



April 7, 2015

To: California Mental Health Planning Council

From: Jane Adcock
Executive Officer

Subject: April 2015 Planning Council Meeting

CHAIRPERSON
Cindy Claffin

EXECUTIVE OFFICER
Jane Adcock

Enclosed is the packet for the April 15-17, 2015 Planning Council meeting at the DoubleTree Hotel in San Pedro, CA. The hotel is located at 2800 Via Cabrillo-Marina, San Pedro, CA 90731. The hotel offers complimentary 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, April 16**, 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 Thursday afternoon. 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

AGENDA
CALIFORNIA MENTAL HEALTH PLANNING COUNCIL
April 15, 16, 17, 2015
San Pedro Doubletree
2800 Via Cabrillo-Marina
San Pedro, CA 90731

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, April 15, 2015

COMMITTEE MEETINGS

Time	Event	Room
9:00 a.m.	Executive Committee Meeting	Portofino Room
10:30 a.m.	New Member Orientation Meeting	Madeo Room
11:00 a.m.	Patients' Rights Committee Meeting	Santa Rosa Room

PLANNING COUNCIL GENERAL SESSION

Madeo Ballroom

Conference Call 1-877-951-3290

Participant Code: 8936702

Time	Topic	Presenter or Facilitator	Tab
1:30 p.m.	Welcome and Introductions	Cindy Claflin, Chairperson	
1:40 p.m.	Opening Remarks	Dave Pilon, Ph.D., President and CEO, Mental Health America Los Angeles	
2:00 p.m.	Approval of Minutes from January 2015 meeting	Cindy Claflin, Chairperson	G
2:05 p.m.	Measurements, Outcomes and Quality Assessment (MOQA)	Debbie Innes-Gomberg, Ph.D., District Chief, LA County Dept. of Mental Health	H
2:40 p.m.	Council Questions and Discussion	All	
2:55 p.m.	Public Comment	Cindy Claflin, Chairperson	
3:00 p.m.	Break		

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3:15 p.m.	Behavioral Health Integration: National Perspective	Jon T. Perez, Ph.D., Regional Administrator, Region IX, SAMHSA and Bruce D. Emery, M.Ed., MSW, Advocates for Human Potential	I
3:45 p.m.	Facilitated Council Discussion and Next Steps	Bruce D. Emery	
4:40 p.m.	Public Comment	Cindy Claflin, Chairperson	
5:00 p.m.	Recess		

Thursday, April 16, 2015

COMMITTEE MEETINGS

Time	Event	Room	Tab
7:00 a.m.	Children's Caucus	Hotel Restaurant	
8:30 a.m.	Advocacy Committee	Portofino Room	
to 12:00 p.m.	Continuous System Improvement	Sta Rosa Room	
	Health Care Integration Committee	Madeo Room	
12:00 p.m.	LUNCH (on your own)		

PLANNING COUNCIL GENERAL SESSION

Madeo Ballroom

Conference Call 1-877-951-3290

Participant Code: 8936702

Time	Topic	Presenter or Facilitator	Tab
1:30 p.m.	Welcome and Introductions	Cindy Claflin, Chairperson	
1:40 p.m.	Office of Statewide Health Planning and Development: Status of WET 5-Year Plan Implementation	Lupe Alonzo-Diaz, Deputy Director, and Brent Houser, Healthcare Workforce Development Division	J
2:30 p.m.	Public Comment	Cindy Claflin, Chairperson	
2:40 p.m.	Report from Dept. of Health Care Services	Brenda Grealish, Assistant Deputy, Mental Health and Substance Use Disorders	
3:00 p.m.	Break		
3:15 p.m.	Overview of Data Notebook 2015 and Committee Report for Continuous System Improvement Cmte	Susan Wilson, Chair CSI and Linda Dickerson, Ph.D., Council Research Analyst	

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3:45 p.m.	Committee Reports Cont. – Patients’ Rights, Health Care Integration and Advocacy	Daphne Shaw, Chair PRC Steven Grolnic-McClurg, Chair HCI and Adam Nelson, Chair Advocacy	
4:30 p.m.	Report from CA Behavioral Health Directors Association	Noel O’Neill, Director, Trinity County	
4:50 p.m.	Public Comment	Cindy Claflin, Chairperson	
5:00 p.m.	Recess		

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

Friday, April 17, 2015

PLANNING COUNCIL GENERAL SESSION

Madeo Ballroom

Conference Call 1-877-951-3290

Participant Code: 8936702

Time	Topic	Presenter or Facilitator	Tab
8:30 am	Welcome and Introductions	Cindy Claflin, Chairperson	
8:40 am	Opening Remarks	Assembly Member Sebastian Ridley-Thomas (invited)	
9:10 am	Report from the California Association of Local Mental Health Boards/Commissions	Larry Gasco, Ph.D., LCSW, President	
9:30 a.m.	Council Member Open Discussion	Cindy Claflin, Chairperson	
10:00 am	BREAK		
10:15 a.m.	Report from Mental Health Services Oversight and Accountability Commission	Toby Ewing, Ph.D., Executive Director (invited)	
10:45 a.m.	Public Comment	Cindy Claflin, Chairperson	
11:00 a.m.	Diversion Services for Mental Health Consumers in our Local Criminal Justice System	LA County District Attorney Jackie Lacey, J.D. and Marvin J. Southard, DSW, Director, Los Angeles County Dept. of Mental Health	
11:55 a.m.	Closing	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.

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If Reasonable Accommodation is required, please contact Chamenique Williams at 916.552.9560 by April 6, 2015 in order to work with the venue to meet the request.

2015 MEETING SCHEDULE

June 2015	June 17, 18, 19	Burlingame	Crowne Plaza San Francisco Airport 1177 Airport Blvd. Burlingame, CA 94010
October 2015	October 14, 15, 16	Sacramento	Lake Natoma Inn 702 Gold Lake Drive Folsom, CA 95630

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	Santa Clara	To Be Determined
October 2016	October 19, 20, 21	Sacramento	To Be Determined

California Mental Health Planning Council

Patients' Rights Committee

April 15, 2015

**Double Tree Hotel
2800 Via Cabrillo Marina
San Pedro, CA 90731**

**Santa Rosa Room
11:00 a.m. to 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 January, 2015 meeting	All members	A
3.	11:10 am	Update: PR Survey for MH Boards – online and print versions	All members	B
4.	11:15 am	New Business: Review of PR Advocates Survey	All members	C
5.	11:30 am	Presentation: Patients' Rights Advocates for Los Angeles County	All members	D
6.	12:10 pm	Update: Patients' Rights Committee Work Plan 2014-15 – State Hospitals	All members	E
7.	12:25 pm	Public Comment	<i>Daphne Shaw, Chairperson</i>	
8.	12:30 pm	Meeting adjourned		
9.				
10.				

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

Committee Members:

Co-Chairs: **Daphne Shaw** **Cindy Claflin**

Members: Adam Nelson, MD Dan Brzovic
 Carmen Lee Richard Krzyzanowski
 Walter Shwe

Staff: Andi Murphy Jane Adcock, EO

Advocacy Committee

Thursday, April 16, 2015

Doubletree San Pedro
 2800 Via Cabrillo-Marina
 San Pedro, CA 90731
 (310) 514-3344

Portofino Room
8:30 a.m. - Noon

Time	Topic	Facilitator/Presenter	Tab
8:30 a.m.	Welcome and Introductions	Adam Nelson, MD, Chair	
8:35	Agenda & Packet Review	Kathleen Derby, Chair-Elect	
8:40	Council Requests/New Business	Adam Nelson	
8:45	Refresher: The Legislative Process	Kathleen Derby	A
8:55	Review of Proposed Legislation	Adam Nelson	B
9:50	Break		
10:10	Mary Marx, LCSW; Mental Health Clinical District Chief, LA County Mental Health, <i>IMD Utilization Rates and Social Reinvestment</i>	Adam Nelson	C
11:10	Discussion & Next Steps on Committee Work Plan	Kathleen Derby	
11:35	Public Comment	Kathleen Derby	
11:45	Develop Report Out	Adam Nelson	
11:50	WWW/ Plan for Future Meetings	Andi Murphy, Staff	
11:55	Plus/Delta	Kathleen Derby	
Noon	Adjourn		

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

Committee Members:

Chair: Adam Nelson, MD

Chair-Elect: Kathleen Derby

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

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

**California Mental Health Planning Council
Continuous System Improvement Committee**

April 16, 2015

**Double Tree Hotel
2800 Via Cabrillo Marina
San Pedro, CA 90731**

**Santa Rosa Room
8:30 a.m. to 12:00 p.m.**

Item #	Time	Topic	Presenter or Facilitator	Tab
1.	8:30 am	Planning Council Members Issue Requests	All Members	
2.	8:35 am	Welcome and Introductions	<i>Susan Morris Wilson, Chair Lorraine Flores, Chair-Elect</i>	
3.	8:40 am	Review and Approve January, February Minutes	All Members	A
4.	8:45 am	Update: Preliminary Data Notebook draft, proposed questions	<i>Susan Morris Wilson, Linda Dickerson</i>	B
5.	9:45 am	Break		
6.	10:00 am	Update: OAC research update; CMHPC and OAC Priority Indicators Joint Task Force	<i>Renay Bradley, Linda Dickerson</i>	
7.	10:15 am	Update: New Community Forum report, and Approval: revised 2014 Trauma report	All Members	C
8.	10:30 am	CSI Committee Work Plan 2015	<i>Susan Morris Wilson, Chair Lorraine Flores, Chair-Elect</i>	D
9.	11:30 am	Public Comment		
10.	11:45 am	Evaluate Meeting/Develop Agenda for Next Meeting	<i>Susan Morris Wilson, Chair Lorraine Flores, Chair-Elect</i>	

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

Committee Members:

Co-Chairs: **Susan Morris Wilson – Chair** **Lorraine Flores, Chair-Elect**

Members: Patricia Bennett, PhD Raja Mitry
 Renay Bradley, PhD Monica Nepomuceno
 Kathleen Casela Noel O’Neill
 Amy Eargle, PhD Walter Shwe
 Karen Hart Bill Wilson
 Celeste Hunter

Staff: Laura Leonelli Linda Dickerson, PhD

California Mental Health Planning Council

Healthcare Integration Committee

April 16, 2015

Double Tree

2800 Via Cabrillo Marina

San Pedro, CA 90731

Madeo 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.	Review and Approve January Meeting Highlights		
8:45 a.m.	Presentation: California Health Care Foundation	Catherine Teare, Associate Director, California Health Care Foundation	A
9:40 a.m.	Questions/Comments		
10:30 a.m.	Break		
10:45 a.m.	Work Plan Review and Update		B
11:25 a.m.	Committee Discussion		
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 McClurg

Chair-Elect: Terry Lewis

Members:

Dale Mueller

Josephine Black

Cindy Clafin

Joseph Robinson

Deborah Pitts

Jeff Riel

Robbie Powelson

Cheryl Treadwell

Daphyne Watson

Melen Vue

Staff:

Tracy Thompson

INFORMATION

TAB SECTION G

ACTION REQUIRED

DATE OF MEETING 04/15/15

**MATERIAL
PREPARED BY: Thompson**

**DATE MATERIAL
PREPARED 03/18/15**

AGENDA ITEM:	Review and Approve January 2015 CMHPC Quarterly Meeting Minutes
ENCLOSURES:	January 2015 CMHPC Quarterly Meeting Minutes
OTHER MATERIAL RELATED TO ITEM:	

ISSUE:

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL MEETING MINUTES

January 14, 15, and 16, 2015
Crowne Plaza San Diego
2270 Hotel Circle
San Diego, CA 92108

CMHPC Members Present:

Cindy Claflin, Chair	Maya Petties, Psy.D.
Jo Black	Deborah Pitts, Ph.D.
Kathleen Derby	Robbie Powelson
Lorraine Flores	Darlene Prettyman
Nadine Ford	Jeff Riel
Steven Grolnic-McClurg	Joseph Robinson
Karen Hart	John Ryan
Celeste Hunter	Daphne Shaw
Steve Leoni	Walter Shwe
Terry Lewis	Cheryl Treadwell
Barbara Mitchell	Arden Tucker
Raja Mitry	Daphyne Watson
Dale Mueller, Ed.D.	Bill Wilson
Adam Nelson, M.D.	Susan Wilson
Noel O'Neill	

Staff Present:

Jane Adcock, Executive Officer	Andi Murphy
Linda Dickerson, Ph.D.	Tracy Thompson
Tamara Jones	Chamenique Williams
Laura Leonelli	

Wednesday, January 14, 2015

A.M.: Committee Meetings

- **Executive Committee**
- **New Member Orientation**
- **Patients' Rights Committee**

P.M.: Planning Council General Session

1. Welcome and Introductions

Chair Claflin welcomed everyone and invited them to introduce themselves.

Ms. Adcock extended a welcome to Robbie Powelson, Raja Mitry, and Daphyne Watson.

2. Opening Remarks

Michael Krelstein, M.D., welcomed the Planning Council to San Diego. He is the Clinical Director for Behavioral Health Services for the County of San Diego under Human Health and Services. A psychiatrist, he has a great deal of experience working with community mental health populations.

Dr. Krelstein spoke about accomplishments in 2014.

- With the Affordable Care Act (ACA) implementation, San Diego had 200,000-300,000 new Medi-Cal enrollees; statewide the numbers are already in the millions. With this growth, as well as the success of anti-stigma campaigns and parity, behavioral health needs have exploded – with access and workforce challenges.
- San Diego County is six months into its Coordinated Care Initiative (CCI) implementation and its dual project.
- The recent national election results have the potential to flip the political underpinnings of the ACA upside down.
- Dr. Krelstein’s department has been working with several Medi-Cal health plans in the county to develop the next generation of MOAs, policies, and political and administrative scaffolding to ensure equal access for all beneficiaries.
- San Diego County is proud of its No Wrong Door policy.
- Recognizing the new cultural differences between the public and private sectors, a conceptual framework has been developed for analyzing cases, developing screening tools, and resolving disputes.

Dr. Krelstein spoke about the vision for 2015 and beyond.

- Careful use of language can challenge dogmatic views which are supported by imprecise or even prejudicial language. Dr. Krelstein had seen evidence of this during a review of Skilled Nursing Facility charts: large numbers of older “psych” patients there have “secondary” medical ailments – multiple chronic medical and neurological problems.
- Dr. Krelstein described California’s Behavioral Health Home Design concept: behavioral health homes “that take responsibility for the health quality and outcomes of individuals with serious behavioral health disorders and co-occurring chronic health conditions.” Dr. Krelstein noted that there are several competing models at play, however. Nuances in each of the models speak to tensions between intended populations – ongoing carve-outs, carve-ins, relationships with health plans, and integration.
- Dr. Krelstein continued that science does not allow us to determine primary versus secondary as a cause for global dysfunction in an individual. Promoting behavioral health homes distinct from whole-person or client-centered continues

to carry forward a dualistic myth, and with it, the disadvantages of a subsystem of disintegrated care (even though it may be better than the system which preceded).

- Dr. Krelstein requested for the Planning Council to bear in mind that language must evolve along with our systems of care.

Questions and Discussion

Ms. Shaw inquired as to whether the Skilled Nursing Facilities were Institutes for Mental Disease (IMDs). Dr. Krelstein answered that they were not.

Mr. Leoni commented on a pattern: for years, if a consumer had a mental health diagnosis, that became the consumer's identity regardless of the presence of other causes or issues such as stigma or crime.

Dr. Krelstein closed by referring to the renewal of the Bridge to Reform Medi-Cal 1115 Waiver: we really do need to look at the whole person and to create integrated kinds of services that will be more effective for the individual receiving them, and more cost-effective as well.

Dr. Nelson expressed concern that while there are forces in place to promote the concept of whole-person health care, much of what keeps health care divided has to do with pots of money. Siloed health care is a worrisome issue. The solution is going to take financial finesse as well as semantic awareness.

Dr. Krelstein responded that the interface between the health plans and the counties has picked up regarding sharing populations. Issues around the Skilled Nursing Facilities are currently a real dialogue between the providers and the health plans, for example, *primary* versus *secondary* and *mild*, *moderate* and *severe* diagnoses.

3. Election of Chair-Elect and Changing of the Officers

Ms. Flores stated that the Planning Council has been using an informal process to determine the next Chair-Elect. The position seems to rotate through the various categories (Direct Consumer, Family Member, Consumer-Related Advocate, and Provider). This year, the category of Direct Consumer has come up; the Nominating Committee has selected Josephine Black as the nominee.

The Planning Council unanimously elected Ms. Black as Chair-Elect.

Chair Claflin requested Mr. Ryan to serve as Co-Chair during this meeting; he agreed.

4. Approval of Minutes from October 2014 Meeting

Ms. Shaw commented that the minutes had reflected that several questions were asked but not answered. She suggested a "parking lot" to take care of such questions.

Motion: The approval of the October 2014 Meeting Minutes was moved by Steven Grolnic-McClurg, seconded by Celeste Hunter. Motion passed with two abstentions.

5. Overview of the Health Care Integration Committee and Health Care Integration in California

Mr. Grolnic-McClurg provided an overview of health care integration in California.

- People have hugely varying levels of information on health care integration.
- The purpose of the Health Care Integration Committee is to develop a framework for tracking, addressing, and responding to the multitude of issues resulting from federal health care reform, that impacts California's mental health system.
- In California, specialty mental health services are carved out from the rest of the health care services for individuals who have Medi-Cal as stipulated by the Waiver.
- A set of dollars is given basically by the state to the county specialty mental health care plan to provide that care for the individuals with Medi-Cal. Those dollars are then matched by doing a reimbursable service and billing the federal government.
- That entire stream of dollars is separated from where individuals get their physical health care; the two systems do not interact.
- This system did not address the problem that individuals with serious mental illness were dying decades earlier than the general population.

Physical Health Care Issues for Mental Health Consumers

- With physical health care and mental health care happening in separate places, the money doesn't mix; there are no incentives for the two systems to talk to each other.
- Mental health consumers are very expensive to the physical health care system. In three of the five most expensive co-occurring diagnoses, one of those diagnoses is a mental health issue.

Parity

- The Mental Health Parity and Addiction Equity Act states that if a health plan offers any mental health or substance abuse benefits, the plan must provide these benefits at the same level as medical and surgical benefits.

Health Care Expansion

- Prior to the ACA, roughly seven and a half to eight million Californians had Medi-Cal. That number has now increased by three to four million people.
- Through Covered California, another huge number of people now have subsidized private insurance.

Counties have generally decided that mild-to-moderate mental health issues go to the health plan, and moderate-to-severe mental health issues which generally lead to functional impairment go to the mental health plan. This arrangement officially started in January 2014 while the corresponding county MOUs had to be in place by July 2014.

Challenges

- What is the difference between mild-to-moderate and moderate-to-severe mental health issues?
- Whose mental health stays in one “box” for a long period of time?
- For those with mild-to-moderate mental health issues, where do the counties send them? Who will provide this care? The system hasn’t been built to do this.
- The rules for the mental health plan are that unless it makes an agreement with the health plan, it will not get reimbursed for providing the care.

A major implication for the Planning Council is that the public mental health system is now the specialty mental health plans and the managed care health plans – which are now responsible for providing behavioral health and mental health care for people with Medi-Cal who have mild-to-moderate mental health issues.

Mr. Grolnic-McClurg stated that the Planning Council needs to welcome those new providers into the system. Further, the Planning Council needs to ensure that they are providing good care.

He continued that much work has been done toward integrated care models – how to do a better job of supporting the physical health care for individuals with serious mental health issues and children with serious emotional disturbances. Those models are:

- Primary health care homes place mental health care providers inside the primary care center.
- Primary care doctors are placed in specialty mental health care homes.
- A care coordinator navigates between the two systems.

Challenges

- Capacity issues:
 - In specialty mental health care there need to be enough peer providers, psychiatrists, licensed professionals of color, and providers speaking languages other than English.
 - The health plans are experiencing huge problems finding providers who will accept the given rates.
 - There are not enough primary care providers.
- In the new setup, people are not fitting neatly into one system or the other – the mental health plan or the health plan.
- Oversight issues for the health plans. Right now the Department of Managed Health Care is responsible for the health plans.
- The new system is very complicated. Mr. Grolnic-McClurg described navigation of the complex mental health system in the city of Berkeley.

Questions and Discussion

Mr. Leoni raised the dilemma that if a person in the moderate-to-severe category obtains a job, it could put the person over the 138% poverty mark, making him or her ineligible for the plans. Mr. Leoni also mentioned the peer certification issue, which revolves around Medi-Cal.

Mr. Wilson agreed that the system is complicated, even more than before. However, he felt that there are solutions to every problem.

Ms. Mitchell asked if the committee has looked at any of the articles about the mental illness morbidity rate. It is not necessarily lack of health care availability; it is risk behaviors associated with mental illness, especially tobacco use, suicidality, psychotropic medication, sedentary lifestyle, etc. The system needs to look at changing behaviors associated with mental illness.

Mr. Grolnic-McClurg agreed. It is a complicated problem; that is why lots of different models are being tried out – none of which are showing overwhelming immediate success.

Ms. Derby asked if Mr. Grolnic-McClurg had reached out to peers and consumers to be part of the panel. He responded that he wished the cohort talking about the issues could be more robust.

Mr. O'Neill mentioned the different set of challenges for rural areas. In his county there is a Partnership HealthPlan responsible for the mild-to-moderate category; they don't have providers. County Mental Health is prohibited from seeing them unless the county has a contract with Beacon (the provider for Partnership Health Plan).

Mr. Grolnic-McClurg agreed that the goal should be for integrated care, not new silos.

Mr. Mitry felt that in looking further at integrated care, we should give more attention and value to the importance of an individual's healthy personal relationships.

Mr. Leoni mentioned that he had attended a meeting the previous day about devising ideas for legislative bills. He encouraged Planning Council members to contact the Steinberg Institute with ideas.

In closing, Mr. Grolnic-McClurg stressed the importance of starting to build new and better relationships in the health care system – both the health plans and the primary care centers. In working all of this out over the next decade, we must not lose all of the lessons learned within the specialty mental health care system about what works in supporting individuals with serious mental illness and children with serious emotional disturbances.

6. Panel Presentation: Health Care Integration and Family Member Experience within San Diego

Sue Moore introduced herself as the mother of a 21-year-old daughter, Emily, with schizoaffective disorder and borderline personality disorder, and a 27-year-old son with Asperger's.

Ms. Moore described Emily's journey over the past two and a half years, with 23 visits to psychiatric hospitals, detox from meds, cognitive therapy, dialectical behavior therapy,

dual diagnosis programs, electroconvulsive therapy treatments, 28 different medications, and a suicide attempt.

The new Health Insurance Portability and Accountability Act (HIPAA) laws are supposed to help, but they make it hard to work on a treatment plan.

Ms. Moore has had to quit her job to care for her daughter. She tries to take care of herself and to get help from family and friends.

Currently Emily is in an adult intensive outpatient program at a psychiatric hospital three mornings a week which offers transportation. She attends a peer-run clubhouse once or twice a week, depending on her daily functionality. She works on life skills there, and develops self-help skills at a recovery-based peer-run nonprofit organization. A very important resource has been a weekly social group for young adults in recovery from mental illness.

Ms. Moore described her experience navigating the system. In trying to get Emily into a special treatment center, she was told that if her daughter was indigent or on Medi-Cal, she could get in. But because she had private insurance she could not qualify unless her parents would pay \$12,000 at the outset and the same amount per month thereafter.

Ms. Moore stressed that there are times when she has serious difficulty caring for her daughter's overwhelming mental and physical needs.

The family has United Health Care and a case manager, which has helped with obtaining medication.

Ms. Moore said that Mesa Vista Hospital, in particular, has been wonderful: staff, nurses, social workers, and Emily's psychiatrist. Physical health needs such as dental care can fall by the wayside; Ms. Moore commented on the value of having primary care doctors come to the mental hospital to see patients.

Navigating between public and private insurance had been a real obstacle.

Emily is getting fairly good care now, but there have been times when she needed more care and couldn't get it because she has both private insurance and Medi-Cal. The family has thought in the past about dropping their private insurance

The next speaker was Linda Richardson, Ph.D., clinical psychologist and psychiatric nurse. She currently works for the National Alliance on Mental Illness (NAMI) San Diego. She spoke about her career journey through integrated care.

After graduate school Dr. Richardson had moved from New England to Houston with the goal of providing integrated care: caring for the mental health needs in people with physical problems. She could not find such a position, and in time became a clinical psychologist.

In San Diego Dr. Richardson worked as Program Manager of North Inland Mental Health Center, a county-funded specialty mental health clinic. The clinic partnered with several groups and obtained a grant through the Substance Abuse & Mental Health Services Administration (SAMHSA) called Primary Behavioral Health Care Integration. The program intent was to bring physical health care into a clinic serving persons with serious mental illness. The clinic partnered with a federally-qualified health center, which sent a

qualified nurse practitioner, a nurse, and a wellness coordinator who were physically located full-time at the site. Unfortunately, the four-year grant has ended.

Dr. Richardson then became the manager of Hope Connections, a three-year county-funded innovations project. Every year, San Diego County funds a small number of programs that are trying out new ideas in the mental health field. The programs are funded initially for three years; if they look promising, they are put on a regular funding cycle.

The staff there are certified peer specialists and trained family specialists. The idea was to engage individuals at the county psychiatric hospital and follow them into the community, linking them to any and all services they need. Staff worked with family members and significant others as well. The individuals received help from the programs for as long as it took to get them linked up with services.

The focus was with individuals for whom mental health issues were primary. UC San Diego had a program called Bridge to Recovery where they worked also with individuals at the county psychiatric hospital but whose primary issues were substance use-related.

Both programs were very successful.

The new grant combines the two programs as well as a third. The new program is called Next Steps and will deal with the whole person. All individuals at the county psychiatric hospital can be served: those with mental health, substance use, and co-occurring issues. The program will also look at physical health needs. It is unique in that it is a partnership of multiple agencies: NAMI San Diego, Mental Health Systems, United Pan-Asian Communities, and Family Health Centers.

Questions and Discussion

Mr. Powelson mentioned that dynamic, informal consumer social connections play a role in triaging people to different services. Dr. Richardson stated that her complete staff is comprised of peers – people with lived experience or family members. Ms. Moore commented that finding out about NAMI San Diego was a turning point for her family, with their website and the information they gave about the clubhouses. She felt that the family-to-family program is key for education, support, and resource information.

Ms. Moore explained to Ms. Lewis that the temporary conservatorship they had for their daughter had happened because she was still using drugs. Emily was not supportive of her parents' efforts to conserve her.

Dr. Mueller asked how Dr. Richardson tracks successes because in writing grants, data rules. Dr. Richardson responded that SAMHSA had prescribed the data collected for their grant. They were looking for mental health service usage, physical health care service usage, ER usage, hospitalization, risk factors, tobacco and alcohol usage, blood pressure, diabetes, and so on. She stressed that these are complicated issues and it is very difficult to discern what to measure, how long to measure, how to quantify interventions, etc.

(Ms. Adcock gave Planning Council members instructions for making travel arrangements; she requested them to keep the time deadlines in mind in their interactions with Ms. Williams.)

(15.) Report from California Behavioral Health Directors Association

Mr. O'Neill reported on the following.

- The federal government has approved the new Certified Community Behavioral Health Clinic Grant. The federal government is interested in having a standard of care for behavioral health established throughout the United States that would include accreditation requirements and essential benefits such as crisis stabilization. Ms. Shaw noted that Congresswoman Matsui of Sacramento carried the bill.
- Regarding whole-person care: as we move into the Bridge to Reform Waiver renewal discussion, the Delivery System Reform Incentive Program (DSRIP) is a mechanism for drawing down federal funds for innovative plans. The California Behavioral Health Directors Association (CBHDA) has formally sent a letter to the California Department of Health Care Services (DHCS) suggesting that not only should they continue the existing DSRIP with the hospital system, but they should also consider one for behavioral health – specifically to address the issue of the high early morbidity rate of mental health patients.
- The Drug Medi-Cal Waiver has been submitted and we are more than halfway through the analysis period. The DHCS is asking counties which ones would like to participate. It will change the way addiction services are offered, using the mental health managed care system paradigm. If the waiver passes, consumers receiving Medi-Cal drug and alcohol services are going to have a much wider array of services – for example, residential treatment will be paid for.
- The counties are trying to do better on data collection. CBHDA CEO Robert Oakes has been working with the counties trying to devise a dashboard. It would have certain domains such as timeliness of services.
- The merger of the California Mental Health Directors Association (CMHDA) with the County Alcohol & Drug Program Administrators Association of California (CADPAAC) is legally completed. Of the 58 counties, 54 are integrated services: the same Behavioral Health Director oversees both alcohol/other drug, and mental health. It makes a more streamlined approach for funding.

Questions and Discussion

Mr. Powelson asked about the CMHDA/CADPAAC merge. Mr. O'Neill explained that under Governor Schwarzenegger, the California Department of Mental Health and the California Department of Alcohol and Drugs had been absorbed into the California DHCS. For the CMHDA/CADPAAC merge, membership had not doubled because some staff had already been covering both jobs. Every issue that comes up at CBHDA is addressed by both mental health, and alcohol/other drug.

Mr. Leoni expressed concern about the system waiver bringing the substance use component into a county-based system. He was concerned about triage issues – counties only have so much money; and the natural tendency of bureaucrats is to create rigid systems. Different kinds of access problems may result.

Mr. O’Neill responded that the DHCS was under tremendous pressure from the Centers for Medicare and Medicaid Services (CMS) to do something different in the midst of an ongoing fraud investigation. The waiver that was submitted was their best effort to make the system predictable and accountable. He agreed with Mr. Leoni that flexibility and accessibility are critical.

(16.) Approve 2015 Legislative Platform

Dr. Nelson reported for the Advocacy Committee on the proposal for the CMHPC legislative platform. From year to year the platform has remained fairly consistent. Dr. Nelson explained the revisions for 2014.

- Two planks have been moved from the Discretionary platform to the Mandatory platform:
 - Support adequate funding for evaluation of mental health services.
 - 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.
- A new Mandatory Plank states:
 - Support any policy that requires the coordination of data and evaluation processes at all levels of mental health services.
- A Mandatory Plank has been modified:

“Support initiatives that maintain or improve access to mental health services, *particularly to underserved populations*, and maintain or improve quality of mental health services.”

Motion: The approval of the 2015 California Mental Health Planning Council Legislative Platform was moved by Adam Nelson, seconded by Barbara Mitchell.

Questions and Discussion

Mr. Powelson asked about bills addressing stigma and discrimination: are they inclusive of not only mental illness, but also LGBT, racial, and age discrimination? Dr. Nelson responded that the CMHPC would certainly oppose anything discriminatory. However, it is not within the Planning Council’s purview to take up issues of discrimination purely on demographic or epidemiologic criteria.

Ms. Shaw suggested adding the word “quality” to the phrase “affordable supportive housing.” Ms. Prettyman noted that in the past her son had been placed in housing of poor quality. Ms. Mitchell said that all federal and state-funded new housing requires a substantially higher quality of construction than any other kind of housing project.

Ms. Ford responded to the term “affordable housing.” If it is a regulated project, a certain level of quality will be required. If it is affordable by nature of the marketplace it will not be required.

The addition of the word “quality” was a Friendly Amendment to the motion.

Mr. Shwe expressed concern about the second new plank. Dr. Nelson explained its history: it has been difficult to measure standards and improvements to mental health care services in any uniform way. The plank involves behavioral health directors developing a means of gathering data uniformly, to measure the effectiveness of programs and allocations.

Motion: The approval of the 2015 California Mental Health Planning Council Legislative Platform was moved by Adam Nelson, seconded by Barbara Mitchell, with the Friendly Amendment given above. Motion passed unanimously.

(The group again discussed travel arrangements and reimbursements.)

8. Public Comment

Luvenia Jones, a family member from Alameda County, expressed appreciation for the content of the Planning Council meeting. She emphasized the need to come up with solutions to physical conditions, particularly obesity, causing the early morbidity rate. She pointed out that getting more types of people involved – young people, doctors, psychiatrists, holistic care providers, and so on – would benefit the Planning Council. She welcomed a complete new look at the mental health system.

9. RECESS

Chair Claflin adjourned the meeting at 5:01 p.m.

Thursday, January 15, 2015

A.M.: Committee Meetings

- **Advocacy Committee**
- **Continuous System Improvement**
- **Health Care Integration Committee**

P.M.: Planning Council General Session

10. Welcome and Introductions

Chair Claflin began the meeting with introductions from the Planning Council members and the audience.

11. Public Comment

There was no public comment.

12. Report from DHCS

There was no report.

13. Overview of Options and Selection of Option for Mental Health Master Plan

Ms. Adcock stated that the Executive Committee had decided to hire a consultant to explore options for the update of the Mental Health Master Plan.

Consultant Cynthia Burt presented the options she had devised.

- Ms. Burt thanked the Ad Hoc Committee (Ms. Black, Ms. Mitchell, Ms. Prettyman, and Ms. Shaw) for their assistance.
- Ms. Burt explained a chart depicting the unique situation of the Planning Council in the mental health community.
- Ms. Burt presented four options. With each she costed the staff requirements.
 1. First option: **Do nothing.** Cost: \$0.
 2. Second option: **Extract Recommendations.** It would entail placing the 181 recommendations into a matrix and evaluating their status with the questions: Has the mission been accomplished? Is it a county responsibility? Is it an unresolved or pending issue? Cost: \$13,850.
 3. Third option: **Update Unmet Needs.** It would extract the data from the 2003 document and add new identifiers such as TAY, expand the cultural and ethnic communities, create a channel to obtain data on a regular basis, and provide an analysis of the unmet needs identified in the new data. Cost: \$19,100.
 4. Fourth option: **Amend Existing Plan.** It would use the existing structure while adding new data and chapters. Includes Options 2 and 3. Cost: \$132,300.
- Ms. Burt explained the eliminated options.

Questions and Discussion

Mr. Leoni observed that the cost of Create New Plan – an eliminated option – was substantially less (\$116,200) than the cost of **Amend Existing Plan** (\$132,300). Ms. Burt explained that **Create New Plan** would involve a new structure with three perspectives: Consultative, Legal, and Proactive.

Mr. Powelson asked how the current Master Plan has been used throughout the state. Ms. Adcock replied that it was the go-to document for one of former Senator Steinberg’s Chief Analysts for mental health. It was also used in the crafting of the Mental Health Services Act (MHSA). The Planning Council itself didn’t use the Master Plan much.

Mr. Robinson inquired as to whether the Planning Council has the budget for the **Amend Existing Plan** option. Ms. Adcock replied that it does.

Mr. O’Neill asked what kind of timeline framework the Planning Council is considering in reforming the Master Plan. Ms. Adcock replied that this is part of the discussion. The options require the development of an RFP, then the process of receiving and reviewing

proposals; this can take about six months. Then comes the work itself, and the Planning Council needs to decide how to accomplish it.

Mr. Leoni commented that **Update Unmet Needs** would be difficult to do without doing **Extract Recommendations** first. Ms. Burt responded that each of the eight chapters contains recommendations that are easy to lift out. The costs of the two options are separate. Mr. Leoni suggested doing those two options now, then evaluating the situation and possibly creating an amended version.

Ms. Mitchell commented that for new Planning Council members who have not read the Master Plan, it is important to understand what the recommendations look like. She read several of the recommendations for the members. Ms. Burt noted that some of the recommendations have not been completed or are only partially completed. There are also goals in some chapters that are purely aspirational.

Ms. Mitchell added that the update will require some kind of stakeholder input process.

Mr. O'Neill observed that although a contractor may be hired to perform the work, the Planning Council will still need to be intimately involved with it (and the members' efforts are voluntary).

Ms. Shaw reminded the newer members of the process for the original Master Plan. It had been an overwhelming project that consumed the energies of the Planning Council; all meetings for about two years were centered around its composition. Ms. Shaw asked the members to consider how much time they want to devote to this project going forward.

Mr. Ryan asked for the opinion of the four members who had worked on the original Master Plan: Ms. Shaw, Ms. Mitchell, Ms. Prettyman, and Ms. Black.

Ms. Hart added that the Planning Council had spent long evenings as well as days participating in workgroups. They had tried to be both realistic and visionary. She pointed out that some of the original recommendations may not be as relevant today; she also pointed out that the Planning Council must be visionary in whatever it does.

Ms. Derby asked if the estimated costs included the stakeholder process; Ms. Burt replied that they did not.

Mr. Wilson complimented the four original members on the job they had done back then on the Master Plan.

Ms. Shaw spoke regarding the timing: the Planning Council was also going to be choosing whether to go forward with becoming a behavioral health council rather than a mental health council.

Mr. Leoni remembered that although he was not a Planning Council member in 2002-3, he participated in the committee meetings and effected substantive changes to the Master Plan in that way. The stakeholder process had been built in as such.

Ms. Flores agreed with Ms. Shaw that the Planning Council needed to consider writing a Behavioral Health Master Plan.

Ms. Adcock suggested that this may not be the right time to make a decision.

Mr. Wilson felt that setting up a priority that would benefit the consumers as well as the professionals was important.

Mr. Leoni noted that the concept he had mentioned of extracting and updating unmet needs was specific to mental health, and could guide the council in developing a behavioral health side. In any case those two pieces could be done now.

Mr. Ryan recommended modifying and updating Unmet Needs first.

Ms. Prettyman felt that the idea of extracting the information in the Unmet Needs was a good one, providing a base to go on several months from now. With health care reform and the possible merge with substance abuse, this may not be the best time to address rewriting the plan.

Motion: The selection of a combination of options **Extract Recommendations** and **Update Unmet Needs** option was moved by John Ryan, seconded by Noel O'Neill.

Ms. Black recommended deciding which parts of the existing Master Plan are still relevant, adding in the missing elements, and considering the current environment to discern what we need.

Ms. Mitchell noted that she had used the Unmet Needs section to obtain millions of dollars in funding for her county. An expert would now have to look at the chapter to estimate prevalence rates for different types of psychiatric disabilities by age band. They would also need to examine the Poverty Index and the Racial/Ethnic Index – we need someone who can locate the methodology that we would accept. It may be more worthwhile to examine the Unmet Needs section before we extract the recommendations out of the whole plan.

Mr. Leoni pointed out that Extract Recommendations was a platform upon which to look for Unmet Needs.

Chair Claflin called the question. The motion carried unanimously.

14. Substance Abuse Panel and Continued Discussion of Possible Integration to Behavioral Health Council

Ms. Adcock stated that the panel was intended to provide a local-level perspective on being a provider. They were also to address to question of whether the Planning Council's possible merge with the substance abuse component would be advantageous to them.

Ms. Adcock added that Captain Jon Perez from Region 9 would provide a national perspective on the integration to behavioral health.

Panel members were Susan Wilson and Noel O'Neill of the Planning Council (giving a provider perspective); Tom Renfree, Executive Director for Substance Use Services at CBHDA (giving a county perspective); and Jon Perez.

Mr. Renfree began. He stated that the public system of care for substance use disorder, prevention, and treatment is a county-based system. It is administered at the local level by the County Alcohol and Drug Program Administrator.

- 56 of the 58 counties now have some type of integration with mental health.
 - Substance Use Disorder (SUD) has been underfunded compared to mental health. About half the public funding comes from the Substance Abuse Prevention and Treatment (SAPT) block grant, administered by SAMHSA.
 - About 20% is from federal financial participation in the Medi-Cal match program (Drug Medi-Cal). Historically, benefits have been low.
 - About 25% comes from Realignment.
- Health care reform has set a benchmark plan for behavioral health services that substantially increased the kinds of services that can be reimbursed under Drug Medi-Cal.
- Medi-Cal expansion means more federal funding for the 12.2 million newly eligible Californians.
- 70% of the SUD population is childless males who, prior to 2014, were not Medi-Cal eligible. Many came from the criminal justice system.
- If the Drug-MediCal 1115 Waiver is approved by CMS, an organized continuum of care for the SUD population will be the result.

Mr. O'Neill spoke about what an integrated system looks like in a small county.

- Two Boards of Supervisors participate on the Advisory Board. They are well aware of what is happening in the agency.
- Office space is fully physically integrated.
- The Alcohol and Other Drug (AOD) Administrator is also the agency Assistant Director.
- They have separate staff who are certified counselors.
- Both sides use the Anasazi electronic health record. However, because of 42 CFR, there is a firewall between the two systems. Every person receiving dual treatment would need releases on both sides to allow communication between the two.
- The mental health side also has its own division and staff meeting.
- Crisis services are completely unified with staff from both sides participating.
- Both sides attend a weekly staff meeting called Clients of Concern.
- Mr. O'Neill felt that a legislative fix is needed for 42 CFR – confidentiality foils full integration.

- Another problem is that AOD is not well-funded. Until now, mental health would actually help underwrite AOD services – many clients desire both types of treatment.
- With the ACA and the Drug Medi-Cal Waiver, substance use is going to be much better funded – a win for mental health as well.
- Some advantages of the integration:
 - The AB 109 program. When the AOD Administrator attends that community partnership meeting, everyone knows she is speaking for both mental health and AOD.
 - There is no wrong door for consumers. The psychiatrist on the mental health side will be able to sign off for an AOD treatment plan.
 - Staff morale is better, especially on the AOD side.
- In every county, integration is going to look a little different. However, with the ACA, both AOD and mental health are considered essential benefits. Counties want their residents to stay within the county to get the services they need.
- The IMD exclusion will be very beneficial, providing more dollars to spend for mental health kinds of issues.
- If California wins the Certified Community Behavioral Health Clinics grant, the requirement for accreditation will be present for both AOD and mental health; it will raise the bar for level of service.

Ms. Wilson gave a ground floor perspective.

- The counties provide substance disorder treatment in different ways. In Shasta County, no services are provided except perinatal; the rest is outsourced.
- In anticipation of integration, the three treatment centers have worked closely with the county.
 - They are required to attend at least 50% of the Mental Health Board meetings.
 - Everyone who comes through the door applies for Medi-Cal if there is any chance that they are eligible.
- Everyone who comes into SUD treatment has a treatment plan. A new emergency regulation from the DHCS states that the treatment plan must address the physical needs of the client. This change has worked very well for the client.
- Shasta County works closely with the community corrections partnership, which is the AB 109 implementing group. In this area, nearly all the clients need to have both mental health and substance abuse addressed.
- The three treatment centers have contracted with the county to provide education in the jail.

- Nursing students from Simpson College work at least six hours per week in the clinic.
- Every year Shasta County gets an intern from the University of Southern California.
- A weekly clinic on reproductive health care usually draws 40 people.
- First Five Shasta and the Health and Human Services Agency in Shasta County have combined to fund \$50,000 for parenting classes.
- Ms. Wilson commented that with HIPAA, it is difficult to exchange information between physical health, mental health, and SUD providers.
- Funding is slowly but surely increasing. A failure of the system is that most people do not complete their substance use treatment. This is a funding issue as well as a workforce issue.

Captain Perez spoke last.

- Integration is the trend in funding, management, and accreditation criteria.
- Integration facilitates the ability to treat holistically.
- Parity is enforceable now.
- The state of Arizona contracts out to three Regional Behavioral Health Authorities, which must have an entire continuum of care. The health care entities provide a range of services out of the three Regional Behavioral Health Authorities.
- If the 1115 Waiver goes through as written, it will create significant positive changes in the delivery of services.

Questions and Discussion

Mr. Wilson felt that with integration, it is very important for everyone to work together as a team. The main focus for all of us is to ensure that everyone who needs services can get them in the most effective and healthy way.

Ms. Flores commented that in her environment, “integration” includes physical health; the Planning Council uses the term to include mental health and substance abuse only. She asked about that difference. Ms. Adcock stated that to the Planning Council, “integration” means becoming a behavioral health council.

Ms. Adcock has been providing the tools and resources that members need to make an informed decision.

Captain Perez noted that Congressman Tim Murphy will be reintroducing AB 3717; it has potential to change the way health care is funded.

Mr. Leoni reinforced an earlier comment he had made regarding the need to integrate with physical health care. Another integration we have not yet examined is with social services; in California the Full Service Partnerships involve that body. Mr. Leoni

suggested having a Substance Use Council and a Mental Health Council with shared membership.

Mr. O'Neill commented that when two programs such as AOD and mental health are working together they do really support each other.

Mr. Ryan asked about the integration criteria used by the councils in Captain Perez's other three states, and what they are doing now that they didn't do before. Captain Perez responded that their integration was not recent and that their function remains the same – the block grant requires advisory boards for anyone who is receiving federal dollars. He felt that having a unified voice is much more powerful.

Mr. Renfree clarified that years ago California had a Directors Advisory Council for Alcohol and Drug Issues run by the Director of Alcohol and Drug Programs. That council was only advisory and operated at the pleasure of the current director; subsequent directors let it dissolve. That has been the only body comparable to the CMHDA. Counties, however, have Behavioral Health Advisory Boards.

Ms. Wilson answered Ms. Prettyman that Shasta County does have an M.D. on staff. Ms. Prettyman commented that a main concern of many family members is that their children receive mental health but not physical health services.

Ms. Prettyman asked about medical detox. Mr. Renfree answered that acute care hospitals do medical detox. There are freestanding detox programs, but they face the barrier that a state law forbids residential substance use treatment programs from having medical staff.

Ms. Mitchell asked if the state has analyzed the cost of implementing Medi-Cal billing in drug and alcohol programs. Ms. Wilson responded that they all bill Medi-Cal now; the increase is in the number of clients coming in for services, and that is a workforce issue. Mr. Renfree added that the Department of Finance has done calculations on the cost of implementing new services from the state perspective; they have put money in the budget to cover those projected costs.

Ms. Mitchell asked if they have calculated the rise in the cost of a service when staffing and billing time are added in. Mr. Renfree responded that it is a work in progress; they are working with individual counties because of the difference in rates among them.

Ms. Shaw conveyed the concern of many that the IMD Exclusion will spread from SUD to mental health. Mr. Renfree noted that it pertains to short-term residential – 90 days or fewer. He said that currently it is crippling any kind of residential treatment for SUD.

Mr. Mitry said that while being supportive of integration, he is aware of the role that stigma plays in both the mental health and the SUD communities – among both stakeholders and providers. It takes a long time to break those barriers, through education, partnering, and other strategies. He asked about how to reduce stigma.

Captain Perez replied that the closer and more often you work together, the better you work together and stigma decreases. It is the first step that is the most difficult part. Mr. Renfree added that in talking about SUD as a chronic disease, the mental health community can be an important advocate.

Ms. Adcock stated that the Planning Council would continue the discussion in April. Meanwhile the ad hoc group will work on the topic.

(7.) Presentation: Health Care Integration San Diego, Community Health Group

Mr. Grolnic-McClurg introduced George Scolari, Chair of the Healthy San Diego Behavioral Health Work Group, who provided a health plan perspective on integrated physical and mental health care. Mr. Scolari spoke about Healthy San Diego.

- Healthy San Diego is the umbrella under which the five Medi-Cal managed care plans operate: Care 1st, Community Health Group, Health Net, Kaiser, and Molina.
- When Healthy San Diego began in 1998, it was comprised of mainly of children under age 18. Now, everyone on Medi-Cal is under the plan.
- It is a collaborative that is funded directly to the county of San Diego from the state.
- Cal MediConnect, which began in 2014, is the state’s dual demonstration project. It is for Medi-Cal beneficiaries who have full-scope Medi-Cal and Medicare. It is about coordinating care and reducing unnecessary spending.
- The Coordinated Care Initiative is about bringing long-term services and supports to Medi-Cal and Cal MediConnect.
- Mr. Scolari listed all of the Cal MediConnect benefits, including behavioral health.
- A stakeholder advisory committee and a Healthy San Diego Behavioral Health workgroup both meet once a month.
- County providers for all four health plans (excluding Kaiser) have one place to go to get credentialed.
- Mr. Scolari described the Medi-Cal behavioral health delivery system from 1998-2014 which worked well and offered outstanding access, but had no coordination between physical and behavioral health providers.
- Beginning in January 2014 with the expanded Medi-Cal benefits, the health plans became responsible to cover some mental health treatment. A huge number of people came into the system.
- The DHCS and the Department of Managed Health Care make sure that every managed care plan has a network of providers to serve its members.
- Since January 2014 Mr. Scolari has used a “no wrong door” approach.
- He explained the “Timely Access to Behavioral Health Services” directives from the San Diego County Mental Health Plan and the Medi-Cal Managed Care Plan.
- For grievance and appeals, the County Mental Health Plan contracts with the Consumer Center for Health Education & Advocacy which was formed out of

Healthy San Diego. All of the health plans have a grievance and appeals system that is very regulated and complicated.

- The Healthy San Diego Behavioral Health Work Group developed a Pharmacy Contact Card in 1998 and made sure every pharmacy got it. In 2013 the same group also mandated use of its Physical & Behavioral Health Coordination of Care form.
- Mr. Scolari provided a list of advocates.

Questions and Discussion

Mr. Scolari clarified for Ms. Derby that anti-psychotic medication is paid for by the health plan.

Mr. Mitry asked if any education is offered regarding the health system, coverage, grievances, etc. for people from other cultures. Mr. Scolari said that different federally qualified health centers get funding for outreach to sign people up for Medi-Cal. Healthy San Diego also holds health fairs as well as training for primary care doctors and pharmacists.

Mr. Grolnic-McClurg asked if each of the five health plans contracts with its own panels of providers. Mr. Scolari responded that for mild-to-moderate mental health, Kaiser uses its own staff; Community Health Group and Molina use contracted providers; Care First has contracted with a managed behavioral health organization; and Health Net owns Managed Health Network (a managed behavioral health organization).

Mr. Leoni asked about the IMD; Mr. Scolari said that it is covered by county behavioral health in the context of an IMD being a long-term locked psychiatric hospital. It is not a Medi-Cal benefit.

Mr. Leoni raised the issue of seamlessness for clients. He mentioned that the Grievance and Appeals piece would look overwhelming for clients. They are directed to talk first with their providers, but they may find that intimidating. Mr. Scolari responded that with the grievance system for County Mental Health, clients with more serious mental health problems go through the Consumer Center for Health Education and Advocacy – they have a person there who can advocate for them.

17. RECESS

Chair Claflin adjourned the meeting at 4:54 p.m.

Friday, January 16, 2015

18. Welcome and Introductions

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

19. Opening Remarks

Assembly Member Rocky Chavez could not make the meeting.

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

Larry Gasco, Ph.D., California Association of Local Mental Health Boards/Commissions (CALMHB) President, commented that the local mental health boards contain a lot of talent throughout the state. They serve well on CALMHB.

Dr. Gasco hoped to have CALMHB and CMHPC participating in joint projects in the future. He and Ms. Adcock are having preliminary discussions.

Sharon Roth of CALMHB stated that local mental health boards have been requesting training from CALMHB. She and Carol Marasovic have given trainings for the boards in Sonoma, Alameda, and Santa Cruz Counties.

22. Committee Reports

Continuous System Improvement Committee

Ms. Wilson reported on the following.

- The committee had heard a presentation on the intersection of Juvenile Justice and Mental Health in San Diego County.
- Ms. Leonelli had produced three reports from the committee in addition to the Data Notebook:
 - Trauma Informed Care. Content is being added then it will go into committee review.
 - AB 114 Transition of Special Education Mental Health Services from Counties to School Districts. Approved by the committee.
 - Community Forums. Approved by the committee.

The committee requested feedback on the reports from the Planning Council members.

Ms. Adcock stated that she was interested in going into non-English-speaking communities – Vietnamese, Hmong, Spanish, Arab – as she felt that they have issues not being heard. Ms. Adcock was also interested in holding forums in the LGBTQ and Native American communities.

- Ms. Wilson stated that the committee had received very diverse answers to the questions in the Data Notebook. They had received responses from 49 counties, largely due to the efforts of Dr. Dickerson and the CALMHB members' input.
- The committee produced a report giving an overview of the Data Notebook response. They intend to produce more white papers that will delve into areas of the Data Notebook.
- Dr. Dickerson explained the content of the Data Notebook, including basic county data, specialty mental health clients, integrating behavioral and physical health care, measuring access/classifying “new” clients, reducing re-hospitalization/ access to follow-up care, access by unserved and underserved communities,

- effectiveness of services for adults, youth, and parents of children, unmet needs/gaps in services/improvements to existing programs, and barriers to access.
- Ms. Wilson stated that the Data Notebook is an ongoing project – the committee will be starting on the new one immediately. The committee intends to keep five different notebooks to be able to look at change in five-year cycles.
 - This year the committee is looking at juvenile justice, justice as a whole, the intersection between mental health and justice, homelessness/justice/mental health, and so on. The committee may become more thematic in future Data Notebooks.

Questions and Discussion

Mr. Ryan commented that a friend of his, the chair of a local board, considered the Data Notebook very valuable and had plans for using it. Mr. Ryan asked about the 17 counties who had not reported back – what was the barrier? Ms. Wilson replied that those counties are extremely small and the problem is workforce. She stressed that the Data Notebook is for the boards to think about and work on. To address the problem, the committee is going to hold another data training session for the counties this year. Mr. Ryan suggested asking the counties whether the Data Notebook had resulted in any forward movement between the director and the board.

Dr. Dickerson added that of the counties who had not responded, all but one indicated that they were involved in considering or preparing their response. She also emphasized that many of the reports they had received, from small, medium, and large counties alike, were excellent. The counties are welcome to post the information on their websites. Ms. Wilson added that the counties are encouraged to use the information as their Annual Reports to their Boards of Supervisors.

Ms. Wilson stated how pleased they were that Renee Bradley and Sheridan Merritt from the Mental Health Services Oversight and Accountability Commission (MHSOAC) were active on the Continuous System Improvement Committee.

Ms. Wilson added that the Planning Council has active participants on the MHSOAC's Priority Indicators Joint Task Force.

Mr. Leoni stated that a presentation to the MHSOAC on the Data Notebook would be effective. A CALMHB member and a county Mental Health Board chair could also attend.

Ms. Lewis commented that in Los Angeles County, one challenge had been getting the people who contributed the data not to give large voluminous reports. She referred to page 10 in the Data Notebook: the mention of clients who had been referred to primary care. She hoped to get more data on that in the next report. She also hoped to see Los Angeles County listed in Table 3.

Ms. Lewis' other recommendation was to have George Muriel, an expert in AB 114, give a presentation.

Dr. Dickerson stated that she had been told that the three large counties do not capture data on the number of new clients.

Mr. Mitry asked if the surveys that gather information about perceived satisfaction on outcomes and quality of life, include parents of adult children and caregivers. Dr. Dickerson agreed that those populations would be important to include. However, her understanding was that with the data coming from the California Institute for Mental Health (CiMH) Consumer Perception Survey, they have very specific categories. There is a discussion at various state agencies about modifying the survey to reflect current data needs. Mr. Mitry suggested advocating for those groups.

Ms. Hart added that her county captures that information twice a year when people come into the clinic. However, some people typically do not come in.

Ms. Wilson added that the Consumer Perception Survey is not administered consistently across counties – its data is problematic and must be taken with a grain of salt.

Ms. Tucker asked about the forums: would the committee be open to holding them within the deaf community? Ms. Wilson and Dr. Dickerson assented.

Patients' Rights Committee

Ms. Shaw reported on the following.

- The committee discussed the response to a letter they had sent to the Mental Health Directors, relating concerns they identified when they had feedback from the Patient Rights Advocates to the committee's first survey. The first response had been positive while the second had been puzzled.
- They had discussed a letter they were writing to the Mental Health Boards and Commissions with a survey attached, speaking to the Welfare and Institutions Code (WIC) requirements. The letter is finalized and a copy will be sent to the Director. They will use snail mail to try to ensure that the current chair does indeed receive the letter. The committee seeks to bring awareness of patients' rights to the Mental Health Boards.
- They discussed a training meeting sponsored by the state Office of Patients' Rights. The committee is considering doing the exact same survey as last year.
- They are considering looking into patients' rights as they exist in the state hospital system.

Questions and Discussion

Mr. Leoni asked if the committee had looked at the California Institute for Behavioral Health Solutions (CIBHS) project, called the Statewide Clinical Assessment Guidelines. It examines what happens within the clinical assessment for someone coming in for a 5150. CIBHS is open for input at this point.

Mr. Powelson supported the decision to invite mental health boards to look into patients' rights. It honors the influence of those bodies; many of the boards are underutilized and underappreciated.

Health Care Integration Committee

Mr. Grolnic-McClurg reported on the following.

- The committee has been trying to discern what kind of work product is appropriate. Yesterday they made progress in focusing on two areas:
 1. The health plans and supporting best practices within them in providing mental health services to Medi-Cal beneficiaries.
 2. Supporting the best integration and collaboration between the mental health plans and those health plans.
- They decided to write a letter to the Mental Health Boards, suggesting that they may want to invite the head of their local health plans and their Mental Health Director to talk about their local MOU regarding triage and service for mental health beneficiaries.
- They heard a presentation by Dr. Peter Currie, Clinical Director of Behavioral Health, Inland Empire Health Plan. He had argued for the good work a health plan can do if they carve in and retain the mental health benefit for themselves for low to moderate beneficiaries.
- They formally elected a Vice-Chair: Terry Lewis.

Ms. Lewis added that since the Planning Council will be recognizing the importance of CALMHB in the letter, they should attach the compiled list of health care agencies and their meetings.

Mr. Ryan observed that the concrete example of the most experienced health care provider is Kaiser – and their mental health staff is presently on strike. He suggested looking at that system because of its experience with integration and examining its issues. Mr. Grolnic-McClurg noted that prior to 2014, Kaiser was under no responsibility to provide a different level of health care than other managed health plans. Along with all the other health plans, Kaiser has a new responsibility and a Medi-Cal population that is not large. Dr. Currie had pointed out the importance of having a mental health professional in a high position in the organization to educate the other staff. Currently there is a wide variety of approaches among the health plans.

Questions and Discussion

Mr. Leoni suggested that with the steep learning curve the Planning Council was facing regarding the integration with behavioral health, it might behoove the group to include a representative from the Department of Managed Health Care or the Department of Insurance.

Advocacy Committee

Dr. Nelson reported on the following.

- The committee had heard from Roselyna Rosado, Program Administrator for San Diego's In-Home Outreach Team. Their target demographic is those diagnosed with severe mental illness who are not currently enrolled in any system of mental health care. Their approach involves significant persistence and education services to family members and others supporting the individuals. Hearing from this speaker addressed the committee's interest in peer-driven services.

- The committee is working on a document about the development of a peer certification process. Ms. Murphy has drafted a document making an effective case for peer specialist certification. The main barrier to the process is identifying a lead agency. The committee has found that Darrell Steinberg’s group has an interest in moving the process forward. The decision at the moment looks to be one of legislative action; the committee will continue communications with that group.
- The committee is attempting to finalize its Work Plan for 2015. Three topics are of interest to the members:
 - Evaluation of the sufficiency of a culturally diverse mental health workforce.
 - Evaluation of county utilization rates of locked facilities and available options.
 - Evaluation of county strategic reinvestment practices.
- Dr. Nelson shared data on cultural diversity from a website of the Board of Behavioral Sciences that explored the demographic characteristics from a number of licensees surveyed in 2007.

Mr. Leoni mentioned a meeting held by Darrell Steinberg on January 13. He felt that the committee needs to continue collaborating with the “group of committed individuals” on peer certification.

Mr. Leoni felt that the In-Home Outreach Team complements the committee’s objective of reinvestment in the mental health system. The team produced a wonderful report, and they utilize gentle yet effective persistence techniques. Many of the recipients of this in-home outreach can end up under conservatorships in locked facilities. Mr. Leoni explained how this program is run in two-thirds of the county by Telecare, a Full-Service Partnership (FSP) geared to people who have been on the streets.

Ms. Mitchell agreed with Mr. Leoni on the issue of being unable to transfer to the FSP because of restrictions. However, she did not think that the group’s data indicated that they were transferring an inordinate number of people to conservatorships. She had thought that their success rate looked remarkably good. The committee is waiting to receive their data to analyze.

Mr. Leoni concurred, adding that the group was very much hoping to have a residential treatment program of their own.

Ms. Tucker stated how pleased she was that Mr. Powelson had joined the Planning Council. The youth voice is important and necessary.

23. Executive Committee Report

Ms. Adcock reported on the following.

- There are going to be new mechanisms to keep Planning Council members informed on emerging and ongoing issues. Staff attend numerous meetings

around Sacramento and Northern California in order to keep their fingers on the pulse.

- To funnel information to the Planning Council, Ms. Adcock is going to create a monthly report. It will go first to the Executive Committee, who will assign any appropriate items to the various committees.
 - In addition, a Meeting Recap will be instituted. Two to three weeks after the Executive Committee meeting, the Meeting Recap will summarize what they accomplished. It will enable the Executive Committee to pick up where they left off from the prior meeting.
 - For Planning Council meeting report-outs from the DHCS, the MHSOAC, and the CBHDA, the Executive Committee will provide them with topics to be addressed.
- Ms. Adcock is working with a consultant to organize Planning Council work in order to make it meaningful and relevant. With the knowledge and experience around the table, the Planning Council can continue to develop useful products such as the Data Notebook report, the Trauma Informed Care report, the Peer Certification white paper, and so on.

Ms. Adcock suggested selecting a yearly general theme or area of focus, for the presentations at the General Session. At the end of the year, the information collected from the regional meeting, as well as the work of the committees, can roll up into a report on that topic.

(26.) New Business and Council Member Open Discussion – Discuss Areas of Focus

Mr. Wilson felt the idea was good for everyone involved because it would cover a lot of area at one time, and give a broader spectrum of everyone's concerns.

Mr. Leoni also affirmed the ideas and pointed out that this kind of communication would help not only the Planning Council members, but also the public looking over our shoulders.

Ms. Flores saw that this would provide continuity to all reports, the Data Notebook, and the presenters. Using a theme would get the Planning Council more into the trenches. Ms. Adcock informed her that the committees would not have to alter their work plans to focus on the chosen area. She illustrated the idea using workforce as the chosen area: workforce issues include cultural competency, the Office of Statewide Health Planning and Development (OSHPD) Five-Year Strategic Plan, and MHSA services.

Ms. Prettyman felt that if the brainpower of the Planning Council focused on one area, the results would be astronomical. She asked how the area of focus would be decided upon; Ms. Adcock replied that the Executive Committee would make the determination. Other possible areas would be criminal justice/at-risk youth in the juvenile justice system and the overarching question of how the mental health system is doing.

Ms. Flores suggested the topic of homelessness and mental illness.

Mr. Powelson spoke in favor of the topic of at-risk youth in the juvenile justice system – an area in need of consumer empowerment.

Ms. Lewis noted that the Data Notebook had reflected strong concern among the counties about transportation.

Chair Claflin asked for any objections to the theme idea; there were none.

Ms. Mitchell suggested the topic of effective treatment of co-occurring disorders for mental illness and substance abuse, and the cross to the implications of the state and federal policy of housing first before treatment.

Ms. Prettyman suggested the topic of integrating people who are in IMDs or facilities far from their home counties, before they return to their counties.

Ms. Mitchell clarified that she is interested in all age groups, not just TAY, with dual diagnoses. She is interested in the implications of state and federal policy changes in housing and the criminal justice system.

Mr. Ryan suggested the topic of impact of serious mental illness on families – what can the system do to support families?

Ms. Derby suggested the topic of alternative interventions to locked facilities.

Dr. Pitts suggested including the Olmstead implementation in that topic.

Mr. Leoni suggested the topic of the status of evaluation efforts around the state at all levels – agency, county, and state. How much is being done; what kind; the amount of investment.

Mr. Powelson suggested involuntary intensive treatment for minors (the boot camps for troubled kids). Dr. Nelson elaborated that in California there is a greater than average amount of concern regarding the individual rights of minors who are in need of treatment. A cottage industry has developed that transports minors to programs in other states where their individual rights are more restricted.

Mr. Grolnic-McClurg had four suggestions: cultural and ethnic disparities in treatment, the stakeholder process, a specific age group, and the integration.

Ms. Lewis suggested the LGBT population – they are totally unserved and underserved.

Ms. Treadwell suggested adding child welfare to the topic of juvenile justice/at-risk youth.

For New Business, Ms. Treadwell announced that the Department of Social Services issued a legislative report on the continuing care reform on January 9. It is significant in its effort to reform the state congregate care system. Group homes will become short-term residential treatment facilities rather than permitted placements. Providers will be required to have certification from mental health plans or foster family agencies. Accreditation and the assessment process are changing. Ms. Treadwell encouraged the Planning Council members to read the report, entitled *Continuum of Care Reform*.

Ms. Shaw reported that Mr. O'Neill had spoken about the Matsui bill to allow eight states to request a planning process for providing a Federally Qualified Health Center (FQHC).

DHCS must apply to the federal government. Ms. Shaw felt it important for the Planning Council to communicate by letter to DHCS, encouraging them to seek the grant.

Motion: For the Planning Council to support staff to draft and obtain approval for a letter to communicate with Department of Health Care Services that they should pursue obtaining the planning grants that are part of the Excellence in Mental Health Act (HR 4302) was moved by Daphne Shaw, seconded by John Ryan. Motion passed unanimously.

Mr. Leoni reported on the status of the regulatory package for PEI and Innovation. The MHSOAC was going to review it again on January 22. A remaining issue was county-reported demographics. At the last MHSOAC meeting they had wanted to approve the package then start the year-long process over again with amendments. They have done a wonderful job of incorporating public input.

Mr. Leoni also reported that OSHPD's efforts on the Workforce Education and Training (WET) Regulations seem to be on hold.

Mr. Leoni continued that he had attended the DHCS Behavioral Health Forum. The 1915(b) Waiver (Freedom of Choice) is up for renewal. DHCS will be submitting to CMS around March, although there really had not been any public process. Mr. Leoni had requested some kind stakeholder meeting; Dina Kokkos-Gonzales will look into it.

Ms. Adcock responded that OSHPD was moving its proposed regulations forward. They were inviting stakeholder feedback at a meeting on January 26.

24. Public Comment

Sharon Roth, San Mateo County, addressed SB 11, Senator Beall's proposal for mental health training for California peace officers. He is trying to standardize 40 hours of training and mandate an extra four hours in the police academies as well. Ms. Roth also mentioned a major project called Directing Change for high school students to make short films on mental health; they are looking for judges for the films. (Ms. Lewis commented that she is a judge, and that it is a great opportunity to look at unique ways for preventing suicide.)

Dr. Gasco was pleased to hear of plans for the Data Notebook to examine mental illness in the criminal justice system – a critical issue. The other issue regarding the Data Notebook was the experience of Los Angeles County in finalizing its report: the pervasive issue was homelessness. Dr. Gasco also referred to the importance of getting information on patients' rights in each of the counties. All of the statewide organizations will benefit from having contact information with the county boards and mental health commissions (including the staff person for each).

Ken Bonner, Santa Barbara County Mental Health Commissioner and CALMHB member, expressed concern about young people and children in the mental health system. He also expressed concern about the homelessness in every city in this state. We need to have an approach. This problem includes veterans and disabled veterans.

Ms. Jones addressed locked facilities. In Alameda County, the locked facility requires conservatorship. The clients keep recycling. We should ask why they can't maintain

their wellness. Kaiser costs and services should also be looked at, as should homeless people being placed in institutions.

Ms. Shaw mentioned that there had been no report from the DHCS. Could some information on the mental health budget be sent to the Planning Council members? Ms. Adcock assured her that this would happen.

Ms. Shaw clarified the name of the new clinics: Certified Community Behavioral Health Clinics.

Mr. Leoni noted that at that moment in Sacramento, Rusty Selix and a representative of the CBHDA were speaking to the Finance Committee of the MHSOAC on the Governor's Budget. Some of the information would be rolled over to the next full MHSOAC meeting on January 22; a listen-in line would be available for those interested.

25. Report from Mental Health Services Oversight and Accountability Commission

There was no report.

27. Evaluation of the Meeting

There was no evaluation.

28. ADJOURN

In closing, Chair Claflin shared a quote from St. Francis of Assisi:

Start by doing what's necessary, then do what's possible, and suddenly you are doing the impossible.

She adjourned the meeting at 11:26 a.m.

X INFORMATION

TAB SECTION H

ACTION REQUIRED

DATE OF MEETING 4/15/15

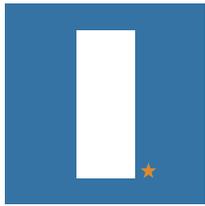
MATERIAL
PREPARED BY: Jane Adcock

DATE MATERIAL
PREPARED 3/17/14

AGENDA ITEM:	Measurements, Outcomes, and Quality Assessment (MOQA)
ENCLOSURES:	Press Release and Data Report
OTHER MATERIAL RELATED TO ITEM:	

ISSUE:

The California Behavioral Health Directors Association (CBHDA) has been working with counties to develop a data dashboard and reporting system to collect information report to the state on the outcomes from the implementation of the Mental Health Services Act in California. On March 11, 2015, along with the Steinberg Institute for Advancing Behavioral Health Policy and Leadership, CBHDA released its first data-driven report. The enclosed report summarizes data from fiscal year 2011-12 and includes some outcomes reported through June 2014.



STEINBERG
INSTITUTE

PO I
LEADERSHIP



MARCH 11, 2015 • SACRAMENTO, CALIFORNIA

In 2014, Senate President pro Tempore Darrell Steinberg (Ret.) founded the Steinberg Institute for Advancing Behavioral Health Policy & Leadership.

Together with the County Behavioral Health Directors Association of California (CBHDA), the Steinberg Institute undertook a survey to quantify what we know: The Mental Health Services Act (MHSA) created in 2004 by Proposition 63 is working.

Since Prop. 63 passed, hundreds of thousands of Californians suffering from the effects of mental illness – including children and families – have utilized local services funded by the Act. Data show that the services offered at the county level provide relief to people with mental illness and their families while also reducing the demands on the criminal justice, healthcare and social services systems.

The attached report summarizes publicly available data on MHSA from the 2011/12 fiscal year, including outcomes reported through June 2014.

By analyzing the life impacts of more than 35,000 Californians who received “Whatever-It-Takes” intensive services in 2011 from MHSA, in addition to the other outcomes produced in this report for 2012 and 2013, the evidence is clear that MHSA is reducing hospitalizations, jail time, out-of-home placement for children, and improving the lives of thousands of people.

This report offers a strong beginning to more regular reporting of outcome-based data that the public and state government can rely on for proper oversight. The authors of this report are committed to working with the California State Legislature and agencies to ensure that going forward there is no question as to the effectiveness of the MHSA program or the means by which the results are proven.

Everyone agrees that to build consensus for sustained mental healthcare funding, the state must demonstrate the effectiveness of existing programs in an objective and consistent way. Californians are entitled to data that shows thousands of real people are being helped as a result of Prop. 63, and that the quality of life is improved for everyone.

Our most important mission is to tell this story, help erase the stigma surrounding mental illness, and encourage those suffering in silence to seek help.

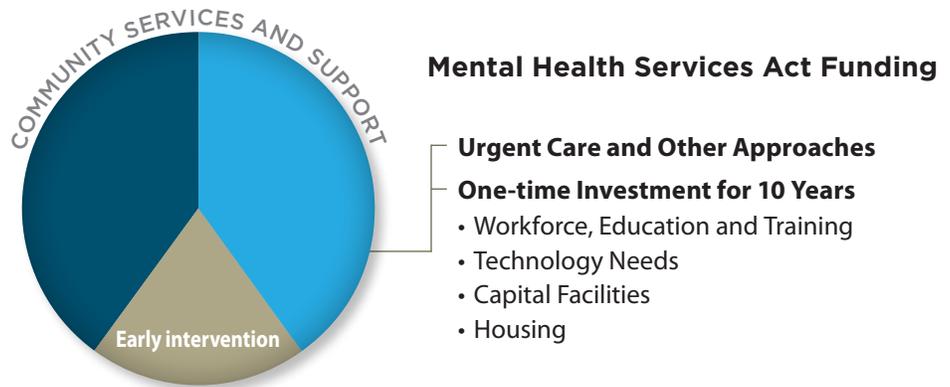
Darrell Steinberg -
Founder, Steinberg Institute -

Robert Oakes
Executive Director, County Behavioral
Health Directors Association of California

Mental Health Services Act Delivering on Promise to Californians

California’s counties, in partnership with the Steinberg Institute for Advancing Behavioral Health Policy & Leadership, present the first comprehensive, data-driven evaluation of the Mental Health Services Act (MHSA). The following evaluation draws from data reported by counties to state agencies for Fiscal Year 2011/12.

The evaluation represents approximately \$500 million of the \$947 million invested in 2011/12 in a range of services delivered at the county level into both full service partnerships: “Whatever-It-Takes” mental health services for the homeless and others with the most severe mental illnesses, and urgent care for those with more moderate conditions.



I. FULL SERVICE PARTNERSHIP PROGRAMS (40%)

“Whatever-It-Takes”

Forty percent of MHSA dollars allocated to counties are directed to intensive Full Service Partnership (FSP) programs. Another 15-20% is dedicated to system improvements such as urgent care for psychiatric emergencies and crisis diversion.

Full Service Partnership programs are intensive services delivered to individuals with the highest mental health needs, such as those who are homeless or at risk of homelessness.

- In FY 2011/12, 35,110 people were served through California county FSP.
- FSP programs produce dramatic improvements in clients’ lives and invest in communities.

A full analysis of the three target populations enrolled in an FSP program for FY 2011/12, Transition Age Youth “TAY” (ages 16-25), Adults (ages 26-59), and Older Adults (60+), showed significant improvements in these categories:

- 1) Homelessness and Emergency Shelter Use
- 2) Emergency Medical and Psychiatric Services (including inpatient care)
- 3) Legal Involvement (arrests and incarcerations)
- 4) Independent Living

Homelessness
DOWN 47%

**Emergency
Mental Health/
Substance
Abuse Care**
DOWN 79%

**Psychiatric
Hospitalizations**
DOWN 42%

Arrests
DOWN 82%

*Above percentages averaged
across all age groups.*

Homelessness and Emergency Shelter Use

Comparing the number of clients who were homeless (living on the street) or in an emergency shelter the year prior to entering an FSP program with those same clients at discharge from an FSP program.

AGE GROUP	BEFORE FSP	AT DISCHARGE	% DECREASE
TAY	10%	7%	▼ 28%
Adults	21%	9%	▼ 54%
Older Adults	9%	4%	▼ 58%

Emergency Mental Health and Substance Use Intervention

Comparing the number of clients who utilized emergency care for a mental health and/or substance use condition (via an Emergency Department admission) the year prior to entering an FSP to the first year enrolled in an FSP program for those clients who were enrolled in FSP for one year or more.

AGE GROUP	BEFORE FSP	AFTER 1+ YEAR OF FSP	% DECREASE
Children	19.2%	4.1%	▼ 79%
TAY	45%	11%	▼ 76%
Adults	46.8%	9.6%	▼ 79%
Older Adults	36.5%	6.2%	▼ 83%

Psychiatric Hospitalizations

Comparing the number of clients who had one or more psychiatric hospitalizations the year prior to entering an FSP program to the number of clients with one or more psychiatric hospitalizations during the first year of FSP for clients who were enrolled in an FSP for one year or more.

AGE GROUP	BEFORE FSP	AFTER 1+ YEAR OF FSP	% DECREASE
Children	13%	8%	▼ 40%
TAY	28%	17%	▼ 41%
Adults	34%	20%	▼ 40%
Older Adults	28%	14%	▼ 50%

Arrests

Comparing the number of clients who were arrested the year prior to entering an FSP to the number of clients with an arrest during the first year of FSP for those clients who were enrolled in FSP for one year or more.

AGE GROUP	BEFORE FSP	AFTER 1+ YEAR OF FSP	% DECREASE
TAY	28%	8%	▼ 71%
Adults	25%	4%	▼ 85%
Older Adults	8%	1%	▼ 90%

Incarcerations
DOWN 27%

Living Independently
UP 14%

Child Out-of-Home Placements
DOWN 60%

Academic Improvement
UP 22%

Incarcerations

Comparing the number of clients who were incarcerated in a county jail the year prior to entering an FSP with the number of clients incarcerated during the first year of FSP for clients who were enrolled in FSP for one year or more.

AGE GROUP	BEFORE FSP	AFTER 1+ YEAR OF FSP	% DECREASE
TAY	24%	19%	▼ 17%
Adults	21%	13%	▼ 41%
Older Adults	5%	4%	▼ 24%

Independent Living

Comparing the number of adults living independently (either in their own apartment or in a Single Room Occupancy unit) the year prior to FSP to the number of clients living independently after two years of FSP services for those clients who were enrolled in FSP for two or more years.

AGE GROUP	BEFORE FSP (living independently)	AFTER 2+ YEARS IN FSP (living independently)	% INCREASE
Adults	4,475	5,117	▲ 14%

CHILDREN

- In 2011/12, 8,968 children were served by Full Service Partnerships at the county level.
- Children enter an FSP program experiencing poor academic performance and residing in out-of-home placements.

A full analysis of children (ages 0-15) enrolled in an FSP program for FY 2011/12 showed significant improvement in the following categories:

- 1) Out-of-home Placement
- 2) Academic Performance

Out-of-Home Placement

Comparing the number of children living in out-of-home placement (Group Home, Level 0-11, 12-14, or Community Treatment Facility) the year prior to FSP to the number of children in out-of-home placement who were enrolled in FSP for two or more years.

AGE GROUP	BEFORE FSP	AFTER 2+ YEARS IN FSP	% DECREASE
Children	808	485	▼ 60%

Academic Performance

Comparing the number of children with good or very good grades at the beginning of FSP with the number of children with good or very good grades after one year of FSP for those children who were enrolled in FSP for one or more years.

AGE GROUP	BEFORE FSP	AFTER 1+ YEAR IN FSP	% INCREASE in good grades
Children	21.5%	27.4%	▲ 22%

Data Open to Public Inspection

The data used to make the conclusions in this evaluation is reported by each county to the Department of Health Care Services (DHCS) and the Mental Health Services Oversight and Accountability Commission (MHSOAC) via the County's Annual Update for MHSOAC Three-Year Program and Expenditure Plan on an annual basis. This data is open to public review.

II. URGENT CARE AND OTHER APPROACHES (20%)

In addition to the 40% invested in Full Service Partnership programs, an additional 15-20% of MHSOAC funds allocated to counties are directed to meet a wide range of client needs from crisis response, employment support, housing, and strategies to identify at-risk individuals and connect them with support needed before a crisis event.

Each county develops a plan based on its unique needs, in consultation with stakeholders and has this plan approved by the local Board of Supervisors. Below is a sample of the diverse ways counties respond to local needs, and the results delivered by local communities.

Urgent Care and Crisis Stabilization: Three Representative California Counties

BUTTE COUNTY

Crisis Stabilization

The Crisis Stabilization Program in Butte County immediately connects individuals 24 hours a day, 7 days a week to a mental health professional for telephone intervention, information or referrals. Walk-in counseling is also available 8:00 am to 5:00 pm for individuals to receive face-to-face crisis intervention and assessment.

An average of 61% of consumers who were in the Crisis Stabilization Program were not admitted to an inpatient setting (Psychiatric Health Facility or out-of-county hospitalization) within the same fiscal year. In the first year of the Crisis Stabilization Program (2008-09), 100 were assisted in alternatives to inpatient care. In 2013-14, the program diverted 515 individuals from hospitalization, a four-fold change within the six fiscal years.

Youth hospitalizations decreased by 75% from July 2008 through June 2014.





SAN BERNARDINO COUNTY

Psychiatric Triage Diversion Program

In San Bernardino County, the Psychiatric Triage Diversion program was created to address and minimize inappropriate and/or unnecessary admissions to the county Arrowhead Regional Medical Center inpatient psychiatric unit, as well as provide linkages to an array of community mental health services and supports.

- In FY 2012/13 to FY 2013/14, 7,563 people were screened/assessed by the Triage Diversion Team.
- Of those screened, 82% were diverted from unnecessary hospitalization.

Community Crisis Response Team

The Community Crisis Response Team (CCRT) in San Bernardino County utilizes specially trained mobile crisis response teams to provide crisis interventions, assessments, case management, relapse prevention, medication referrals, and linkage to resources through collaboration with law enforcement, hospitals, Children and Family Services, Adult Protective Services, schools, and other community organizations.

- The CCRT receives over 7,000 calls per year.
- Approximately 60% of the calls received are crisis calls.
- Of those crisis calls, nearly 50% of the clients were diverted from unnecessary hospitalization.
- Only 32% of clients receiving services from CCRT are admitted to a psychiatric inpatient facility within 30 days of the visit.

LOS ANGELES COUNTY

Mental Health Urgent Care Centers (UCC)

In Los Angeles County in FY 13-14, Mental Health Urgent Care Centers served 26,350 clients and achieved the following outcomes:

- Only 6% of clients visiting a Mental Health Urgent Care Center are seen in a psychiatric emergency department within 30 days of the UCC visit.
- Only 11% of clients visiting a Mental Health Urgent Care Center are admitted to a psychiatric inpatient facility within 30 days of the UCC visit.

***Mental Health Urgent Care Centers** provide an array of mental health crisis services such as screening, assessment, crisis intervention, medication services, referrals, and short-term treatment for adolescents and adults. These centers also provide linkages to services and support.*



Total
Cost Savings
\$87,479,568

III. OTHER KEY FINDINGS

Full Service Partnership Programs: Dramatic Cost Savings

The Mental Health Services Oversight and Accountability Commission (MHSOAC) contracted with the University of California, Los Angeles in 2012 to perform a cost analysis of FSP programs in each California county, comparing per-client program expenditures with cost offsets realized through the program. The study reviewed data from two fiscal years: FY 2008/09 and FY 2009/10. The cost offsets are not exhaustive, and they only include reductions in expenditures for:

- Inpatient Psychiatric Hospitalizations
- Long Term Psychiatric Care
- Juvenile Hall and Camp Involvement
- Skilled Nursing Facilities
- Emergency Room Use
- Jail

Total Full Service Partnership Services: Costs and Cost Savings

AGE GROUP	NEW FSP ENROLLEES	TOTAL COST FOR NEW FSP ENROLLEES	TOTAL COST SAVINGS	PERCENT SAVINGS
TAY (16-25)	2,977	\$ 18,681,553	\$ 27,501,007	147%
Adults (26-64)	4,702	\$ 56,212,502	\$ 56,120,875	100%
Older Adults (65+)	645	\$ 5,325,034	\$ 3,857,684	72%
TOTAL	8,324	\$80,219,091	\$87,479,568	109%

IV. MENTAL HEALTH WORKFORCE DEVELOPMENT

When voters passed Proposition 63, they called on California to address the long-standing shortage of qualified mental health workers who reflect the rich array of cultures and ethnicities in our state. A 2008 University of California San Francisco (UCSF) report on the mental health workforce in California found that the vacancy rate for mental health providers in California was 20-25%; these numbers are higher in rural areas.

An influx of new students in the mental health professions will be needed in order to serve a growing number of Californians. In addition, a more diverse mental health workforce is desired in order to better reflect the increasing diversity in California's population.

To build a stronger and more diverse mental health workforce, a 10-year investment of \$444.5 million in MHSA funds was set aside for programs to recruit and train employees at all levels. About half (\$228 million) of these funds are for local and regional strategies, and the other half (\$216.5 million) for statewide approaches.

To attract new people to work in the mental health field, efforts are being made throughout California to recruit high school students into these careers, and offer loan repayment, scholarships, and stipends to people who want to pursue mental health careers. Since FY 2008/09, 4,110 individuals have benefited from a new mental health loan assumption program, and 2,687 graduate students have received stipends to help with the cost of their schooling (1,838 Master's in Social Work students, 474 Master's in Marriage and Family Therapy students, 283 Clinical Psychology PhD students, and 92 psychiatric nurse mental health practitioners).

V. MHSA STATEWIDE HOUSING PROGRAM

The Mental Health Service Act Housing Program was developed to create permanent supportive housing opportunities for Californians with mental illness, who are either homeless or at risk of homelessness. A number of research studies have demonstrated the benefits of permanent supported housing for individuals living with a mental illness including reductions in hospitalizations and improved clinical outcomes.

In 2007, a one-time allocation of \$400 million was set aside for a statewide housing program. With interest, the fund has grown to \$422.8 million. These program funds are managed by the California Department of Health Care Services and the California Housing Finance Agency.

With 51 counties participating, 82% (\$350.8 million) of the MHSA Housing Program funds have been allocated to provide capital loans and long term operating subsidies for the development of affordable rental housing for 2,270 individuals, some of whom are veterans and Transition Age Youth leaving the foster care system. Each county's Department of Behavioral Health provides the tenants with an array of supportive services needed for recovery and the opportunity to become fully functioning community members.

The majority of funding and projects are still in development. It is estimated that the program funds allocated to date will leverage over \$2.8 billion dollars for the development of more than 9,000 affordable units in 157 rental housing properties throughout California.

VI. THE EVALUATION PROCESS

The Full Service Partnership outcome data referenced in this report are collected by providers of FSP services. Upon each client's entry into an FSP program, the provider team gathers information on the client's living arrangements, employment/education status, utilization of emergency mental health and substance use services as well as other data for the year prior to the client entering the program. When a client's status changes in any of these areas, that information is entered into a data collection and reporting system.

State regulations for MHSA Community Services and Supports dictate the data that must be collected and reported for each FSP client served and data submitted meets verification criteria.

CBHDA and the Steinberg Institute will update this data on a bi-annual basis for County MHSA programs and expand the analysis to include Prevention and Early Intervention programs which account for 20% of county MHSA dollars.

Plans for Updating Data

The County Behavioral Health Directors Association of California and the Steinberg Institute will update this data in six months and annually thereafter.

How Client Progress was Evaluated

35,110 clients were tracked from the year before they received services to one full year after receiving services.

Upon enrollment in an FSP program, a history is taken of each client's living arrangements, hospitalizations, legal involvement, income, employment, and education status, as well as access to healthcare, for the year prior to entering an FSP. As any of those statuses change after enrollment, the FSP provider enters the status change into the state database.

As a result of this data collection approach, the impact of FSP services on the clients served can be clearly tracked and documented.

This information is reported by each county to the Department of Health Care Services (DHCS) and the Mental Health Services Oversight and Accountability Commission (MHSOAC) on an annual basis.

March 11, 2015

INFORMATION

TAB SECTION I

ACTION REQUIRED

DATE OF MEETING 04/15/15

MATERIAL

DATE MATERIAL

PREPARED BY: Adcock

PREPARED 03/18/15

AGENDA ITEM:	Behavioral Health Integration: National Perspective
ENCLOSURES:	
OTHER MATERIAL RELATED TO ITEM:	

ISSUE:

In October 2014, representatives from the Department of Health Care Services presented information and detail on the funding sources and delivery systems for substance abuse services in California. At the January 2015 Council meeting, provider representatives from the California Behavioral Health Directors Association and our own Susan Wilson and Noel O'Neill presented and discussed issues, challenges and successes from the substance abuse provider perspective.

These presentations provided Council members with background information to inform their discussion and contemplation whether to become a Behavioral Health Council. The next step in the process is to begin the discussion whether to integrate.

Jon T. Perez, Ph.D., Regional Administrator, Region IX, Substance Abuse and Mental Health Administration and Bruce D. Emery, M.Ed., MSW, Advocates for Human Potential will present and discuss the trends and drivers of integration to Behavioral Health from the national perspective. Additionally, Bruce will facilitate the Council's discussion.

It is anticipated that 1 of 2 outcomes from this discussion will occur: either the Council will arrive at a decision or the Council will identify further information needed to deliberate and decide. Stakeholder input into the deliberation is welcome.

INFORMATION

TAB SECTION J

ACTION REQUIRED

DATE OF MEETING 04/16/15

MATERIAL

DATE MATERIAL

PREPARED BY: Adcock

PREPARED 03/18/15

AGENDA ITEM:	Office of Statewide Health Planning and Development: Status of WET 5-Year Plan Implementation
ENCLOSURES:	
OTHER MATERIAL RELATED TO ITEM:	

ISSUE:

Lupe Alonzo-Diaz and Brent Houser of the Healthcare Workforce Development Division from the Office of Statewide Health Planning and Development will update Council members on the status of the implementation of the various elements contained within the Workforce Education and Training (WET) Five-Year Plan.