keep the agenda moving and manage the discussion. Vice-chairs can ask questions about techniques they observed or how to handle various problems that might occur during the course of a meeting. It is our hope that, through this process, the Planning Council will enable more members to feel qualified to serve as committee chairs or officers.

Committee Reports

We have allocated 25 minutes for committee reports on Friday morning. The focus of the committee reports will be what tasks or objectives the committee has completed on its projects and on its work plan. In addition, the committee should report any action items that it has adopted.

Please call me at (916) 319-9343 if you are unable to attend the Planning Council meeting so we can determine if we will have a quorum each day. See you soon!

Enclosures

MS 2706
PO Box 997413
Sacramento, CA 95899-7413
916.323.4501
fax 916.319.8030

RESTAURANTS NEAR CROWNE PLAZA SAN DIEGO

- **Islands 72%**
Mission Valley - Hawaiian 2270 Hotel Cir N
Distance of 0.1mi
- **The Islands Sushi and Pu Pu... 78%**
\$\$\$\$ Mission Valley - Sushi, Hawaiian 2270 Hotel Circle North
Distance of 0.1mi
- **Hunter Steakhouse 86%**
\$\$\$\$ Mission Valley - Steakhouse, American 2445 Hotel Circle PI
Distance of 0.4mi
- **Villani's**
\$\$\$\$ Mission Hills - Italian 1515 Hotel Cir S
Distance of 0.6mi
- **Rocking Tanuki 73%**
\$\$\$\$ Linda Vista - Japanese, Sushi 6110 Friars Road
Distance of 0.7mi
- **Mr. Peabody's 94%**
Linda Vista - American 6110 Friars Rd
Distance of 0.7mi
- **Nypd Pizza 77%**
Linda Vista - Pizza, Italian, Sandwiches/Subs 6110 Friars Rd
Distance of 0.7mi
- **Oliva Ristorante**
Linda Vista - Pizza, Italian, Sandwiches/Subs 6110 Friars Rd
Distance of 0.8mi
- **Espresso Mio 85%**
\$\$\$\$ Mission Hills - Coffee, Bakery, Tea 1920 Fort Stockton Dr
Distance of 0.8mi
- **Amigo Spot 84%**
Mission Hills - Mexican 1333 Hotel Cir S
Distance of 0.8mi
- **Waffle Spot Kings Inn Hotel... 79%**
Mission Hills - Breakfast 1333 Hotel Cir S
Distance of 0.9mi
- **Shiraz Coffee & Deli**
\$\$\$\$ Linda Vista - Coffee 5505 Friars Rd
Distance of 1.0mi
- **B'Sters Coffee Juice Bar**
\$\$\$\$ Linda Vista - Coffee 5505 Friars Rd
Distance of 1.0mi

- **Adam's Steak & Eggs 76%**
 \$\$\$\$ Mission Valley - Breakfast, American 1201 Hotel Cir S
 Distance of 1.1mi
- **Albie's Beef Inn 80%**
 \$\$\$\$ Mission Valley - Seafood, American, Steakhouse 1201 Hotel Cir S
 Distance of 1.1mi
- **Old Town Tequila Factory**
 \$\$\$\$ Old Town - American, Mexican 2467 Juan St
 Distance of 1.1mi
- **Executive Deli 90%**
 Mission Valley - Sandwiches/Subs 1660 Hotel Cir N
 Distance of 1.1mi
- **Postcards American Bistro**
 \$\$\$\$ Mission Valley - Modern 950 Hotel Cir N
 Distance of 1.1mi
- **Miguel's Cocina 83%**
 \$\$\$\$ Old Town - Mexican, Seafood, Breakfast 2444 San Diego Ave.
 Distance of 1.2mi
- **Miguel's 83%**
 \$\$\$\$ Old Town - Latin American, Breakfast, Caribbean 2444 San Diego Ave
 Distance of 1.2mi
- **Fred's Mexican Cafe 80%**
 \$\$\$\$ Old Town - Mexican, Tex-Mex 2470 San Diego Ave
 Distance of 1.2mi
- **New Orleans Creole Cafe 82%**
 \$\$\$\$ Old Town - Southern/Soul, Cajun/Creole, French 2476 San Diego Ave
 Distance of 1.2mi
- **D'O Thai Cottage 85%**
 \$\$\$\$ Old Town - Thai, Asian 2414 San Diego Ave.
 Distance of 1.2mi
- **Cosmopolitan Restaurant and... 86%**
 \$\$\$\$ Old Town - American, Seafood, Mexican 2660 Calhoun St
 Distance of 1.2mi
- **Alamo 86%**
 \$\$\$\$ Old Town - Mexican 2543 Congress St
 Distance of 1.2mi
- **Cafe Coyote 81%**
 \$\$\$\$ Old Town - Mexican, Breakfast 2461 San Diego Ave
 Distance of 1.2mi

- **Old Town Root Beer**
Old Town - Dessert 2415 San Diego Ave
Distance of 1.2mi
- **Craze Burger 87%**
\$\$\$\$ Old Town - Burgers 2415 San Diego Avenue
Distance of 1.2mi
- **Old Town Mexican Cafe 78%**
\$\$\$\$ Old Town - Mexican 2489 San Diego Ave
Distance of 1.2mi
- **Urbane Cafe 96%**
\$\$\$\$ Linda Vista - American, Sandwiches/Subs, Salad 5375 Napa St
Distance of 1.2mi
- **Kona Kakes**
\$\$\$\$ Linda Vista - Bakery 5401 Linda Vista Rd
Distance of 1.2mi
- **Casa de Reyes at Fiesta de... 84%**
\$\$\$\$ Old Town - Mexican 2754 Calhoun Street
Distance of 1.2mi
- **Old Town Mexican Cafe 73%**
Old Town - Mexican 4010 Twiggs St
Distance of 1.2mi
- **Old Town Market Cafe 82%**
\$\$\$\$ Old Town - Coffee, Tea, Organic 4010 Twiggs st
Distance of 1.2mi
- **Living Room Cafe & Bistro 56%**
\$\$\$\$ Old Town - Mexican, Diner, Italian 2541 San Diego Ave
Distance of 1.3mi
- **Valencia's Mexican Food**
\$\$\$\$ Linda Vista - Mexican 5201 Linda Vista Rd, Ste 102
Distance of 1.3mi
- **Living Room Coffeehouse 58%**
\$\$\$\$ Old Town - Coffee 2541 San Diego Ave
Distance of 1.3mi
- **O'Hungry's 80%**
\$\$\$\$ Old Town - American, Burgers 2547 San Diego Ave
Distance of 1.3mi
- **Jack & Giulio's 83%**
\$\$\$\$ Old Town - Italian 2391 San Diego Ave
Distance of 1.3mi

- **El Patio of Old Town**
 \$\$\$\$ Old Town - Mexican 2611 San Diego Ave
 Distance of 1.3mi
- **Fiji Yogurt**
 \$\$\$\$ Linda Vista - Dessert 5401 linda vista Rd.
 Distance of 1.3mi
- **Ballast Point Brewing Co. 95%**
 Linda Vista - Pub Food 5401 Linda Vista Rd
 Distance of 1.3mi
- **Korky's Ice Cream & Coffee 79%**
 \$\$\$\$ Old Town - Coffee, Dessert, Ice Cream/Gelato 2371 San Diego Ave
 Distance of 1.3mi
- **Rancho la Lena**
 Old Town - Mexican 2367 San Diego Ave
 Distance of 1.3mi
- **Indian Grill**
 \$\$\$\$ Old Town - Indian 2367 San Diego Ave
 Distance of 1.3mi
- **Harney Sushi 90%**
 \$\$\$\$ Old Town - Sushi, Japanese 3964 Harney St
 Distance of 1.3mi
- **Olde San Diego Soda Shoppe**
 Old Town - Smoothies 3964 Harney St
 Distance of 1.3mi
- **Tu Mercado**
 \$\$\$\$ Linda Vista - Sandwiches/Subs, Bagels, Dessert 5998 alcala park
 Distance of 1.3mi
- **La Gran Terraza at... 90%**
 \$\$\$\$ Linda Vista - California, Mediterranean, Wine Bar 5998 Alcalá Park
 Distance of 1.3m
- **El Agave 85%**
 \$\$\$\$ Mission Hills - Mexican 2304 San Diego Ave
 Distance of 1.3mi

AGENDA
CALIFORNIA MENTAL HEALTH PLANNING COUNCIL
January 14, 15, 16, 2015
Crowne Plaza San Diego
2270 Hotel Circle
San Diego, CA 92108

Notice: All agenda items are subject to action by the Planning Council. The scheduled times on the agenda are estimates and subject to change.

Wednesday, January 14, 2015

COMMITTEE MEETINGS

Time	Event	Room
9:00 a.m.	Executive Committee Meeting	Pacific Room
10:00 a.m.	New Member Orientation Meeting	Tropic Room
11:00 a.m.	Patients' Rights Committee Meeting	Surf Room

PLANNING COUNCIL GENERAL SESSION

Kona Coast Room

Conference Call 1-866-723-8689

Participant Code: 8356601

Time	Topic	Presenter or Facilitator	Tab
1:30 p.m.	Welcome and Introductions	Monica Wilson, Ph.D., Chairperson	
1:40 p.m.	Opening Remarks	Alfredo Aguirre, Director, San Diego County Behavioral Health Department (Invited)	
2:00 p.m.	Election of Chair-Elect and Changing of the Officers	Lorraine Flores, Chair, Nominating Committee	
2:05 p.m.	Approval of Minutes from October 2014 meeting	Cindy Claflin, Chairperson	XYZ
2:10 p.m.	Overview of the Health Care Integration Committee and Health Care Integration in California	Steven Grolnic-McClurg, LCSW, Mental Health Manager, Berkeley Department of Health, Housing, and Community Services.	
2:30 p.m.	Panel Presentation: Health Care Integration and Family Member experience within San Diego	Family Members (Invited)	A

3:30 p.m.	Break		
3:45 p.m.	Presentation: Health Care Integration San Diego, Community Health Group	George Scolari, Behavioral Health Program Manager, Community Health Group	B
4:50 p.m.	Public Comment		
5:00 p.m.	Recess		

Thursday, January 15, 2015

COMMITTEE MEETINGS

Time	Event	Room	Tab
8:30 a.m.	Advocacy Committee	Pacific Room	
to 12:00 p.m.	Continuous System Improvement	Surf Room	
	Health Care Integration Committee	Tropic Room	
12:00 p.m.	LUNCH (on your own)		

PLANNING COUNCIL GENERAL SESSION

Kona Coast Room

Conference Call 1-866-723-8689

Participant Code: 8356601

Time	Topic	Presenter or Facilitator	Tab
1:30 p.m.	Welcome and Introductions	Cindy Claflin, Chairperson	
1:40 p.m.	Public Comment	Cindy Claflin, Chairperson	
1:50 p.m.	Report from Dept. of Health Care Services	Brenda Grealish, Assistant Deputy, Mental Health and Substance Use Disorders	
2:10 p.m.	Overview of Options and Selection of Option for Mental Health Master Plan	Cynthia Burt, Consultant	C
3:00 p.m.	Break		
3:15 p.m.	Substance Abuse Panel and Continued Discussion of Possible Integration to Behavioral Health Council	Tom Renfree, Deputy Director, Substance Use Disorders, CA Behavioral Health Directors Assoc, Susan Wilson, SUD Program Director, Noel O'Neill, Trinity County Behavioral Health Director and Alfredo Aguirre, Director, San Diego County Behavioral Health	D
4:30 p.m.	Report from CA Behavioral Health Directors Association	Noel O'Neill, Director, Trinity County	

4:50 p.m.	Approve 2015 Legislative Platform	Adam Nelson, Chair, Advocacy Committee	E
5:00 pm	Recess		

Mentorship Forum for Council member, including Committee Chairs and Chair-Elects, will occur immediately following the recess of Thursday's General Session.

Friday, January 16, 2015

PLANNING COUNCIL GENERAL SESSION

Kona Coast Room

Conference Call 1-866-723-8689

Participant Code: 8356601

Time	Topic	Presenter or Facilitator	Tab
8:30 am	Welcome and Introductions	Cindy Claflin, Chairperson	
8:40 am	Opening Remarks	Assemblymember Rocky Chavez (Invited)	
9:10 am	Report from the California Association of Local Mental Health Boards/Commissions	Larry Gasco, Ph.D., LCSW, President	
9:35 a.m.	Committee Reports – Continuous System Improvement and Patients' Rights	Susan Wilson, Chair CSI and Daphne Shaw, Chair PR	
10:00 am	BREAK		
10:15 a.m.	Committee Reports Cont. – Health Care Integration and Advocacy	Steven Grolnic-McClurg, Chair HCI and Adam Nelson, Chair Advocacy	
10:45 a.m.	Executive Committee Report	Cindy Claflin, Chairperson	
11:00 a.m.	Public Comment	Cindy Claflin, Chairperson	
11:10 a.m.	Report from Mental Health Services Oversight and Accountability Commission	Victor Carrion, M.D., Chair (invited)	
11:30 a.m.	New Business and Council Member Open Discussion - Discuss Areas of Focus	Cindy Claflin, Chairperson	F
11:50 a.m.	Evaluation of the Meeting	Cindy Claflin, Chairperson	
12:00 p.m.	ADJOURN		

All items on the Committee agendas posted on our website are incorporated by reference herein and are subject to action.

If Reasonable Accommodation is required, please contact Chamenique Williams at 916.552.9560 by January 5, 2015 in order to work with the venue to meet the request.

2015 MEETING SCHEDULE

January 2015	January 14, 15, 16	San Diego	Crowne Plaza San Diego, 2270 Hotel Circle North, San Diego, CA 92108
April 2015	April 15, 16, 17	Los Angeles	San Pedro Doubletree, 2800 Via Cabrillo-Marina, San Pedro, CA 90731
June 2015	June 17, 18, 19	Santa Clara	To Be Determined
October 2015	October 14, 15, 16	Sacramento	To Be Determined

2016 MEETING SCHEDULE

January 2016	January 20, 21, 22	San Diego	To Be Determined
April 2016	April 20, 21, 22	Ontario/Riverside	To Be Determined
June 2016	June 15, 16, 17	SF/Burlingame	To Be Determined
October 2016	October 19, 20, 21	Sacramento	To Be Determined

Patients' Rights Committee

January 14, 2015

Crowne Plaza San Diego
2270 Hotel Circle North, San Diego, CA

Surf Room
11:00 a.m. - 12:30 p.m.

Item #	Time	Topic	Presenter or Facilitator	Tab
1.	11:00 am	Welcome and Introductions	<i>Daphne Shaw, Chairperson</i>	
2.	11:05 am	Review/Approval: Minutes for October, 2014 meeting	All members	A
3.	11:15 am	Update: Plan to send PR Survey – online and print versions	All members	
4.	11:30 am	Update: Response to PR letter to County Mental Health Directors	All members	
6.	12:00 pm	New Business: Patients' Rights Committee Work Plan 2014-15	All members	B
7.	12:25 pm	Public Comment	<i>Daphne Shaw, Chairperson</i>	
8.	12:30 pm	Meeting adjourned		

The scheduled times on the agenda are estimates and subject to change. Any accommodations needed, please contact Laura Leonelli at 916-324-0980

Committee Members:

Co-Chairs: **Daphne Shaw, Chair** **Cindy Clafin, Chair-Elect**

Members: Carmen Lee Richard Krzynowski, DRC
 Adam Nelson, MD
 Walter Shwe

Staff: Laura Leonelli

Advocacy Committee

January 15, 2015

Crowne Plaza Hotel
2270 Hotel Circle N
San Diego, CA 92108
(619) 297-1101

PACIFIC ROOM
8:30 a.m. to 12:00 p.m.

Time	Topic	Facilitator/Presenter	Tab
8:30 a.m.	Welcome and Introductions	Adam Nelson, Chair	
8:35 a.m.	Brief Orientation/Mentor Assignments	Adam Nelson	
8:45 a.m.	Agenda Review and/or Adjustments	Kathleen Derby, Chair-Elect	
8:50 a.m.	Council Requests/ New Business	Adam Nelson	
8:55 a.m.	2015 Work Plan Development	Adam Nelson	A
10:00 a.m.	Break		
10:15 a.m.	San Diego In-Home Outreach Team (IHOT) Presentation	Roselyna Rosado, LCSW; Program Administrator; In Home Outreach Team (IHOT) & Team	B
11:15 a.m.	Committee Discussion/Next Steps	Adam Nelson	
11:30 a.m.	Public Comment	Kathleen Derby	
11:45 a.m.	Develop Report-Out	Adam Nelson	
11:50 a.m.	WWW & Plan Future Meeting(s)	Kathleen Derby	
11:55 a.m.	Plus/Delta	Andi Murphy, Staff	
12:00 p.m.	Adjourn		

The scheduled times on the agenda are estimates and subject to change.

Committee Members:

Chair: Adam Nelson, MD

Chair-Elect: Kathleen Derby

Members:	Karen Bachand	Nadine Ford	Carmen Lee
	Steve Leoni	Barbara Mitchell	Maya Petties, PhD
	Darlene Prettyman	John Ryan	Daphne Shaw
Staff:	Andi Murphy	Arden Tucker	Monica Wilson, PhD

If reasonable accommodations are required, please contact Andi Murphy at (916) 323-4501 within 5 working days of the meeting date in order to work with the meeting venue.

Healthcare Integration Committee
January 15, 2015
 2270 Hotel Circle North, San Diego, CA 92108
 (619) 297-1101
 Tropical Room
8:30 a.m. to 12:00 p.m.

Time	Topic	Presenter or Facilitator	Tab
8:30 a.m.	Planning Council Member Issue Requests		
8:35 a.m.	Welcome and Introductions	Steven Grolnic-McClurg, LCSW, Chairperson	
8:40 a.m.	Presentation: Behavioral Health Inland Empire Health Plan	Dr. Peter Currie, Clinical Director of Behavioral Health Inland Empire Health Plan	A
9:40 a.m.	Questions/Comments		
10:15 a.m.	Break		
10:30 a.m.	Committee Discussion		
10:45 a.m.	Discuss Chair and Vice-Chair Assignments		
10:55 a.m.	Choose mentors for new members		
11:05 a.m.	Work Plan Review and update		
11:40 a.m.	Public Comment		
11:50 a.m.	Next Steps/Develop Agenda for Next Meeting	Steven Grolnic-McClurg, LCSW, Chairperson	
11:55 a.m.	Wrap up: Report Out/ Evaluate Meeting	Steven Grolnic-McClurg, LCSW, Chairperson	
12:00 p.m.	Adjourn Committee		

The scheduled times on the agenda are estimates and subject to change.

Committee Members:

Chair: Steven-Grolnic
Vice-Chair: McClurg
Members: Josephine Black Terry Lewis
 Dale Mueller Deborah Pitts Jeff Riel
 Joseph Robinson Cheryl Treadwell Cindy Claflin
 Daphyne Watson Robbie Powelson
Staff: Tracy Thompson

INFORMATION

TAB SECTION XYZ

ACTION REQUIRED

DATE OF MEETING 01/13/15

**MATERIAL
PREPARED BY: Jones**

**DATE MATERIAL
PREPARED 12/19/14**

AGENDA ITEM:	Review and Approve October 2014 CMHPC Quarterly Meeting Minutes
ENCLOSURES:	October 2014 CMHPC Quarterly Meeting Minutes
OTHER MATERIAL RELATED TO ITEM:	

ISSUE:

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL MEETING MINUTES

October 16 and 17, 2014
Lake Natoma Inn
702 Gold Lake Drive
Folsom, CA 95630

CMHPC Members Present:

Monica Wilson, Chair	Noel O'Neill
Cindy Claflin, Chair-Elect	Maya Petties
Kathleen Derby	Deborah Pitts, Ph.D.
Lorraine Flores	Darlene Prettyman
Steven Grolnic-McClurg	Jeff Riel
Karen Hart	Joseph Robinson
Celeste Hunter	Daphne Shaw
Steve Leoni	Walter Shwe
Terry Lewis	Cheryl Treadwell
Barbara Mitchell	Arden Tucker
Dale Mueller	Bill Wilson
Adam Nelson, M.D.	Susan Wilson

Staff Present:

Jane Adcock, Executive Officer	Andi Murphy
Linda Dickerson	Tracy Thompson
Laura Leonelli	

Thursday, October 16, 2014

1. Welcome and Introductions

Chair Wilson welcomed everyone to the meeting. The Planning Council members, staff, and audience introduced themselves. Chair Wilson extended a welcome to new members Kathleen Derby, Noel O'Neill, and Arden Tucker.

To mark the last meeting at which she would preside, Chair Wilson shared a quote from Dr. Martin Luther King. She then shared a personal video that Carmen Lee had provided for the Planning Council members.

2. Opening Remarks

Chair-Elect Cindy Claflin introduced Tom Campbell, Chair of the Sacramento County Mental Health Board.

Mr. Campbell stated that his goal is to make the Board more responsible to tangible results, specifically regarding cooperation with the Board of Supervisors. Mr. Campbell described some of the Board's activities in Sacramento County.

- AB 109 funding: the Division of Behavioral Health Services has received a \$500,000 partnership with the county probation department to address mental health needs of inmates.
- Mental Health Services Act (MHSA): The Board is discussing how to allocate some of the growth funding that they have seen in the Community Support Services component. The county MHSA Steering Committee is conducting a workgroup on Transition-Age Youth (TAY) which will be released in November.
- The Sheriff's Department is taking the lead on a multi-agency implementation of the Crisis Intervention Team, using the Memphis model.
- The county has expanded its work with data and outcomes measurement; they have worked with the CMHPC Data Notebook Committee. The county looks to have the notebook completed by November.
- The Board has worked with the County Board of Supervisors in the area of Assisted Outpatient Treatment (AOT). In spite of differences of opinion on AOT, the two agencies held a vetting process on whether to implement it, which led to conditional support. The Mental Health Board is researching the topic and may possibly make a recommendation for the Board of Supervisors to go forward.
- As of January 1, the Mental Health Board roster will be down to eight out of 16 members. Mr. Campbell said that he was accepting recommendations for new members.

Questions and Discussion

Ms. Hart requested a copy of the MHSA Steering Committee TAY report for Planning Council staff when it comes out.

Ms. Prettyman suggested for Mr. Campbell to contact the National Alliance on Mental Illness (NAMI) Sacramento to enlist family members to serve on the board.

Mr. Leoni recommended for Mr. Campbell to consider the In-Home Outreach Team (IHOT) program in San Diego County for Laura's Law implementation.

3. Approval of June 2014 Meeting Minutes

Ms. Prettyman noted that on page 7, Ms. Hart had asked about the Compliance Advisory Committee. Ms. Adcock and Ms. Hart had attended the next meeting. Ms. Hart felt that the CMHPC should maintain representation on the committee; Ms. Prettyman suggested establishing a "Parking Lot" in the CMHPC minutes to keep track of actions such as this.

Mr. Leoni had made a comment on page 28; he wished to have added to the minutes his statement that he found the Second Story program impressive.

Motion: The approval of the June 2014 Meeting Minutes with the addition noted above was moved by Darlene Prettyman, seconded by Lorraine Flores. Motion passed with one abstention.

4. Mental Health and Substance Use Overview

Ms. Adcock stated that the present meeting was focused on informing the Planning Council members about substance use services as they consider becoming a behavioral health council. The next speakers were to compare and contrast the mental health system and the substance use system in California.

Ms. Adcock referred to the chart entitled “Community Mental Health Funding Amounts – Role of Major Funding Sources.” The chart shows the eight funding sources for the public mental health system. The chart shows how the funding sources lead to the different requirements for the funds; it also provides context for the substance use delivery system.

5. Introduction to Mental Health and Substance Use Disorders at Department of Health Care Services

Karen Baylor, Ph.D., Deputy Director, Mental Health and Substance Use Disorder Services at the Department of Health Care Services (DHCS), gave a high-level overview.

- The Chief of Mental Health Services at DHCS is Brenda Grealish.
- The Substance Use Disorder Services (SUD) side at DHCS has two divisions:
 - Licensing and Compliance
 - Prevention, Treatment, and Recovery Services (PTRS).
- Serving under the Division Chiefs are Branch Chiefs; serving under the Branch Chiefs are Unit Supervisors.
- There are about 300 people working in Mental Health and SUD. 56 of the 58 counties have integrated into Behavioral Health, where Mental Health and Substance Use Disorder Services are integrated under one director.
- The structure of SUD is very different from the Mental Health side: the majority of work done there is through the Substance Abuse Prevention Treatment (SAPT) block grant.
- Drug Medi-Cal’s benefits have just been expanded.
- Mental health services are all county-driven. The SUD side is more provider-driven.
- Mental health services are provided by licensed clinicians. SUD services are mostly provided by certified counselors; there are four certifying organizations.
- Mr. O’Neill added that the reimbursement rate on the mental health side is based on rates from actual cost reports. The SUD side has fixed rates – which are sometimes far lower than the actual costs.
- Quality Improvement is far more defined and active on the mental health side. Because there are many more non-profits involved in providing SUD services, there isn’t a lot of oversight.
- Dr. Baylor stated that SUD funding is not as robust although there is some flexibility in the SAPT funds.

- Mental health has far more regulations and requirements, as well as checks and balances. SUD regulations are fairly minimal.
- What brings the two sides together is the predominant number of people with co-occurring disorders: 50-70%.
- Much of the same work had been in progress within the two sides, but there was no communication. The efforts have now been combined in 56 counties.
- DHCS is looking at combining the fiscal departments.

Ms. Wilson asked who determines how SAPT money is spent. Dr. Baylor replied that money goes directly to the counties through methodology developed long ago. DHCS wants to examine how the counties are spending their SAPT funds, to ensure that it is equitable.

Mr. O'Neill added that some of the counties are not Drug Medi-Cal certified yet; their SAPT dollars are what run their programs.

He also pointed out that on the mental health side, there is far stronger family advocacy and involvement. Dr. Baylor agreed and commented that there are different confidentiality rules for SUD; CFR 42 may be examined as it is a barrier to data-sharing.

Mr. Leoni asked if the same lopsided structure between mental health and SUD exists in other states; most states do not even have a county system like California's. Dr. Baylor answered that the federal government has declared California unique, and that states are all over the map in their structures. The federal government wants California to take the lead, especially with the rollout of the waiver and the alignment of the system with mental health. Many states are watching California's actions.

Ms. Mitchell inquired about certification of facilities and staff screening on the SUD side. Dr. Baylor responded that DHCS has gone through a process of having all Drug Medi-Cal providers go through recertification. It is a different system from the mental health side, where counties are responsible for certifying their providers and the state then certifies the counties. A DHCS division called Provider Enrollment has been doing the Drug Medi-Cal provider recertification.

Dr. Baylor continued that the counseling organizations do not have the same screening and background checking as the mental health side.

Ms. Prettyman asked for an explanation of the waiver. Dr. Baylor answered that the 1115 Waiver is a demonstration waiver, which means that it will involve counties that opt in. DHCS wants to demonstrate a new model of an organized delivery system with a continuum and continuity of care: you can access any service anywhere in the state anytime you want; there is no case manager monitoring the care.

She continued that the waiver will attempt to lift up the system to have set criteria for assessment; you must meet medical necessity; and the county is responsible for assigning a case manager. This may prevent relapsing and recycling of people into higher levels of care where lower levels are more suitable.

Mr. Leoni referred to the problem he had seen in San Francisco of long waiting lists. Will the waiver aid the need for treatment on demand? Dr. Baylor replied DHCS was hopeful that the waiver and the expanded benefits would alleviate this problem.

6. Overview of Substance Abuse Prevention and Treatment Block Grant

Don Braeger, Chief, SUD PTRS Division, gave a high-level overview of that division. The four branches are:

- Policy and Grants Management Support. Its functions are fiscal policy, administrative policy, program policy, and grants management oversight with the Substance Abuse & Mental Health Services Administration (SAMHSA) for the SAPT block grant.
- Prevention Programs and Services. Its three areas oversee all of the prevention data. Up to 20% of SAPT funds are set aside for primary prevention programs. Technical assistance contracts for cultural competency are also in this area.
- Fiscal Management and Accountability. This branch settles the year-end cost reports that counties have to submit. It also processes all contracts that go out to the counties and direct contract providers.
- Performance Management. It monitors the counties and settles for utilization, looking for medical necessity – did they spend the dollars in the right way? Disallowances come in here.

Mr. Braeger explained the SAPT block grant.

- It is historically the main funding source for SUD services.
- The majority of the funds go to the counties for local assistance.
- The state retains roughly 8% for administrative costs and overhead.
- Mr. Braeger provided a breakdown for the 60% discretionary dollar amounts.
- States are encouraged to spend their SAPT dollars.
- A large component of the SAPT block grant is Maintenance Of Effort (MOE): ensuring that you spend a certain amount on SUD services.
- SUD is not sure where SAMHSA is going with the SAPT funding; they may be waiting to see what DHCS does with the waiver.

Questions and Discussion

Mr. Grolnic-McClurg asked if SAPT funds are used as a basis to match for Medicaid billing (similar to mental health); Mr. Braeger indicated that they pay for the entire service. Dr. Baylor stated that the only billable service is on the Drug Medi-Cal side. Every year SUD looks at claims – how much counties billed – in order to adjust Realignment to fit more closely with that dollar amount.

Mr. O'Neill stated that counties can never use any part of the SAPT block grant for a match. When there is a nonprofit provider that has a contract directly with the state, the

match comes out of the county Realignment pot. With the recent Drug Medi-Cal changes, counties can draw down money through the Drug Medi-Cal program and use their SAPT dollars for other kinds of services (for instance, residential treatment).

Ms. Mitchell asked if anyone is looking at dual licensing issues, and billing both the mental health and the substance abuse sides for the same person. Dr. Baylor responded that DHCS has indeed been asked that question and will be looking into it. A mechanism to prevent double-billing will be necessary.

Dr. Baylor clarified for Mr. Leoni that when providers contract directly with the state, the state takes the counties' Realignment dollars for payment – not the ideal situation. Only the counties are able to get the SAPT funds.

Mr. Leoni pointed out the situation where counties have excellent mental health programs funded by a SAMHSA block grant – but when the money runs out, the county does not pick it up and the program goes away. This does not happen on the substance abuse side. Dr. Baylor agreed, and noted that many of the states are now combining their block grant applications. DHCS is looking at this option.

Mr. O'Neill added that a private provider offering substance use services would be either a Drug Medi-Cal provider, or an acceptor of private pay. The SAPT dollars that the county gets, however, enable the county to offer very low cost services to anyone who walks in the door. Going forward, it will be important to move to a managed care model in the substance use world; the counties will provide oversight to all private providers, resulting in one standard of care.

Ms. Adcock asked about counties opting not to do substance abuse; how does that work for the SAPT dollars? Dr. Baylor replied that it won't be affected: the waiver is focused on Drug Medi-Cal dollars and services only. Every county receives SAPT dollars.

Ms. Adcock clarified with Dr. Baylor that Drug Medi-Cal does not mean the pharmacy, but rather it means services paid for by Medi-Cal for people who suffer from substance abuse. Dr. Baylor added that it goes mostly to methadone with a small amount to perinatal.

Mr. Leoni asked about the Governor's Prevention Advisory Council (GPAC). Mr. Braeger responded that it is a collective effort of the 15 or so members at the table (who come mostly from state agencies) coordinating with the CHP, law enforcement, the UC system, CSUs, and so on. It is a membership-driven collective. It has been more of an information-sharing group than a working group. DHCS is looking to make some changes to the GPAC by expanding into the mental health realm.

7. Continued Overview of SAPT Block Grant and Follow-Up Questions and Discussion

Ms. Flores requested to let Ms. Lee know how much her video had meant to the Planning Council. Ms. Adcock said that she had emailed Ms. Lee to express those sentiments.

Ms. Derby asked if there were consumers and family members represented on the GPAC. Mr. Braeger did not think so, and said that during the meetings' Public Comment period

those voices could be heard. Ms. Derby recommended adding members of that status (consumers and family members) to the GPAC.

Mr. Wilson commented that he missed the presence of Ms. Lee and her dog.

Mr. Leoni commented that in substance use, many of the service providers are former users themselves. He asked if any with that background have gotten into the state bureaucracy. Mr. Braeger said that on the SUD side, there is a large provider influence; that is where people with that background come in. Dr. Baylor commented that on the mental health side, consumer and advocacy groups seem much more organized. On the SUD side, when DHCS was developing its waiver advisory group, it was difficult to find where to go for that kind of voice. She agreed that it is desperately needed on the table.

Chair Wilson asked if any M.D.s and educators serve on the GPAC. Mr. Braeger responded that the membership is large, and GPAC is on the DHCS website. Although it may change in the future, its purpose is meant to be primary prevention.

Mr. Grolnic-McClurg asked how an integrated Planning Council would help in improving the system. Mr. Braeger replied that DHCS is finding that there is duplication of services between the mental health and SUD sides. Integration can increase resources. Mr. Braeger stated that the bottom line is that the two sides seek to help the individual consumer – that is the one whom integration will help.

Mr. Grolnic-McClurg asked how integrating the Planning Council would help the system to be more efficient. Dr. Baylor responded that it gives you a stronger voice when you are representing both sides of the house. Joining forces in a collaborative partnership to fight stigma is far more powerful. In addition, DHCS wants to align the SUD side more with mental health; the Planning Council has expertise in what that looks like and SUD can learn from them. She did understand that the complexities of mental health would make it difficult to carve out time for a whole other host of issues.

Mr. O'Neill commented that in his county, as in Dr. Baylor's former county, the advisory boards have united. One reason is that substance use does not have strong advocacy – NAMI on the mental health side is much more powerful. In addition, whether consumers need AOD services or mental health services, sometimes they need crisis services. In Mr. O'Neill's county, with the integrated system, there is no wrong door.

Ms. Mitchell asked if the drug abuse side is interested in the integration. In regard to stigma, many alcohol and drug providers do not want to be associated with behavioral health – they feel that it stigmatizes their clients more.

Ms. Wilson commented that every county approaches substance use disorders in a unique way, depending on their SAPT monies, their county Mental Health Boards, and so on. Perhaps what we need to do as a whole is to get some common regulations, common approaches to clients, more effective regulations, a bigger voice, certification. However, the counties are so different currently that it is hard to manage.

Dr. Pitts asked about the percentage of private funds versus public dollars in the SUD market as a total market of care. Dr. Baylor replied that on the residential side, about

90% is private pay. Mental health services are different and hard to track; comparing the two sides is difficult.

Dr. Pitts continued that the Planning Council's mission has been more around the public side of mental health services. If the Planning Council were to integrate, its focus would be on the public side of SUD. Dr. Baylor noted that this is why the waiver is so important: we want to change the way services are delivered and make it more organized.

Ms. Prettyman asked how the composition of the Board might change with integration. Ms. Adcock stated that the Planning Council would make those decisions, and would make a recommendation to Dr. Baylor about structure, how it would be paid for, and timeline.

Mr. Leoni shared a story about an agency that had integrated, that revealed real stigma toward the mental health side on the part of the substance abuse side. This situation needs to be overcome.

Mr. Leoni pitched the possibility of having two councils as another state had done. The two could have overlapping memberships and perhaps an annual combined meeting. With the Planning Council's current workload, he could not envision cutting half the members and half the time.

Dr. Nelson pointed out that the CMHPC exists by legislative mandate at the state and federal levels. What would its re-envisioning do to affect the mandate? Ms. Adcock replied that the Planning Council could continue to operate and integrate, as long as it continues to perform the functions as mandated in state law. The prudent thing may be to amend state law. The biggest hurdle would be funding those activities; mental health dollars could not be used. Additional funding from substance use would be necessary.

Mr. Wilson commented that prevention is a great way to approach life, and he is completely behind it. He also felt that if the Planning Council stands together, they can make some changes for the people they care about. Combining as a unit can help to end differences as well as discrimination.

8. Report from Mental Health Services Oversight and Accountability Commission

Ms. Sherri Gauger, Interim Executive Director for the Mental Health Services Oversight and Accountability Commission (MHSOAC), gave the report.

- The new Chair, appointed by the Attorney General, is Dr. Victor Carrion. The new Vice-Chair is John Buck. They begin serving on January 1.
- The MHSOAC is beginning the process of recruiting new committee members; Ms. Gauger had brought application forms. Terms last for two years. The five committees are Client and Family Leadership, Cultural and Linguistic Competence, Financial Oversight, Evaluation, and Services Committee.

Ms. Gauger stated that the role of the committees is to advise the MHSOAC on policy issues and to accomplish assigned activities.

- The MHSOAC has almost completed the regulatory process for Prevention and Early Intervention (PEI) programs and Innovation programs. The Commissioners will be voting on the remaining provisions of the regulations, and hope to have the regulations in place by early spring.

Dr. Renee Bradley, Director of the Research and Evaluation Division, continued the report.

- The MHSOAC has completed the prioritization process for the new evaluation activities that will begin in July 2015. They are looking for evaluation advisors for a project focused on older adults and another on recovery orientation of programs.
- They are starting a joint task force with the CMHPC. It will focus on the priority indicators that speak to the performance of the mental health system. The task force will also review the trends report that UCLA contractors completed earlier this year.
- The MHSOAC is always very cautious when presenting reports based on currently available data that DHCS owns – there are many limitations with the data. Accordingly, the MHSOAC will soon enter into a contract for a Feasibility Study Report (a process that DHCS must go through when considering adopting a new IT infrastructure) – in this case, one that would provide the MHSOAC with a new statewide data collection and reporting system.
- Dr. Bradley will be sending a survey to CSI Committee members, seeking input to build a foundation for the community services and supports in adult systems of care.

Questions and Discussion

Ms. Prettyman commented that she is particularly fond of the MHSOAC's Client and Family Leadership Committee; one valuable activity is the community forums that they hold throughout the state's counties. She recommended participation in all of the MHSOAC committees.

Dr. Nelson stated that the CMHPC Advocacy Committee was recently asked to review the PEI regulations. He inquired about the definition of mental illness – specifically the section entitled *Dysfunction in Psychological, Biological, or Developmental Processes*. Mr. Leoni noted that in the modern world, there is often an intertwining of disorders. The committee was concerned that this definition, although adequate for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM5)*, might not work for MHSA funding.

Ms. Gauger stated that the elements of the regulations were quite comprehensive, and that staff, consulting psychologists, and the Chief Counsel were currently reviewing every comment received. She encouraged Mr. Leoni to submit his comment.

Mr. Wilson asked if any consumers were involved in the examination of the information. Ms. Prettyman stated that she herself was involved. Ms. Gauger stated that it has been a

very open process with a task force comprised of stakeholders, CMHPC members, individual providers, California Mental Health Directors Association (CMHDA) county representatives, and so on.

9. Executive Officer Report

Ms. Adcock reported the following.

- The CMHPC held three recent public forums in Merced (50 attendees), San Bernardino, (100 attendees), and Woodland (50 attendees). Issues and themes from the forums are posted on the website.
- Ms. Murphy has revamped the website. As it is imbedded in the DHCS website, Ms. Adcock recommended just Googling it to pull it up.
- All state department websites must be Americans with Disabilities Act (ADA)-compliant, so Planning Council agendas have a different structure now. The Data Notebook does not meet the requirements; we may not be able to post it and other documents. If members want to share a document, a link works out better than a direct post.
- Membership is open in the three Ad Hoc committees:
 - Behavioral Health (will meet for approximately one year)
 - Performance Outcomes and Measurement (will continue indefinitely)
 - Mental Health Master Plan (will end in January)

All meet on an as-needed basis.

10. Public Comment

Dr. Asaid, a family doctor from Imperial County, shared a story about a family with an errant son; instead of going to prison, he received probation, and he is now an immigration officer. Dr. Asaid suggested finding ways to consider the future of the younger generation.

Ms. Adcock requested volunteers for the Nominating Committee, as a new Chair-Elect needed to be elected. Ms. Hart described how the Nominating Committee works. Ms. Flores (Family Member), Mr. Wilson (Consumer), Ms. Mueller (Provider) Mr. Riel (State Agency), and Monica Wilson (Consumer-Related Advocate) volunteered.

11. Committee Reports

Continuous Systems Improvement (CSI) Committee

Ms. Wilson reported on the major areas.

- The committee heard a great presentation from Sacramento area school districts about AB 114. The number of youth in the special education system is tenfold the number they conjectured two years ago. Ms. Leonelli will be presenting a white paper in December.

- The committee and Dr. Bradley discussed the Planning Council’s interaction with the MHSOAC – evaluation efforts, projects, and so on.
- The committee has essentially completed its Work Plan – projects were Trauma-Informed Care, community forums, and the Data Notebook, which ended extremely well with excellent county response. The committee is now considering future projects; a topic under consideration is Residential Care.

Ms. Adcock commented that the committee had utilized data from APS (the External Quality Review Organization contractor). A new contractor is just starting and there may not be any data available by March and April 2015. Ms. Adcock has begun meeting regularly with Robert Oakes from the California Behavioral Health Directors Association – they have put together their own dashboard, called MOQA and could be a source of data for the next Data Notebook.

Mr. Leoni stated that per Dr. Baylor, the APS data will be going back up on the web. Also, at least three of the APS employees have been hired by the new contractor which may result in some continuity.

Ms. Dickerson stated that staff is going to write some summary reports on information in the Data Notebooks from this cycle. Posting the Data Notebooks on the web would be tremendously advantageous; however, the existing format is not compatible with the state’s ADA Guidelines. Ms. Dickerson hoped to find an alternate site for posting.

Ms. Dickerson stated that the new External Quality Review Organization (EQRO) contractor is Behavioral Health Concepts.

Health Care Integration (HCI) Committee

Chair Steven Grolnic-McClurg reported on issues the committee has been tracking.

- Insurance Expansion, particularly Medi-Cal.
- The integration of mental health care with primary health care and substance abuse care.
- The change to the face of the public mental health system – the new mandate for the health plans to provide mental health services to individuals with Medi-Cal, who have low to moderate mental health issues.
- The committee was given a presentation from Abbie Totten, Director of State Programs at California Association of Health Plans. She spoke about the health plan perspective on mental health issues – they have faced enormous challenges in trying to meet the new mandate. She also gave good information on building bridges and getting connected with the health plan.
- Mr. Leoni asked about the recovery orientation of services within these private health plans. Mr. Grolnic-McClurg responded that the committee is introducing the following themes to them:

- Recovery and wellness
- Robust consumer and family input
- Peer providers as an expansion of the workforce
- The cluster of issues tied to poverty that strongly influence an individual in terms of overall health

Mr. Wilson commented that good things take time, and that we can depend on one thing that never fails: change.

Ms. Lewis requested Mr. Grolnic-McClurg to address partnering and the hospital advisories. Mr. Grolnic-McClurg responded that Ms. Totten had suggested going to the public advisory meetings – it is an excellent place for advocacy for people with mental health issues. Another idea was to send a letter to all the mental health boards, addressing the MOU that they must have in place to explain how they will handle mental health plans. The counties could invite the head of the health plans as well as the mental health director to discuss the MOU – a first step in building relationships.

Mr. O’Neill commented that he hadn’t realized that one in three Californians now have Medi-Cal.

Ms. Prettyman noted that Ms. Totten had not known anything about the CMHPC, NAMI, or any of the mental health organizations. They don’t know what services are in place. Mr. Grolnic-McClurg added that feedback is a gift: the CMHPC needs to go out and begin to build bridges.

Chair Wilson asked about the health disparities portion of the conversation. Mr. Grolnic-McClurg said that it had been mentioned in terms of developing provider panels and workforce, but it wasn’t a major piece of the conversation.

Patients’ Rights (PR) Committee

Chair Daphne Shaw reported on the committee’s activities. She noted that the committee has very little time allocated for meetings: they meet at lunchtime on Wednesdays. They have also had monthly teleconferences.

- They reviewed the Patient Rights Survey. They are asking the mental health boards to have discussions, using the survey, about patient rights as an agenda item. The committee will send print versions and surveymonkey versions.
- They are working on a letter to the Behavioral Health Directors, reminding them about the committee’s work on patient rights. They have identified a concern that much of the advocates’ time is bound up in probable cause hearings; because of this, the rest of their responsibilities are not being addressed.
- Besides the issue of patient rights in relation to involuntary care, there is the issue of the grievance process for mental health plans. The committee has looked at data and found that many of the county mental health plans are not in compliance with the requirements, sometimes year after year.

- The committee is also looking at the state hospitals. About nine-tenths of the state hospital population is forensic now with just a small portion that is civilly committed. During the next year the committee will try to move into getting some answers about what is happening at the state hospitals.

Advocacy Committee

Chair Barbara Mitchell began the report.

- The committee heard a presentation from Sunshine Borelli, an aide to Senator Beall. She spoke about the timeline and submittal of legislative proposals. The committee is considering issues about moving forward the peer certification process. The committee will try to work with Office of Statewide Health Planning and Development (OSHPD) and the Health and Human Services Agency.

It is not a money issue at this point; it is a matter of getting an amendment to the Mental Health Plan to enable Medi-Cal billing for peer services.

- Chair-Elect Dr. Nelson reported that the committee had discussed the future work plan. The committee welcomes input from other Planning Council members regarding potential topics for the Committee’s action.
- The committee maintains a legislative platform consisting of mandatory planks and discretionary planks, which it is now in the process of updating. The points of view contained in the mandatory planks reflect the views of the Planning Council as a whole. The discretionary planks are more open to discussion before the committee decides on a position.
- Dr. Nelson referred to “Prevention and Early Intervention Regulations Proposed Changes to Sections …” produced by the MHSOAC. The document is currently open to Public Comment. Ms. Murphy explained differences in the document between its initial introduction and the present. The committee has identified a concern with the definition of mental illness.

Ms. Lewis commented that a requirement to participate in Peer Certification Training is that the client must have a GED; applicants must show proof. Ms. Lewis felt this is a heavy burden to put on a client.

Mr. Leoni made a personal plea to the Planning Council members: to remain at the meeting tomorrow morning for the discussion with OSHPD. A strong presence will give evidence of the Planning Council’s concern to continue efforts to implement Peer Certification in California.

12. Overview of Drug Medi-Cal and the Vision for the Future Including the Proposed Waiver

Dr. Baylor introduced Marlies Perez, Chief, SUD Compliance Division at DHCS. Ms. Perez explained the components of the waiver.

- When DHCS is seeking funds through the Centers for Medicare and Medicaid Services (CMS), it goes through a State Plan Amendment (SPA) process. A

waiver does something different – it can be a pilot – to demonstrate something that is not allowed in federal law, or to try something new.

- A year ago the SUD Compliance Division tried this process in the Drug Medi-Cal system. The waiver sets out to lift the current system up in many areas. Its title is the “Drug Medi-Cal Organized Delivery System Model.” The waiver is meant to facilitate more of a functioning system by organizing different pieces of the system and bringing them together.
- The waiver is an 1115 waiver. It is an amendment to the one started about five years ago (the “Bridge to Reform Waiver”). Its ultimate goal is to improve the quality and availability of services, as well as to provide more authority to the state and the counties who oversee the services. It is consumer-focused. Ms. Perez explained the goals of the waiver, then highlighted its main tenets.
 - Counties will choose to opt in.
 - Continuum of care – clients will need different levels:
 - Withdrawal management or detoxification services.
 - Residential services.
 - Intensive outpatient counseling.
 - Outpatient counseling (fewer hours of individual and group counseling).
 - Recovery services to prevent relapse.
 - Recovery residences (drug-free environments).
 - Case management will be at the county level.
 - Medication-assisted treatment.
- The waiver is built on the American Society of Addiction Medicine (ASAM) criteria.
- The waiver addresses the integration between primary care and substance use.
- Five evidence-based practices are listed in the waiver.
- The counties are enthusiastic about using the waiver for clients whose substance abuse has intersected with the criminal justice system.
- The waiver addresses gaps in the Drug Medi-Cal system.
- Tele-health can be effective for this population.
- The waiver broadens the scope of services to Licensed Practitioners of the Healing Arts (LPHA).
- The stakeholder process began in January.
- The Institution for Mental Disease (IMD) Exclusion includes substance use; out of the 800 residential facilities in California, only 10% would qualify to

provide beds. The waiver addresses the IMD Exclusion. (Mr. Leoni clarified the federal government's definition of an IMD.)

- The Office of Management and Budget (OMB) basically made the law for the IMD. They have approved CMS to allow a few states to pilot the IMD Exclusion, including California.
- A second draft of the Terms and Conditions will be posted on October 18. The SUD Compliance Division is working with the counties on financial provisions.
- Ms. Perez displayed a chart showing what is currently allowable in Drug Medi-Cal and what is being added in the waiver.

Questions and Discussion

Ms. Prettyman asked about detox. Ms. Perez answered that ASAM criteria calls it “withdrawal management.” It has four levels, and counties will be required to have at least one.

Mr. Wilson recommended that people struggling on any of the four levels have something to look forward to, no matter how many times they may relapse. Ms. Perez agreed and stated that relapse is a part of treatment; that is why they wanted to build in recovery services – people will have a place to go before they relapse.

Ms. Perez added that in the Terms and Conditions, they are working with SAMHSA as well as CMS to fund parts of the waiver, and also tying in systems that they already have.

Dr. Pitts asked about the use of LPHAs. Dr. Baylor stated that currently, physicians must sign off on treatment plans even for outpatients, which makes it difficult because of workforce shortages. DHCS wants to open that up the LPHAs, LCSWs, LMFTs, and so on. Dr. Pitts expressed concern that Occupational Therapists (OTs) are not included in lists of LPHAs. Dr. Baylor responded that currently, they are going with whatever Medi-Cal allows.

Mr. Leoni commented that in substance abuse as well as in mental health, people may develop a connection with a counselor on their treatment team. As clients gets better, they may have to move on to a different team – but team members and therapists are not interchangeable. Further, people may show up at certain programs where they have found a connection; moving them to different programs may be detrimental.

Ms. Perez responded that through Proposition 36 many collaborative efforts were built between the treatment side and the law enforcement side. Some of the tenets of the system, including case management, were shown to be very effective. With the waiver, counties will be allowed to contract selectively with providers. This will ensure that they can select providers that are doing evidence-based practices and using ASAM criteria – there is some accountability built in, minimizing disruption when clients must switch programs. Case managers will stay with the beneficiary and advocate for them.

Ms. Shaw mentioned the concern in the mental health community about any change that may occur in the IMDs, based upon the history of the huge 99-bed skilled nursing

facilities that existed and were funded by Medi-Cal before the IMD Exclusion. Will this morph into something that might affect mental health? Ms. Perez replied that at this point, it is only for substance use (and they are barely being allowed to test it in a few counties).

Dr. Baylor further explained that the State of California must have a contract with the federal government in order to implement Medi-Cal benefits. They are just dealing with one piece on the SUD side – that is the only door that’s open. The mental health side has a completely different waiver.

Ms. Mueller asked if the LPHA category would include Registered Nurses, Advanced Practice Registered Nurses, and/or Nurse Practitioners. Dr. Baylor replied that DHCS must follow current Medi-Cal regulations, which list Psychiatrists, Registered Nurses, LCSWs, LMFTs, and Licensed Psychologists as those who can diagnose and sign off on treatment plans.

In answer to a question from Ms. Prettyman, Ms. Perez stated that the age groups included in the waiver are ages 0-21 for EPSDT, and ages 18-65 for adult beneficiaries. Clients will be evaluated for the length of the waiver: 3-5 years.

13. Report from California Behavioral Health Directors Association

Mr. O’Neill reported on the following activities of the California Behavioral Health Directors Association (CBHDA).

- In the last six months the California Mental Health Directors Association (CMHDA) has merged with the California Alcohol and Other Drug Administrators. By the end of December the legal process should be finished. Approximately 54 of the 58 counties are integrated at the county level anyway. The process was lengthy, requiring a sensitive and open process. An integrated website will follow. The committee structure remains the same, with substance use providers functioning as chairs of committees or providers of input.
- The next Katie A. hearing is in court. The most important outcome is that when we use Medi-Cal to provide a service, there has to be a match: 50% from the federal government and 50% from some other source, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). For counties that spent more than their EPSDT allocation, the state made good – there was no penalty to provide adequate service to children.
- The CBHDA Governing Board will meet in November. They will look at two areas: organizational structure, and system and payment reform. The federal government is interested in looking at alternate payment structures. The CBHDA wants to devise a system rather than have the DHCS assign one. Any kind of a waiver that the state achieves must have a component that the federal government calls “cost neutrality.” The CBHDA feels that a payment change would be an attractive feature to the federal government.

- Some counties have expertise in the area of Measurements, Outcome, and Quality Assessments (MOQA). The CBHDA will give a presentation to the MHSOAC on its MOQA program, in terms of trying to achieve universal outcomes that truly make sense to the counties, advisory boards, and constituency.
- The SUD waiver has been a main activity. The CBHDA has held regular meetings with DHCS so that they can understand what it means in the counties. The CBHDA had pushed hard for the \$100,000 minimum-based allocation – there must be a way to pay for services in the rural counties.
- Four counties have volunteered to do financial modeling of the waiver: Butte, Fresno, San Mateo, and San Bernardino.
- The CBHDA has been weighing in heavily with the MHSOAC, encouraging them to keep regulation more general and promoting freedom within each county planning group to decide what is really needed (for example, distribution of PEI funds).

Ms. Shaw asked about terminology in the PEI regulations enabling PEI funds – that is, MHSOAC funds – to be used for developmental disabilities – that is, autism. Would this open up the possibility for people to have their mental health issues funded through MHSOAC rather than the regional centers? Mr. O’Neill responded that DHCS is now allowing a provision that children on the autistic spectrum can receive Medi-Cal treatment. He felt that the CBHDA position would be to let local planning commissions decide what they need in their counties.

Mr. Leoni asked whether that Medi-Cal use was from general Medi-Cal or mental health Medi-Cal. Mr. O’Neill referred to the 1915(b) waiver: children on the autistic spectrum were formerly not on that list.

Mr. Grolnic-McClurg restated that change in the ruling: EPSDT can now be billed for autism. The health plans are primarily responsible for providing that service, but it is now being recognized as a billable mental health condition in California.

Ms. Wilson added that many regional center clients who are not autistic, but have other developmental disabilities such as epilepsy and cerebral palsy, have also been receiving Medicaid monies – Medi-Cal pays for their mental health services.

Mr. Leoni expressed concern that this is opening up the 1915(b) waiver; you are beginning to treat a population through funding streams other than the waiver where they should be treated through Medi-Cal. Money is being diverted from this limited pool when there may in fact be other funding streams to match the cost.

Mr. O’Neill responded that there is no county that spent EPSDT money that was not reimbursed from the state General Fund. When the counties upload their claims, the state knows exactly how much they are claiming for children. If they exceed their allocation, the state makes good the amount.

Dr. Pitts commented that some of the concern around autism is that typical treatments – Applied Behavioral Therapy (ABA) and Occupational Therapy – are long-term. The costs are high.

Ms. Claflin pointed out that many autistic diagnoses combine with mental health diagnoses. Before, the children were falling through the cracks: neither regional centers nor mental health would serve them. With this change, the children are going to receive the services they deserve.

Mr. Wilson thought it might be helpful to do an indicator on the area of autism and severity of the cases.

Mr. O’Neill stated that no matter the condition of the child or adult – bi-polar disorder, schizophrenia, or autism – in the triannual review, all the counties will be held responsible to demonstrate that the child is making progress toward the treatment goals. Services can be provided indefinitely if progress is happening. If not, the auditors will step in.

Mr. Grolnic-McClurg suggested having people who are well-versed on the new guidances to come and speak to the Planning Council.

Ms. Prettyman expressed concern about additional behavioral issues that could also be incorporated this way such as cerebral palsy. The regional centers no longer have their pot of money; is it because of the Affordable Care Act (ACA)?

Dr. Pitts stated that children with autism are also served through Individualized Education Programs (IEPs) – there are multiple funding streams because of the different needs.

Mr. Leoni agreed with the suggestion to have experts come and speak to the Planning Council.

14. Council Member Open Discussion

Ms. Lewis stated that with Senator Steinberg’s upcoming retirement, his staff is putting together a “memory book.” She suggested that the Planning Council include something for the history.

Ms. Shaw suggested that the Planning Council weigh in on the desired qualities and background for the new DHCS Director.

Chair Wilson raised the topic of the Planning Council meeting structure. She asked if the new structure, voted in at the last meeting, could be implemented the January meeting.

Ms. Adcock said she would check with Ms. Jones, and reviewed the new structure. Members of California Association of Local Mental Health Boards (CALMHB) had been present during the last meeting’s discussion. They usually attend on Friday mornings, and the Planning Council would still be meeting at that time.

Ms. Wilson noted that many CALMHB members had shown enthusiasm about attending Planning Council committee meetings.

Ms. Adcock directed the members to proposed definitions of *mental illness*, *serious mental illness*, and *severe mental illness* in the Proposed Prevention and Early

Intervention Regulations, Article 7. The definitions will be used as they relate to the counties' usage of PEI funding. The Advocacy Committee had already discussed the definitions; Ms. Adcock sought to bring the definitions to the Planning Council in its entirety.

Ms. Mitchell reported that the committee never came to a settled conclusion. They intended to send a letter expressing concern, but not rewriting the definitions. Ms. Adcock noted that a general letter does not require the entity to take action to revisit or consider a change.

Dr. Nelson commented that the definition of *mental illness* under Section 3703 is lifted verbatim from the current 5th Edition of the *Diagnostic and Statistic Manual of Mental Conditions (DSM5)*. He explained the Advocacy Committee's concern with the portion of the definition referring to developmental processes. In California we continue to maintain two separate funding silos for delivery of services for mental illness and developmental disability. A regional center client without specific mental health needs may become eligible for PEI programs by virtue of this definition.

He continued that the Advocacy Committee is recommending inclusion of additional language somewhere in the regulations that specifically requires that these PEI programs are only for those with mental illness; this would not necessarily include those with developmental disabilities only. The committee wants their concerns to be made known to the MHSOAC, the organization currently taking public comment.

Mr. Leoni expressed concern with the words "biological" and "developmental." If Medi-Cal is including autism and counties pay for it, one cannot say that autism cannot be treated with MHSA. His interest was protecting the MHSA; he did not want to see MHSA monies drained unnecessarily.

Dr. Nelson clarified how the DSM5 and the psychiatric community looks upon medical (not psychiatric) conditions such as autism and dementia.

Ms. Flores expressed concern with the word "or" in the definition: *...or developmental processes*. This seems to make it a separate category.

Dr. Nelson agreed and noted that the definition is broad rather than precise – mental illness is a broad area of concern. Although autism is not necessarily a mental illness in itself, left untreated, it can lead to behavioral and emotional problems that can constitute a complicating mental illness.

He continued that the burgeoning literature on problematic attachments of childhood explain the difficulties it can lead to later in life, in terms of normal, healthy mental and emotional development. PEI programs could make a significant impact in those lives.

Ms. Derby stated that she was not comfortable excluding people because they also happen to have autism along with a mental illness.

Ms. Mitchell expressed concern regarding changes to Regulation 3706(b) and the impact on peer-led programs. She also noted that limiting 51% of PEI funding to ages 25 and under will have a dramatic impact on Prevention and Early Intervention Programs (PREP).

Mr. Leoni addressed Ms. Derby's comment: nothing in the regulations states that those with autism will be excluded, if they have other mental health conditions.

The Planning Council discussed what future action to take. Mr. Grolnic-McClurg expressed concern with the Planning Council taking a position because they lack full understanding of the intentions and implications of the writing. He agreed with Mr. O'Neill: the world is changing; the services that need to be delivered are changing. Decisions are now made on the local level – which has its pluses and minuses.

Mr. Grolnic-McClurg continued that it is not the Planning Council's role to disagree with an individual county's PEI priorities. Any language that is lifted from DSM5 is pretty well-vetted and accepted. The Planning Council should be advocating for strong local processes to prevent diversion of MHSA funds.

Dr. Nelson commented on the current health care culture throughout the state: there is a well-defined group of individuals seeking care in California who have developmental disorders as well as mental illnesses, who are not able to get services anywhere. He described the experiences of such an individual. He doubted that if these regulations are put into effect, individuals who have been denied health care services will suddenly be able to have access to them. People who provide MHSA services will continue to be very careful to select individuals who specifically have mental health needs.

15. Public Comment

Robbie Powelson of the Marin County CALMHB commented on the systemic problem with PEIs, particularly regarding TAYs and minors: with many programs there is no almost consumer input. Some kind of regulation should ensure that people are listening to the youth who access the services.

Dr. Said affirmed Ms. Dickerson's idea for the next meeting that everyone should be brought to the table to solve problems – this would benefit both the Planning Council and the counties.

Cary Martin, of the San Joaquin County Mental Health Board and CALMHB, expressed concern about Proposition 63: changes to it should only come from the people. Mr. O'Neill explained that while that was true, regulation can be generated by the state.

Mr. Martin pointed out a problem on the world stage: the President had called upon the National Guard to support our national interest in fighting Ebola. Mr. Martin asked the Planning council members to consider whether they believe the National Guard should receive the standard hazard consideration.

16. New Business

There was no new business.

17. RECESS

Chair Wilson adjourned the meeting at 4:50 p.m.

Friday, October 17, 2014

1. Welcome and Introductions

Chair Wilson greeted everyone attending the Friday morning session. Members of the Planning Council and audience introduced themselves.

2. Opening Remarks

Uma Zykofsky, Director of Sacramento County Behavioral Health Services, spoke about how Sacramento County manages the substance use and mental health systems.

- There are two separate boards for mental health and substance use. While there have been trends, funding levels, waivers, and so on to bring the two systems together, there are still many differences in the advocacy, commitment, and perspective from both sides.
- The two sides combined under one division in 2009. Ms. Zykofsky stated the mission and values for the division.
- The division has expanded all cultural competence activities from the mental health side to the alcohol and drug side.
- The county embraces the idea of bringing equal access to all populations.
- There are differences among the two sides in their prevention activities, definition of treatment, and levels of treatment.
- The drug and alcohol side centers around the many partnerships such as Child Welfare. The mental health side has much more of an identity of its own as part of the service delivery system and the MHSA.
- Funding for Alcohol and Drug Services is about \$31 million, which includes the SAPT block grant.
- Mental Health Services has a continuum: PEI activities, specialty mental health programs, crisis intervention/stabilization programs, and more long-term acute and sub-acute services with hospitalization.
- Funding for Mental Health Services is about \$221 million. There is a large MHSA component which has been very valuable for building programs. Much of the MHSA service dollars are also used to draw down federal dollars locally.
- The county has worked with the ACA Managed Care Plans to find where they intersect with mental health, in order to provide greater access to services for consumers.
- Ms. Zykofsky felt that we are in a time period where partnerships with the two systems are going to work together on the ground level. The partnerships include Corrections, Probation, Public Health, and Primary Health; and on the alcohol and drug side, Child Welfare and Human Assistance.

- The service delivery systems are touching each other constantly, while the funding is not quite there yet.
- Ms. Zykofsky displayed a list of agencies the county contracts with.
- Some of the evidence-based practices being utilized by both sides are motivational interviewing, cognitive behavioral therapy, and seeking safety.
- Some of the programs providing co-occurring services are CalWorks, the federally qualified health centers, the full-service partnerships, and the outpatient adult mental health system in Sacramento.
- Ms. Zykofsky felt that new collaborations will be the path of the future: Corrections and AB 109 legislation, adult day reporting centers (for both mental health, and alcohol and drug), and two new programs in Sacramento County as follows.
 - Navigators trained in screening for both sides, located in the ERs, Loaves and Fishes for the homeless, and the jail.
 - Two mobile teams on the ground that will have service integration between the two sides.
- Ms. Zykofsky listed the challenges.
 - Emergency inpatient care on the substance and drug abuse side is very limited.
 - Funding and treatment for both sides is not sufficiently flexible to meet client need.
 - Demand frequently exceeds capacity at every point.

Questions and Discussion

Dr. Pitts asked about Psychiatric Skilled Nursing Facilities and the companies that are providing them. Ms. Zykofsky responded that there are few of these facilities; she will get some information to Dr. Pitts.

Mr. Leoni applauded Ms. Zykofsky for listing Jail Psych on the services continuum.

Mr. Wilson appreciated the well-presented information in the folder.

3. Report from the California Association of Local Mental Health Boards/Commissions

Dr. Larry Gasco, CALMHB President, presented the report on that organization's activities.

- During the past quarter CALMHB held elections.
- Dr. Gasco felt optimistic about the CALMHB program. Its members are enthusiastic with lots of energy and thought. CALMHB has plans to expand both its revenue and its human resources.

- Dr. Gasco thanked Ms. Adcock for organizing the first meeting between DHCS and CALMHB.
- Dr. Gasco offered CALMHB’s assistance to the Planning Council with its initiatives.

Ms. Lewis contrasted the informal way CALMHB does its audits with the way the Planning Council and the MHSOAC do their audits. She asked the Planning Council members to think about that stark difference. The CALMHB members are the ones who are actually doing the footwork, signing off on the MHSA plans – yet they don’t have the resources to get their job done.

At that point, Chair Wilson offered the Planning Council members some time for open discussion.

Ms. Mitchell expressed concern about an aspect of the PEI draft regulations: the new requirement to spend 51% of the funding on the 0-25 age group. She felt that this would be terribly restrictive.

Mr. O’Neill noted that the CBHDA did send a formal letter to the MHSOAC stating that they did not support this change in regulation. The local planning boards from each county should be able to make the decision on how to spend the money.

Mr. Leoni commented that the rationale for the regulation was to get the most “bang for the buck” on the younger age ranges. He was not sure about setting a solid figure of 51%, but did agree with the rationale of ensuring that a substantial amount of money goes to that age bracket.

Ms. Derby felt that this huge amount created a disparity for people of all ages who might need services. Prevention should occur across the lifespan.

Ms. Hart was torn – the money should be spent where its impact would be greatest; however in the past, sometimes children and youth have been given short shrift. She felt that this was an effort to put the money on the front end before they “go over the falls.”

Ms. Treadwell stated that the Department of Social Services had commented and supported the change – children are flying under the radar, and research has established that early intervention makes a difference. Prevention can keep many children out of the social services system.

Mr. Leoni noted that another provision of the MHSA is that the PEI component be at least 20%. The hope was that if you can catch enough people before they “go over the falls,” you can reduce the demand for social services.

Ms. Wilson expressed the hope that the regulation would urge local counties to develop more resources for children. We want to have a variety of resources that meet the variety of needs that youth have – and prevention is the key.

Ms. Mitchell commented that there does not seem to be support for Planning Council action. She also noted that in her county, there are far more resources for kids age 18-25 who do not have a diagnosis of a serious mental illness, but have an anxiety disorder or

depression, than for adults. After age 25 they are not entitled to any resources in the adult system.

Mr. Leoni responded that the disparity in resources for services between adults and children is not affected by this; this is prevention and early intervention only.

Ms. Adcock said that at the last MHSOAC meeting, the room was filled beyond capacity with advocates for children. The public comments all centered around the exemption for small counties to comply with the requirement to use the 51% of PEI funds on individuals age 0-25 years – people thought it was unnecessary and would let small counties off the hook. They pushed for having counties provide rationales for exemption.

4. Overview of Substance Abuse Services Compliance and Licensing

Ms. Perez returned to present on her division's function in licensing and certification in California facilities.

- The SUD Compliance Division is responsible for compliance with federal and state statutes, federal and state regulations, and other governing requirements. They oversee the main licensing and certification functions, including monitoring and complaints.
- It is for Driving Under the Influence programs, narcotic treatment programs, and outpatient and residential providers.
- The division also works with criminal justice treatment programs and counselor certification.
- There are three categories of licensing:
 - Adult residential facilities (approximately 800 in number). Certification is voluntary.
 - DUI programs. All are outpatient and fee-driven.
 - Narcotic treatment programs (NTPs). Most prescribe primarily methadone, with buprenorphine used increasingly for some programs. The facilities are highly regulated.
- DUI funding is easiest, being client-driven. The NTPs are funded primarily through Drug Medi-Cal. The residential facilities can be medical insurance only or private pay only.
- The SUD Compliance Division is responsible for the entire system regardless of how the money is coming in. The division's primary role, function, and duty is to ensure the health and safety of the clients in the facility.
- Ms. Perez reviewed the steps for opening a new facility.
- Facilities are monitored every two years. NTPs are monitored every year.
- All facilities pay application fees and annual fees. The division is funded primarily through the fee structure.

- The division works with facilities to remedy deficiencies.
- The division includes a Complaint section.
- On occasion the division will revoke a facility's license. The provider then has the option to go through an appeals process.
- Ms. Perez supplied general facts:
 - Licensing is mandatory; certification is voluntary.
 - Providers pay fines and fees.
 - The division is governed by statute and regulations.
 - Ms. Perez chairs three advisory groups: DUI, NTP, and Counselor Certification.
- The division also has a Public Record Act Request Unit.

Questions and Discussion

Mr. Leoni asked about the funding stream for counselor certification. Ms. Perez responded that counselors have to pay fees to the certifying organizations for education and tests, as well as annual fees. The division oversees the certifying organizations. The Institute for Credentialing Excellence (ICE) – formerly the National Organization for Competency Assurance (NOCA) – carries the accreditation responsibilities through the National Commission for Certifying Agencies (NCCA).

Ms. Treadwell asked whether the division maintains a list of facilities that are suspended or terminated; Ms. Perez affirmed that they did. A list of counselors with suspended or revoked certification is maintained as well. She also stated that the division investigates unlicensed facilities; extensive complaints are received about them.

Ms. Perez continued that Sober Living environments are drug-free housing with no treatment services. No one oversees or regulates them. When Sober Living environments are acting as licensed facilities, the division must investigate them.

Ms. Wilson asked about the applications left outstanding when the Department of Mental Health was folded into DHCS. Ms. Perez stated that her division does not do Medi-Cal certification; all providers go through the Provider Enrollment Division at DHCS, which is working on the backlog.

Ms. Mueller inquired about counselor certification: how are the programs interfaced with people who want to enroll? In addition, how is cultural competence threaded into the program? Ms. Perez replied that counselors learn best about which Certifying Organizations (Cos) are available by going through recovery themselves. The four certification programs have slightly different focuses – for example, the California Association of DUI Treatment Programs (CADTP) has a DUI focus.

Ms. Perez continued that cultural competency is included in the counselor certification requirements. She felt that this area is definitely an issue to be examined.

In answer to a question from Ms. Flores, Ms. Perez said that the four certification programs are American Academy, CCAP, CADI, and CADTP.

Mr. O'Neill asked whether there are restrictions on the number of people in Sober Living residences. Ms. Perez replied that there are no state restrictions on them, but some counties and cities have local ordinances restricting the number of people. The SUD Compliance Division has no authority over them.

Ms. Mitchell commented on the lack of criminal record screening and fingerprinting for counselors at drug and alcohol facilities versus the mental health facilities, where the Department of Social Services Community Care Licensing must be involved in every aspect. Ms. Perez stated that there is no connection with Social Services on the SUD side of the house. SUD has looked into instituting fingerprinting and background checks, but cannot do it without statutory authority. Many counselors do have criminal backgrounds – at what point is the offense too large for someone to counsel? This seems to be the stumbling block.

Mr. Leoni asked about dual diagnosis programs – who decides on licensing and certification among these two very different systems? Ms. Perez replied that both systems are now under the same umbrella: Mental Health and Substance Use Disorders at DHCS. They are looking hard at the state level on how to integrate some of those functions to make it easier for the providers. At this point, dual diagnosis facilities have both licenses.

5. Status on Implementation of the Workforce Education and Training 5-Year Plan

Lupe Alonzo-Diaz, Deputy Director of the Healthcare Workforce Development Division at OSHPD, gave an update on the implementation of the Workforce Education and Training (WET) 5-Year Plan.

- The Planning Council is responsible for the review and approval of the 5-Year Plan and budget.
- The 5-Year Plan has a four-year fiscal budget that started on July 1, 2014.
- The Needs Assessment is completed and available online.
- The majority of WET funding is tied and distributed back to communities with respect to RFAs and RFPs. Ms. Alonzo-Diaz listed those already awarded, those released, and those in development.
- There is an Advisory Committee with a number of subcommittees; one of the areas of importance is accountability and transparency.
- Brent Houser, WET team member, spoke about implementation efforts.
 - **Stipend programs.** OSHPD contracts with educational institutions to provide stipends for graduate students who plan to work in the Public Mental Health System (PMHS). In exchange, the students agree to perform supervised hours and work for 12 months in the community PMHS.

Mr. Houser provided data for the 369 stipend award winners for FY 2013-14, and showed projected information for FY 2014-15.

- **Mental Health Loan Assumption Program.** It provides loan repayment for up to \$10,000 for professionals working in the PMHS for up to 12 months. In FY 2013-14, 1,300 professionals were awarded the loan repayments.
 - **Education Capacity.** OSHPD contracts with Psychiatric Residency and Psychiatric Mental Health Nurse Practitioner programs to fund residency and training.
 - **Regional Partnerships.** They promote building and improving local WET resources.
 - **Consumer and Family Member Employment.** Mr. Houser explained the potential RFAs.
 - **Recruitment and Retention.** A focus of the 5-Year Plan. The RFAs are under development.
 - **Evaluation.** OSHPD plans on conducting evaluation of current WET needs, as well as implementation efforts.
 - **Peer Personnel Support.** A peer personnel PMHS training program funded through SB 82.
- Stakeholders gave consistent feedback regarding the regulations. The regulations give an opportunity to evaluate the operations aspect of the division's work. In the upcoming months, the division will evaluate and review the regulations, then engage the stakeholders and DHCS (the "parents" of the MHSA).

Questions and Discussion

Ms. Mueller asked about the sequencing of training in order to keep up with the capacity needs for healthcare personnel. Ms. Alonzo-Diaz referred to the training category funding amounts named in the presentation. As the division goes through the stakeholder engagement process, they can make changes to category funding.

Ms. Murphy asked about an email list for the regulations. Ms. Alonzo-Diaz obliged with descriptions of the two listservs.

Mr. O'Neill commented on how valuable the Mental Health Loan Assumption Program was to the Trinity County staff.

Mr. Leoni ascertained with Ms. Alonzo-Diaz that the RFAs and RFPs are listed on the website. He then stated his interest in hearing feedback about the involvement of clients and family members in the training, both directly and in terms of their perspectives and values. There is a specific requirement in the MHSA for that piece. Ms. Alonzo-Diaz responded that in some cases that information is reflected in the RFPs, where appropriate.

Mr. Leoni asked about any possibility of peer certification moving forward. Ms. Alonzo-Diaz responded that the administration has not taken a position on peer certification; the statute is not clear on that subject. However, it is clear on the intention to utilize consumers and family members within the public mental health workforce.

She continued that the Consumer and Family Advisory Committee provides feedback and guidance on using and resourcing the \$10 million. There was consensus on three buckets:

- Technical assistance for employers of the PMHS.
- Education and training. As with technical assistance, training is still an important component for increasing the numbers of consumers and family members working within the public mental health workforce, regardless of the timeframe for peer certification and when it might occur.
- Building blocks. These are the activities that can be done today to support the consumer and family infrastructure. Data, analysis, and the Needs Assessment all support this goal.

Ms. Mitchell questioned whether legislation is needed mandating a movement to peer certification in order to have OSHPD fund specific activities. Ms. Alonzo-Diaz answered that she could not provide advice on legislative advocacy; she could present the OSHPD WET 5-Year Plan interpretation on its statutory authority.

Ms. Mitchell asked if Ms. Alonzo-Diaz had a citation stating that WET funding could only be used for an activity that is already mandated specifically in a state code. Ms. Alonzo-Diaz responded that they derive their understanding of the work they can do from statutory references to increasing consumer and family member employment.

Mr. Wilson paraphrased that the building blocks are going to be a starting point for people to understand the processes involved – professionals and non-professionals getting together and understanding their functions in order to build on them.

6. Public Comment

Dave Speicher, a consumer and peer mentor from Santa Clara County, commented that this county has successfully implemented a peer mentor program with both part-time and full-time employees. He felt that legislating the peer mentor function would be a disservice.

7. New Business

For the last meeting at which she would preside, Chair Wilson shared a quote:

“Challenges are what make life interesting; overcoming them is what makes life meaningful.” – Joshua Murray

She stated that it had been an honor and a delight to serve the Planning Council during her term.

8. ADJOURN

Chair Wilson adjourned the meeting at 11:43 a.m.

X INFORMATION

TAB SECTION A

ACTION REQUIRED

DATE OF MEETING 1/14/15

MATERIAL
PREPARED BY: Tracy Thompson

DATE MATERIAL
PREPARED 12/19/14

AGENDA ITEM:	Presentation: Health Care Integration (Family Member Panel Invited)
ENCLOSURES:	
OTHER MATERIAL RELATED TO ITEM:	

ISSUE:

The Health Care Integration Committee has been focused on issues around health care integration within California and on issues around Parity. The committee has heard presentations from the Department of Managed Health Care, the California Association of Health Plans, and Mental Health Advocacy Services, Inc. The committee has invited a panel of family members that will provide some background on their experiences with health care integration and parity within San Diego County.

X INFORMATION

TAB SECTION B

ACTION REQUIRED

DATE OF MEETING 1/14/15

MATERIAL
PREPARED BY: Tracy Thompson

DATE MATERIAL
PREPARED 12/19/14

AGENDA ITEM:	Presentation: Health Care Integration San Diego Community Health Group
ENCLOSURES:	Medi-Cal Behavioral Health Quick Guide
OTHER MATERIAL RELATED TO ITEM:	

ISSUE:

Community Health Group is a nonprofit health plan operating in San Diego County that has been providing health care services to San Diego County's growing and diverse population since 1982 and currently serving over 235,000 members. Plan members have a wide network of healthcare practitioners, hospitals and ancillary providers from which to choose.

George Scolari, Behavioral Health Program Manager, Community Health Group, will provide a presentation on his work with the Health Plans and how members are being supported during the integration of primary care and mental health



Medi-Cal Behavioral Health Quick Guide

Health Plan	Medi-Cal Specialty Mental Health Services ¹	Medi-Cal Managed Care Plan Behavioral Health Services ²
Care1st Health Plan Care1st.com	San Diego Access & Crisis Line (888) 724-7240	Care1st Health Plan (855) 321-2211
Community Health Group Chgsd.com	San Diego Access & Crisis Line (888) 724-7240	Behavioral Health Services (800) 404-3332
Health Net HealthNet.com	San Diego Access & Crisis Line (888) 724-7240	Managed Health Network (MHN) (888) 426-0030
Kaiser Permanente KP.org	San Diego Access & Crisis Line (888) 724-7240	Kaiser Permanente, Department of Psychiatry (877) 496-0450
Molina Healthcare MolinaHealthcare.com	San Diego Access & Crisis Line (888) 724-7240	Molina Healthcare (888) 665-4621

(*Medi-Cal beneficiaries can access a County Behavioral Health program directly.)

(*For emergencies call 911 or the Access & Crisis Line at (888) 724-7240)

Medi-Cal Specialty Mental Health Services¹

County Behavioral Health Services covers inpatient and outpatient **Medi-Cal Specialty Mental Health** services to all Medi-Cal beneficiaries including those on a Medi-Cal Managed Care Plan. Covered benefits are for clients with serious and persistent psychiatric illness requiring complex biopsychosocial services in order to maintain stability. These services are commonly provided by San Diego County's contracted network and inpatient psychiatric hospitals.

Substance Use Treatment

Medi-Cal beneficiaries can receive substance abuse services through the County Behavioral Health Services' Alcohol and Drug Program. These programs can be accessed by calling the Access & Crisis Line. Medi-Cal beneficiaries in need of Acute Medical Detoxification are covered by their Medi-Cal Managed Care Plan. Acute Medical detoxification means treatment in an acute medical facility for a serious medical condition relating to substance withdrawal.

Medi-Cal Managed Care Plan Behavioral Health Services²

Medi-Cal Managed Care Plans cover behavioral health services for members who do not qualify for **Specialty Mental Health** covered by the County. Each Medi-Cal Managed Care Plan has their own network of contracted behavioral health providers.

Consumer Center for Health Education & Advocacy

The Consumer Center for Health Education & Advocacy helps beneficiaries understand how to use physical and behavioral health services. If there is a problem getting necessary care through a managed care plan, members and providers should first contact the plan's customer service department. In most cases, the health plan will resolve the issue. Occasionally, a plan member may feel his/her needs are not being met and may need a third party to help break down a barrier. The Consumer Center works closely with the health plans to figure out where the barrier is and how to resolve the problem. The Consumer Center for Health Education & Advocacy number is: (877) 734-3258.

**San Diego County
 Medi-Cal Mental Health Severity Screening**



***For new clients who are accessing services; not individuals already connected with a provider**

Service Provider	Indicators
<p>Specialty Mental Health Services Provided by the County Mental Health Plan</p> <ul style="list-style-type: none"> Contact the San Diego County Access & Crisis Line at (888) 724-7240 A member may access a County Behavioral Health Program directly For an emergency, call 911 	<p>If any of the following indicators of serious impairment/disturbance in mood, behavior, and/or psychosocial functioning are met, the member may be referred for Specialty Mental Health Services through the County.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Acute risk of harm to self or others <input type="checkbox"/> Psychotic symptoms (delusions, hallucinations, paranoia) <input type="checkbox"/> Marked cognitive impairment (confusion, disordered thinking, poor concentration) <input type="checkbox"/> Impulsive, reckless, aggressive behavior with marked decline in self-control <input type="checkbox"/> Serious incapacitation or unable to perform key roles and/or usual daily activities, such as work, school, household tasks, or self-care <input type="checkbox"/> Repeated psychiatric hospitalizations <input type="checkbox"/> History of a serious suicide attempt or injury to others <input type="checkbox"/> Appears to need on-going case management or therapy <input type="checkbox"/> On LPS Conservatorship <input type="checkbox"/> Symptoms of chronic mental health condition(s) are significantly exacerbated by new life stressors or circumstances
<p>Behavioral Health Services Provided by the Medi-Cal Managed Care Health Plan*</p> <ul style="list-style-type: none"> Contact the appropriate Health Plan below 	<p>If any of the following indicators of mild to moderate impairment/disturbance in mood, behavior, and/or psychosocial functioning are met, the member may be referred to their Medi-Cal Managed Care Health Plan</p> <ul style="list-style-type: none"> <input type="checkbox"/> In need of behavioral health treatment due to a situational issue such as loss, break up, major life changes <input type="checkbox"/> Isolation or substantial disruption in relationships with family, friends, or other social supports, resulting in extreme distress <input type="checkbox"/> Excessive truancy or suddenly failing school <input type="checkbox"/> Symptoms are likely to be resolved in 6 months or less with psychotherapy <input type="checkbox"/> Member has been stable on psychotropic medications for 1 year or longer and requires medication management only

<p>Care1st Health Plan (855) 321-2211 Care1st.com</p> 	<p>Community Health Group (800) 404-3332 Chgsd.com</p> 	<p>Health Net (MHN) (888) 426-0030 Healthnet.com</p> 	<p>Kaiser Permanente (877) 496-0450 KP.org</p> 	<p>Molina Healthcare (888) 665-4621 MolinaHealthcare.com</p> 
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_____ INFORMATION

TAB SECTION C

X ACTION REQUIRED

DATE OF MEETING 1/15/15

MATERIAL
PREPARED BY: Adcock

DATE MATERIAL
PREPARED 12/18/14

AGENDA ITEM:	Overview of Options and Selection of Option for Mental Health Master Plan
ENCLOSURES:	Powerpoint
OTHER MATERIAL RELATED TO ITEM:	

ISSUE: At the June 2014 Council meeting, the members discussed hiring a consultant to explore options for updating/rewriting/adding to the 2003 Mental Health Master Plan. The consultant would also create a timeline and estimated cost for the various options. This information helps to inform members about the feasibility and resource commitment for each option for the Council to review and select.

Consultant, Cynthia Burt, has been working with a small ad hoc group of Council members over the last several months to identify the audience, purpose and scope of the future document. She will review the options for consideration and participate in the Council discussion. It is expected that a choice will be made by the members which will then lead to a competitive bid solicitation for a contractor to complete the work of the option selected.

California **Mental Health** **Planning Council**

Options for Revising **Master Plan**

A Presentation by: **Cynthia H. Burt**

2014 v4.0
General Session

January 2015, San Diego

51 of 86

Special Thanks To....

- A special acknowledgement to those who contributed to this presentation and who provided in-depth knowledge of the etiology of the current Master Plan.
- My sincerest thanks.

Jo Black

Barbara Mitchell

Darlene Prettyman

Daphne Shaw

Special Thanks To....

- A special acknowledgement to those who contributed to this presentation and who provided in-depth knowledge of the etiology of the current Master Plan.
- My sincerest thanks.

Jane Adcock

California Mental
Health Planning
Council members
and staff

HOW WE GOT HERE

1

- Last Master Plan update 2003, what should the Council do?

2

- Contractor hired to develop options.

3

- Contractor worked with *ad hoc* committee comprised of council members.

4

- Three versions of options reviewed, debated, eliminated

Home Menu

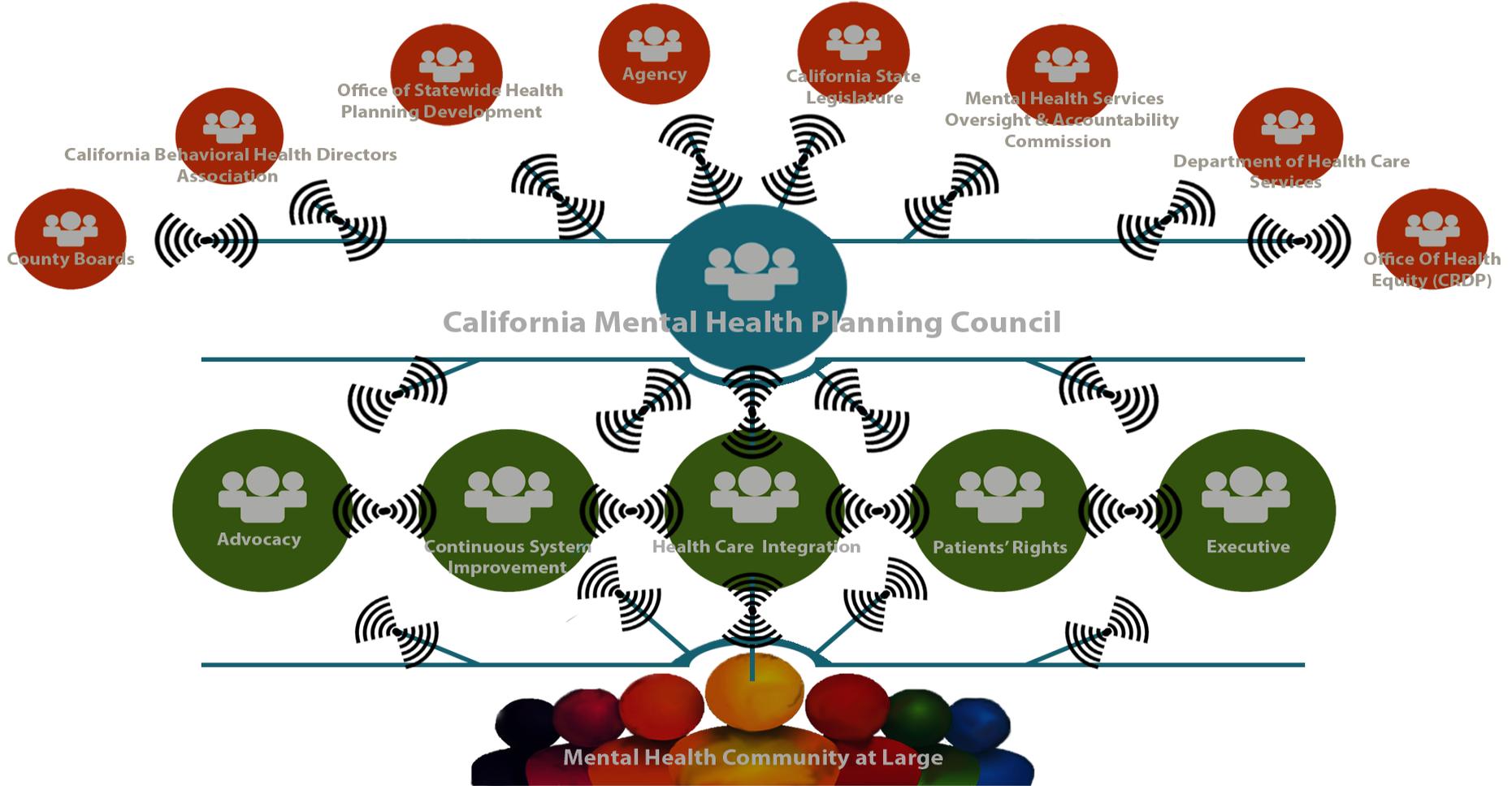
- This “Menu” is intended to help you navigate through the presentation and make it easier for you to get right to the facts that you want to know.
- This menu page also allows you to utilize, and distribute parts of this entire presentation for future CMHPC purposes (e.g. community, educational forums.)
- This page of the presentation also demonstrates the total scope of “Mental Health Master Plan Options” and leads into discussions regarding
 - What are the salient features of a plan
 - What are the costs of a given plan
 - What are the resources required to complete a plan
 - What would be the indication that a particular option would be more successful over another options
- Please Enjoy!

CMHPC Title Page

Presentation

View Relational Diagram

View Eliminated Options



CALIFORNIA MENTAL HEALTH PLANNING COUNCIL OPTIONS FOR REVISING MASTER PLAN (TABLE OF CONTENTS)



Do Nothing (no slide)



Extract Recommendations (slides 12, 13)

- Explanation
- Methodology
- Resources
- Cost
- Success

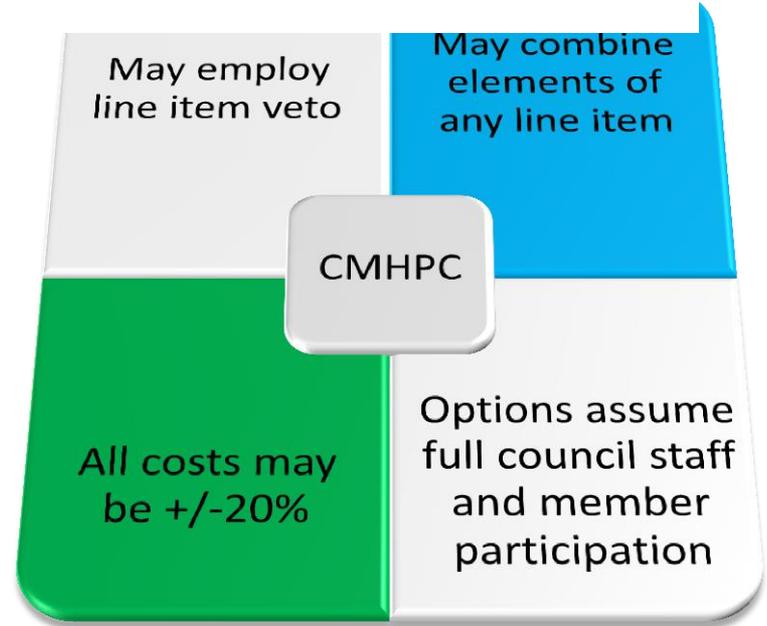
PRESENTATION

Options for Revising **Master Plan**

CMHPC 2014

ASSUMPTIONS

- Only Option “Amend Existing Master Plan” will include Prologue, Table of Contents, Executive Summary, Update Background/History, Extract Recommendations, Unmet Needs and Horizon Issues.
- W1 @ \$15.00 per hour. Good clerical skills. (similar to Office Technician)
- W2 @ \$30.00 per hour. Good analytical skills. (similar to Associate Governmental Program Analyst)
- W3 @ \$125.00 per hour. Project lead, ability to work with diverse situations and constituencies.



ESTIMATED TOTAL COST, BY OPTION

- DO NOTHING
 - \$0
- EXTRACT RECOMMENDATIONS
 - \$13,000
- UPDATE UN-MET NEEDS
 - \$19,000
- AMEND EXISTING PLAN
 - \$132,000

EXTRACT RECOMMENDATIONS

EXPLANATION

- 8 Chapters, over 180 recommendations in 2003 document.
- Status of these recommendations unknown.
- Report of findings, development of prioritization.

METHODOLOGY

- Create, populate matrix with extracted recommendations.
- Review, identify status/outcomes, reconfigure into new recommendations.

RESOURCES

- W1 40 hours, W2 200 hours, W3 50 hours

EXTRACT RECOMMENDATIONS

COST

- \$13,850

SUCCESS

- Services as strategizing tool for Council.
- Identifies gaps in services, mandates, and needs.
- Combines well with un-met needs.

UPDATE UN-MET NEEDS

EXPLANATION

- Data for 2003 document from F/Y 1997-1998.
- 2003 Estimates indicate 600,000 unaccounted for system users.
- Current document not reflective of 2014 understanding of life span, ethnic, cultural affinities.

METHODOLOGY

- Obtain current data used by county, add TAY, expand cultural and ethnic groups, create channel to obtain data on regular basis.
- Evaluate impact of un-met needs on new populations, based on new issues related to mental health delivery and systems.

UPDATE UN-MET NEEDS

METHODOLOGY, Continued

- Synthesize population data, develop recommendations based on gaps.
- Set prioritization and annual review protocols for Council.

RESOURCES

- W1 40 hours, W2 200 hours, W3 100 hours

COST

- \$19,100

SUCCESS

- Enhances Council's relevancy, credibility with refreshed/updated data.
- Council and MH community accepts data accuracy.

AMEND EXISTING PLAN

EXPLANATION

- Use existing structure, update chapters, populate with new data new chapters including TAY, Horizon Issues, Cultural and Ethnic Specific Needs.

METHODOLOGY

- Recommendations, add TAY and cultural/ethnic chapters, codify/add mission/vision of Council.

RESOURCES

- W1 235 hours, W2 689 hours, W3 350 hours.

AMEND EXISTING PLAN

COST

- \$132,300 (\$64,500, plus standard structure cost \$67,800).

SUCCESS

- Acceptance of document by MH community, improve Council relevance.
- Opportunity for Council to continue to lead in MH issues.

ELIMINATED OPTIONS

Create 10 year Plan

- **plan**—report on council work.

Hybrid Plan

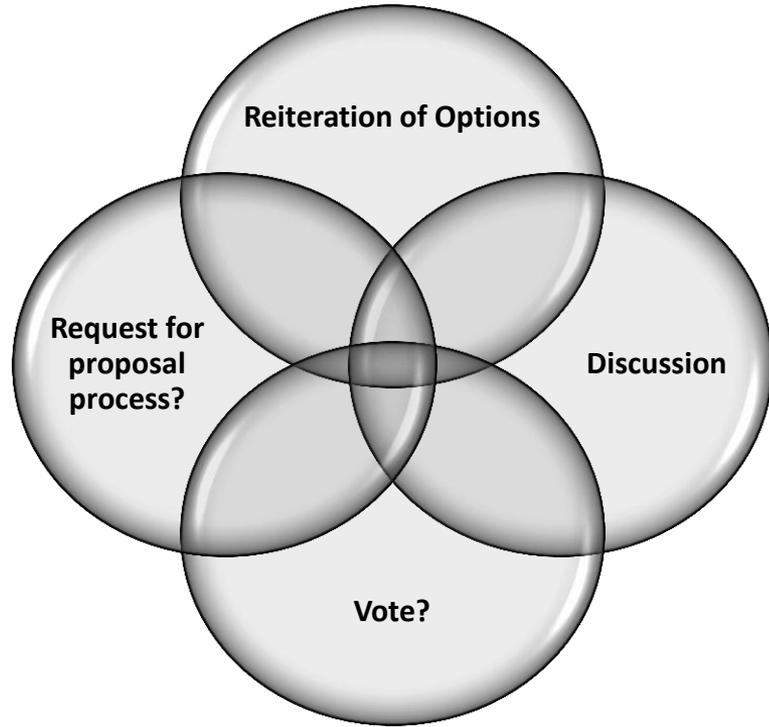
- **plan**—combine new/old mental health activities and developments.

Create New Plan

- **plan**—provides consultative, legal and proactive point of view.

Delay/do nothing Plan

- **plan**—wait for decreased volatility, decide timing/trigger.



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ELIMINATED OPTIONS EXPLAINED

DELAY, DO NOTHING NOW

EXPLANATION

- Wait for various state departments to complete their processes, wait for decreased volatility in mental health arena.

METHODOLOGY

- Define trigger, find gaps, interview all entities, review Council position.

RESOURCES

- W3 80 hours

A wise person once said, "Nothing Should Surprise You"

DELAY, DO NOTHING NOW

COST

- \$10,000

SUCCESS

- No redundancy
- Better collaboration
- Better relational structure

CREATE 10 YEAR PLAN

EXPLANATION (2004-2014)

- Literature and review of MH services.
- Report on work of Council.

METHODOLOGY

- Pull all Council documents, review, create new recommendations.
- Summarize against statutory mandates.

RESOURCES

- W1 52 hours, W2 104 hours, W3 104 hours

CREATE 10 YEAR PLAN

COST

- \$84,180

SUCCESS

- Puts Council in impartial consultative role.
- Fulfills legal mandate.

CREATE HYBRID PLAN

EXPLANATION

- Resultant recommendations from 2003 document.
- Combine/expand new material from MH activities and developments.

METHODOLOGY

- Create new recommendation matrix organized by age/affinity groups.
- Obtain data from other MH entities, summarize, collate.

RESOURCES

- W1 10 hours, W2 104 hours, W3 104 hours

CREATE HYBRID PLAN

COST

- \$86,450

SUCCESS

- Better clarity for age and affinity groups.
- PR and transparency for Council's ideas, mandates.

CREATE NEW PLAN

EXPLANATION

- New organizing principle, each chapter includes section on all populations, provides legal consultative, proactive points of view.

METHODOLOGY

- Sample county requirements and responses to same from all sources (e.g. SAMSHA, CMS), interview, collate all old new developments and data, write protocols.

RESOURCES

- W1 312 hours, W2 1248 hours, W3 196 hours

CREATE NEW PLAN

COST

- \$116,200

SUCCESS

- Creates audit/survey process, creates review schedule, create data extract, allows for research and discussion on best practices, opportunity for Council to take lead on development of MH issues through various PR products.

THANK YOU

INFORMATION

TAB SECTION D

ACTION REQUIRED

DATE OF MEETING 01/15/15

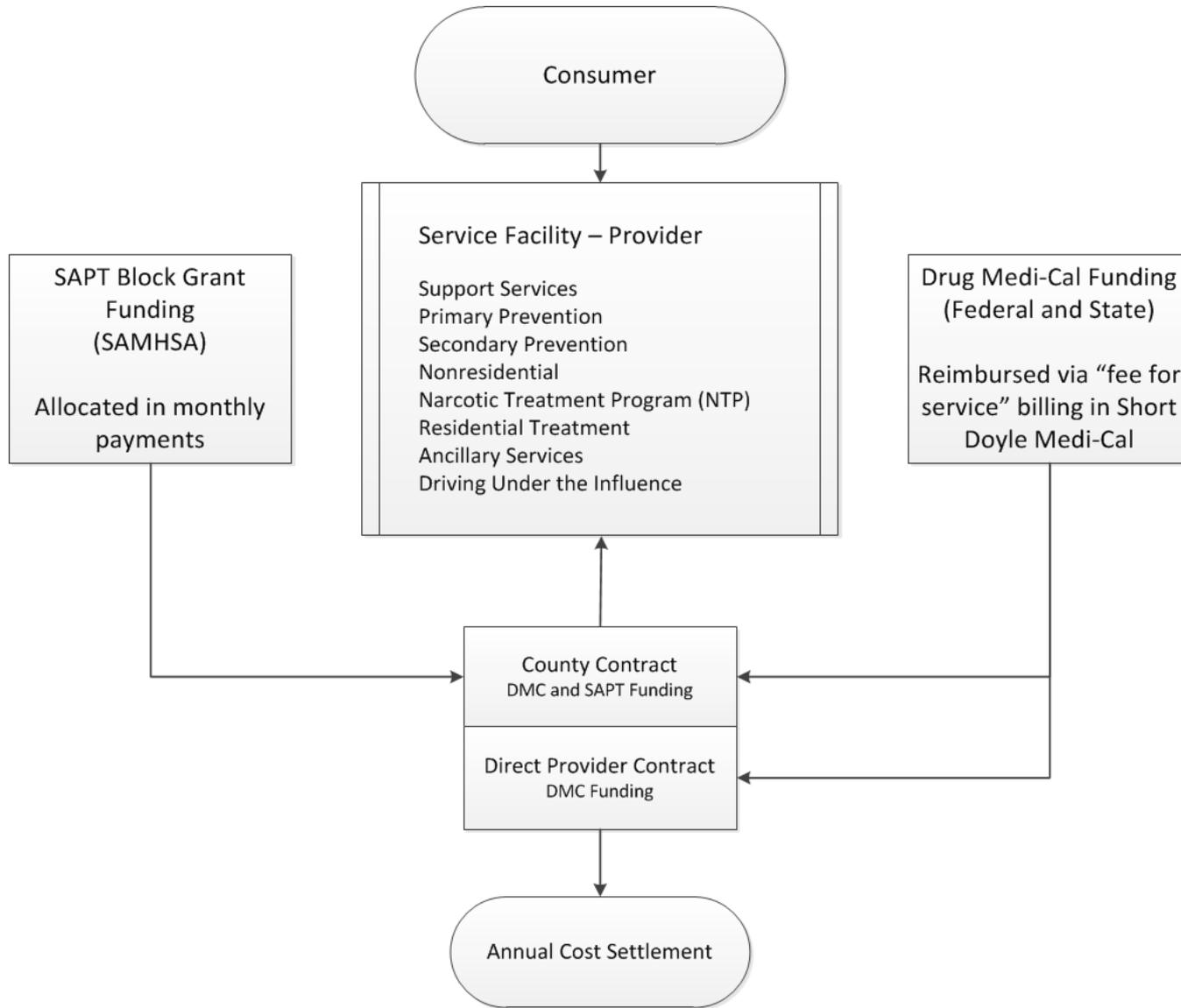
**MATERIAL
PREPARED BY: Adcock**

**DATE MATERIAL
PREPARED 12/22/14**

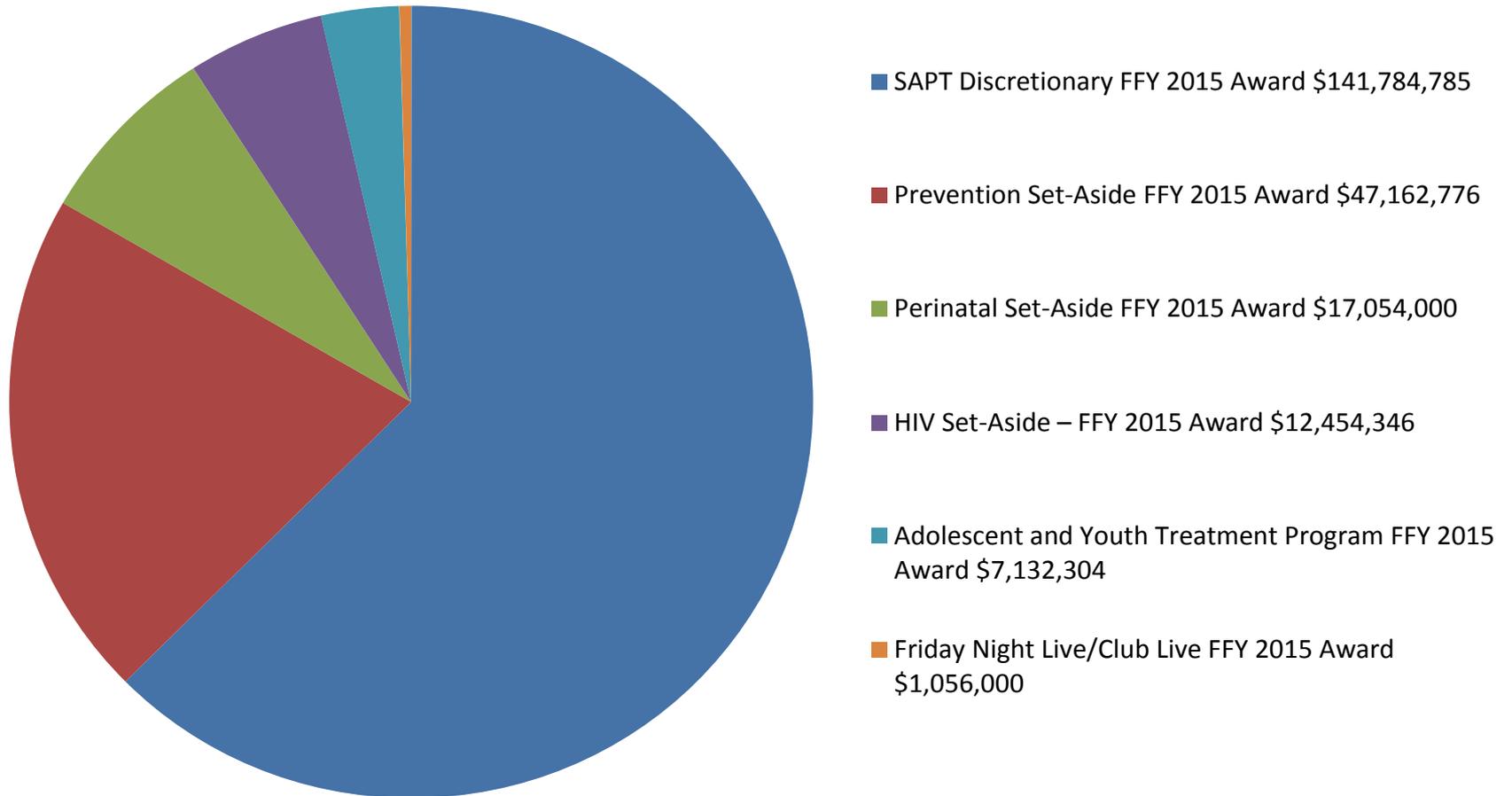
AGENDA ITEM:	Substance Abuse Panel and Continued Discussion of Possible Integration to Behavioral Health Council
ENCLOSURES:	<ul style="list-style-type: none">• Flowchart of SUD Program Funding• Chart of Substance Abuse Prevention and Treatment (SAPT) Block Grant Funding in California for FY 2014-15
OTHER MATERIAL RELATED TO ITEM:	

ISSUE:

In October 2014, the Council heard several presentations regarding the substance abuse service delivery system in California and the funding sources used. These two charts provide a snapshot of the flow of funding for services and also the allocations for the SAPT block grant funds from the federal Substance Abuse and Mental Health Services Administration (SAMHSA).



Fiscal Year 2014-15 Budget Act Allocation SAPT Block Grant Distribution



_____ INFORMATION

TAB SECTION E

X ACTION REQUIRED - Approve

DATE OF MEETING 1/15/2015

MATERIAL
PREPARED BY: Murphy

DATE MATERIAL
PREPARED 12/12/2014

AGENDA ITEM:	Approve revised Legislative Platform
ENCLOSURES:	Revised Legislative Platform for 2015
OTHER MATERIAL RELATED TO ITEM:	

ISSUE:

The proposed legislative platform for 2015 is attached. Proposed changes are in *italics and underlined*. The Advocacy Committee is requesting that these proposed changes be reviewed and approved by the Council.

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL

LEGISLATIVE PLATFORM

March 2014 (DRAFT REVISION NOVEMBER 2014)

Mandatory Planks

- Support any proposal that embodies the principles of the *Mental Health Master Plan*.
- Support policies that reduce and eliminate stigma and discrimination.
- Support any proposal that addresses the human resources problem in the public mental health system with specific emphasis on increasing cultural diversity and promoting the employment of consumers and family members.
- Support any proposal that augments mental health funding, consistent with the principles of least restrictive care and adequate access, and oppose any cuts.
- Support legislation that safeguards mental health insurance parity and ensures quality mental health services in health care reform
- Support expanding affordable housing and affordable supportive housing.
- Actively advocate for the development of housing subsidies and resources so that housing is affordable to people living on SSI.
- Support expanding employment options for people with psychiatric disabilities, particularly processes that lead to certification and more professional status and establish stable career paths.
- Support any proposal to lower costs by eliminating duplicative, unnecessary, or ineffective regulatory or licensing mechanisms of programs or facilities.
- Support any initiatives that reduce or eliminate the use of seclusion and restraint.
- Support adequate funding for evaluation of mental health services.
- Support initiatives that maintain or improve access to mental health services, particularly to underserved populations, and maintain or improve quality of mental health services.
- Oppose all bills related to “NIMBYism” and restrictions on housing and siting facilities for providing mental health services.
- Support initiatives that provide comprehensive health care and improved quality of life for people living with mental illness, and oppose any elimination of health benefits for low income beneficiaries, and advocate for reinstatement of benefits that have been eliminated.
- Oppose any legislation that adversely affects the principles and practices of the Mental Health Services Act.
- Support policy that enhances the quality of the stakeholder process, improves the participation of consumers and family members, and fully represents the racial/cultural demography of the targeted population.
- Support any policy that requires the coordination of data and evaluation processes at all levels of mental health services.

Discretionary Planks (Require Deliberation & Discussion)

- *Support any proposal that advocates for blended funding for programs serving clients with co-occurring disorders that include mental illness.*
- *Support any proposal that advocates for providing more services in the criminal and juvenile justice systems for persons with serious mental illnesses or children, adolescents, and transition-aged youth with serious emotional disturbances, including clients with co-occurring disorders.*
- *Support any proposal that specifies or ensures that the mental health services provided to AB109 populations are paid for with AB 109 funding.*
- *Support the modification or expansion of curricula for non-mental health professionals to acquire competency in understanding basic mental health issues and perspectives of direct consumers and family members.*
- *Promote the definition of outreach to mean “patient, persistent, and non-threatening contact” when used in context of engaging hard to reach populations.*

X INFORMATION

TAB SECTION F

_____ ACTION REQUIRED

DATE OF MEETING 1/16/2015

MATERIAL
PREPARED BY: Adcock

DATE MATERIAL
PREPARED 12/19/2014

AGENDA ITEM:	Council Member Open Discussion
ENCLOSURES:	
OTHER MATERIAL RELATED TO ITEM:	

ISSUE:

The Executive Committee is seeking Council member input on potential area(s) of focus for the 2015 year. It is anticipated that the Council will have a focus for the year and presentations from counties around the state will inform members of programs available that address that area. At the year's end, a report on the area of focus will be generated with input from the committees as well as data from the presentations around the state.

The Executive Committee will present a number of possible areas of focus for member consideration on January 16th and will also accept new areas for consideration. At the February Executive Committee meeting, an area(s) of focus will be selected and the 2015 agenda items will be created accordingly.