

California Mental Health Planning Council

Advocacy Committee

Thursday, October 15, 2015

Lake Natoma Inn
702 Gold Lake Drive
Folsom, Ca 95630
916-351-1500

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

Time	Topic	Facilitator/Presenter	Tab
8:30 a.m.	Welcome and Introductions	Adam Nelson, MD., Chair	
8:35	Agenda Review	Adam Nelson	
8:37	Approval of September Minutes	Erica Canaan, Staff	A
8:40	Council Requests/New Business	Adam Nelson	
8:45	Identify new Chair & Chair-Elect	Adam Nelson	
9:05	Legislative Platform Update	Adam Nelson	B
9:20	Megan Sussman, Representative from Congresswoman Doris Matsui's Office; Federal Legislation; Excellence in Mental Health and the Murphy Bills	Adam Nelson	C
10:20	Break		
10:30	Next Steps – Work Plan Discussion	Adam Nelson	
11:15	Legislative Issues/Updates (tentative)	Adam Nelson	
11:35	Public Comment	Adam Nelson	
11:45	Develop Report-Out	Adam Nelson	
11:50	WWW/ Plan for Future Meetings	Erica Canaan, Staff	
11:55	Plus/Delta	Adam Nelson	
Noon	Adjourn		

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

Committee Members:

Chair: Adam Nelson, MD

Chair-Elect:

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

If reasonable accommodations are required, please contact the CMHPC at (916) 323-4501 not less than 5 working days prior to the meeting date.

California Mental Health Planning Council

Vision and Mission

Vision

The CMHPC envisions a mental health system that makes it possible for individuals to lead full and productive lives. The system incorporates public and private resources to offer community-based services that embrace recovery and wellness. The services are culturally competent, responsive, timely, and accessible to all of California's populations.

Mission

The CMHPC evaluates the mental health system for accessible and effective care. It advocates for an accountable system of seamless, responsive mental health services that are strength-based, consumer and family driven, recovery-oriented, culturally competent, and cost-effective. To achieve these ends, the Council educates the general public, the mental health constituency, and legislators.

**CMHPC
ADVOCACY COMMITTEE
CHARTER 2013**

Purpose: The purpose of the Advocacy Committee is to address public issues affecting the effectiveness of mental health programs and quality of life for persons living with mental illness. This includes increasing public mental health awareness through press and media, partnering with local consumer advocacy agencies for access and improved quality of care, and responding to proposed legislation, rule-making, and budget bills based on the CMHPC platform.

Mandate: WIC 5772. The California Mental Health Planning Council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:

- (a) To advocate for effective, quality mental health programs.
- (e) To advise the Legislature, the State Department of Health Care Services, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.
- (j) To advise the Director of Health Care Services on the development of the state mental health plan and the system of priorities contained in that plan.
- (k) To assess periodically the effect of realignment of mental health services and any other important changes in the state's mental health system, and to report its findings to the Legislature, the State Department of Health Care Services, local programs, and local boards, as appropriate.
- (l) To suggest rules, regulations, and standards for the administration of this division.

Guiding Principles: All advocacy efforts and proposed legislation shall be reviewed to ensure that the following best practices and principles are included.

Cultural Competence	Full Accessibility across the life span	Wellness & Recovery
Community Collaboration	Consumer & Family member driven or influenced	Integrated Services <i>End of description</i>

OBJECTIVES:

1. Review and respond to pending legislation, proposed code language, regulatory, and judicial actions that diminishes or adversely affects MHSAs programs and compromises the state mental health plan.
2. Inform a mental health system that incorporates public and private resources to offer community-based services that embrace recovery and wellness, and are strength-based, culturally competent, and cost-effective.
3. Develop talking points to use for education and commentary on mental health issues in the media.
4. Respond to and partner with Consumer agencies and family member organizations to support their activities when needed.

Roles and Responsibilities:

**CMHPC
ADVOCACY COMMITTEE
CHARTER 2013**

Regular attendance of committee members is expected in order for the Committee to function effectively. If a committee has difficulty achieving a quorum due to the continued absence of a committee member, the committee chairperson will discuss with the member the reasons for his or her absence. If the problem persists, the committee chair can request that the Executive Committee remove the member from the committee.

Members are expected to serve as advocates for the committee's charge, and as such, could include, but are not limited to:

- Attend meetings
- Speak - when authorized - at relevant conferences and summits when requested by the committee or the Planning Council
- Participate in the development products such as white papers, opinion papers, and other documents
- Distribute the committee's white papers and opinion papers to their represented communities and organizations
- Assist in identifying speakers for presentations

Materials will be distributed as far in advance as possible in order to allow time for review before the meetings. Members are expected to come prepared in order to ensure effective meeting outcomes.

Membership:

Name
<i>Adam Nelson, MD, Chair</i>
<i>Kathleen Derby, Chair-Elect</i>
<i>Nadine Ford</i>
<i>Carmen Lee</i>
<i>Steve Leoni</i>
<i>Barbara Mitchell</i>
<i>Maya Petties, PsyD</i>
<i>Darlene Prettyman</i>
<i>John Ryan</i>
<i>Daphne Shaw</i>
<i>Arden Tucker</i>
<i>Monica Wilson, PhD</i>
<i>Staff: Andi Murphy (916) 324-0777 Andi.murphy@cmhpc.ca.gov</i>

**CMHPC
ADVOCACY COMMITTEE
CHARTER 2013**

General Principles of Collaboration:

The following general operating principles are proposed to guide the committee's deliberations:

- The committee's mission will be best achieved by relationships among the members characterized by mutual trust, responsiveness, flexibility, and open communication.
- It is the responsibility of all members to work toward the committee's common goals.
- To that end, members will:
 - Commit to expending the time, energy and organizational resources necessary to carry out the committee's mission
 - Be prepared to listen intently to the concerns of others and identify the interests represented
 - Ask questions and seek clarification to ensure they fully understand other's interests, concerns and comments
 - Regard disagreements as problems to be solved rather than battles to be won
 - Be prepared to "think outside the box" and develop creative solutions to address the many interests that will be raised throughout the Committee's deliberations

Decision Making:

The Committee will work to find common ground on issues and strive to seek consensus on all key issues. Every effort will be made to reach consensus, and opposing views will be explained. In situations where there are strongly divergent views, members may choose to present multiple recommendations on the same topic. If the Committee is unable to reach consensus on key issues, decisions will be made by majority vote. Minority views will be included in the meeting highlights.

Meeting Protocols:

The Committee's decisions and activities will be captured in a highlights document, briefly summarizing the discussion and outlining key outcomes during the meeting. Viewpoints will be recorded, but not be attributed to a specific member. The meeting highlights will be distributed to the Committee within one month following the meeting. Members will review and approve the previous meeting's highlights at the beginning of the following meeting.

Media Inquiries:

In the event the Committee is contacted by the press, the Chairperson will refer the request to the CMHPC's Executive Officer.

State Statutes - Welfare and Institution Code

4033. (a) The State Department of Health Care Services shall, to the extent resources are available, comply with the Substance Abuse and Mental Health Services Administration federal planning requirements. The department shall update and issue a state plan, which may also be any federally required state service plan, so that citizens may be informed regarding the implementation of, and long-range goals for, programs to serve mentally ill persons in the state. The department shall gather information from counties necessary to comply with this section.

(b) (1) If the State Department of Health Care Services makes a decision not to comply with any Substance Abuse and Mental Health Services Administration federal planning requirement to which this section applies, the State Department of Health Care Services shall submit the decision, for consultation, to the California Mental Health Directors Association, the California Mental Health Planning Council, and affected mental health entities.

(2) The State Department of Health Care Services shall not implement any decision not to comply with the Substance Abuse and Mental Health Services Administration federal planning requirements sooner than 30 days after notification of that decision, in writing, by the Department of Finance, to the chairperson of the committee in each house of the Legislature which considers appropriations, and the Chairperson of the Joint Legislative Budget Committee.

5400. The Director of Health Care Services shall administer this part and shall adopt rules, regulations, and standards as necessary. In developing rules, regulations, and standards, the Director of Health Care Services shall consult with the California Mental Health Directors Association, the California Mental Health Planning Council, and the office of the Attorney General. Adoption of these standards, rules, and regulations shall require approval by the California Mental Health Directors Association by majority vote of those present at an official session.

Wherever feasible and appropriate, rules, regulations, and standards adopted under this part shall correspond to comparable rules, regulations, and standards adopted under the Bronzan-McCorquodale Act. These corresponding rules, regulations, and standards shall include qualifications for professional personnel.

Regulations adopted pursuant to this part may provide standards for services for chronic alcoholics which differ from the standards for services for the mentally disordered.

5514. There shall be a five-person Patients' Rights Committee formed through the California Mental Health Planning Council. This committee, supplemented by two ad hoc members appointed by the chairperson of the committee, shall advise the Director of Health Care Services and the Director of State Hospitals regarding department policies and practices that affect patients' rights. The committee shall also review the advocacy and patients' rights components of each county mental health plan or performance contract and advise the Director of Health Care Services and the Director of State Hospitals concerning the adequacy of each plan or performance contract in protecting patients' rights. The ad hoc members of the committee shall be persons with substantial experience in establishing and providing independent advocacy services to recipients of mental health services.

State Statutes - Welfare and Institution Code

5604.2. (a) The local mental health board shall do all of the following:

- (1) Review and evaluate the community's mental health needs, services, facilities, and special problems.
 - (2) Review any county agreements entered into pursuant to Section 5650.
 - (3) Advise the governing body and the local mental health director as to any aspect of the local mental health program.
 - (4) Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.
 - (5) Submit an annual report to the governing body on the needs and performance of the county's mental health system.
 - (6) Review and make recommendations on applicants for the appointment of a local director of mental health services. The board shall be included in the selection process prior to the vote of the governing body.
 - (7) Review and comment on the county's performance outcome data and communicate its findings to the California Mental Health Planning Council.
 - (8) Nothing in this part shall be construed to limit the ability of the governing body to transfer additional duties or authority to a mental health board.
- (b)** It is the intent of the Legislature that, as part of its duties pursuant to subdivision (a), the board shall assess the impact of the realignment of services from the state to the county, on services delivered to clients and on the local community.

5610. (a) Each county mental health system shall comply with reporting requirements developed by the State Department of Health Care Services, in consultation with the California Mental Health Planning Council and the Mental Health Services Oversight and Accountability Commission, which shall be uniform and simplified. The department shall review existing data requirements to eliminate unnecessary requirements and consolidate requirements which are necessary. These requirements shall provide comparability between counties in reports.

(b) The department shall develop, in consultation with the Performance Outcome Committee, the California Mental Health Planning Council, and the Mental Health Services Oversight and Accountability Commission, pursuant to Section 5611, and with the California Health and Human Services Agency, uniform definitions and formats for a statewide, nonduplicative client-based information system that includes all information necessary to meet federal mental health grant requirements and state and federal Medicaid reporting requirements, as well as any other state requirements established by law. The data system, including performance outcome measures reported pursuant to Section 5613, shall be developed by July 1, 1992.

(c) Unless determined necessary by the department to comply with federal law and regulations, the data system developed pursuant to subdivision (b) shall not be more costly than that in place during the 1990-91 fiscal year.

(d) – (f) provides additional requirements regarding reporting/data.

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5611. (a) The Director of Mental Health shall establish a Performance Outcome Committee, to be comprised of representatives from the PL 99-660 Planning Council and the California Conference of Local Mental Health Directors. Any costs associated with the performance of the duties of the committee shall be absorbed within the resources of the participants.

(b) Major mental health professional organizations representing licensed clinicians may participate as members of the committee at their own expense.

(c) The committee may seek private funding for costs associated with the performance of its duties.

5614.5. (a) The department, in consultation with the Quality Improvement Committee which shall include representatives of the California Mental Health Planning Council, local mental health departments, consumers and families of consumers, and other stakeholders, shall establish and measure indicators of access and quality to provide the information needed to continuously improve the care provided in California's public mental health system.

(b) The department in consultation with the Quality Improvement Committee shall include specific indicators in all of the following areas:

(1) Structure.

(2) Process, including access to care, appropriateness of care, and the cost effectiveness of care.

(3) Outcomes.

(c) Protocols for both compliance with law and regulations and for quality indicators shall include standards and formal decision rules for establishing when technical assistance, and enforcement in the case of compliance, will occur. These standards and decision rules shall be established through the consensual stakeholder process established by the department.

(d) The department shall report to the legislative budget committees on the status of the efforts in Section 5614 and this section by March 1, 2001. The report shall include presentation of the protocols and indicators developed pursuant to this section or barriers encountered in their development.

5664. In consultation with the California Mental Health Directors Association, the State Department of Health Care Services, the Mental Health Services Oversight and Accountability Commission, the California Mental Health Planning Council, and the California Health and Human Services Agency, county mental health systems shall provide reports and data to meet the information needs of the state, as necessary.

5664.5. (a) County mental health systems shall continue to provide data required by the State Department of Health Care Services to establish uniform definitions and time increments for reporting type and cost of services received by local mental health program clients.

(b) This section shall remain in effect only until January 1, 1994, and as of that date is repealed, unless a later enacted statute, which becomes effective on or before January 1, 1994, deletes or extends the dates on which it is repealed; or until the date upon which the director informs the Legislature that the new data system is established pursuant to Section 5610, whichever is later, unless the provisions of the section are required by the federal government.

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5701.1. Notwithstanding Section 5701, the State Department of Health Care Services, in consultation with the California Mental Health Directors Association and the California Mental Health Planning Council, may utilize funding from the Substance Abuse and Mental Health Services Administration Block Grant, awarded to the State Department of Health Care Services, above the funding level provided in federal fiscal year 1998, for the development of innovative programs for identified target populations, upon appropriation by the Legislature.

5732. (a) Given the requirements of Public Law 99-660 and the significant policy issues currently facing the mental health system in California, a master plan for mental health is required which integrates these planning and reform efforts and which establishes priorities for the service delivery system and analyzes critical policy issues.

(b) The California Planning Council's scope shall be expanded to include the development of the Mental Health Master Plan. This Mental Health Master Plan shall be distinct but compatible with the plan mandated by Public Law 99-660, the development and implementation of which is the responsibility of the State Department of Mental Health.

(c) Therefore, the California Planning Council required by Public Law 99-660 shall be expanded to include the following members:

- (1) The Speaker of the Assembly shall recommend to the Governor for appointment, one council member.
- (2) The Assembly Minority Floor Leader shall recommend to the Governor for appointment, one council member.
- (3) The President pro Tempore of the Senate shall recommend to the Governor for appointment, one council member.
- (4) The Senate Minority Floor Leader shall recommend to the Governor for appointment, one council member.
- (5) The County Supervisors Association of California shall recommend to the Governor for appointment, one council member.

(d) The Mental Health Master Plan shall be completed and submitted to the Legislature and the Governor by October 1, 1991.

5750. The State Department of Health Care Services shall administer this part and shall adopt standards for the approval of mental health services, and rules and regulations necessary thereto. However, these standards, rules, and regulations shall be adopted only after consultation with the California Mental Health Directors Association and the California Mental Health Planning Council.

5771. (a) Pursuant to Public Law 102-321, there is the California Mental Health Planning Council. The purpose of the planning council shall be to fulfill those mental health planning requirements mandated by federal law.

(b) (1) The planning council shall have 40 members, to be comprised of members appointed from both the local and state levels in order to ensure a balance of state and local concerns relative to planning.

- (2)** As required by federal law, eight members of the planning council shall represent various state departments.

State Statutes - Welfare and Institution Code

(3) Members of the planning council shall be appointed in a manner that will ensure that at least one-half are persons with mental disabilities, family members of persons with mental disabilities, and representatives of organizations advocating on behalf of persons with mental disabilities. Persons with mental disabilities and family members shall be represented in equal numbers.

(4) The Director of Health Care Services shall make appointments from among nominees from various mental health constituency organizations, which shall include representatives of consumer-related advocacy organizations, representatives of mental health professional and provider organizations, and representatives who are direct service providers from both the public and private sectors. The director shall also appoint one representative of the California Coalition on Mental Health.

(c) Members should be balanced according to demography, geography, gender, and ethnicity. Members should include representatives with interest in all target populations, including, but not limited to, children and youth, adults, and older adults.

(d) The planning council shall annually elect a chairperson and a chair-elect.

(e) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

(f) In the event of changes in the federal requirements regarding the structure and function of the planning council, or the discontinuation of federal funding, the State Department of Health Care Services shall, with input from state-level advocacy groups, consumers, family members and providers, and other stakeholders, propose to the Legislature modifications in the structure of the planning council that the department deems appropriate.

5771.1. The members of the Mental Health Services Oversight and Accountability Commission established pursuant to Section 5845 are members of the California Mental Health Planning Council. They serve in an ex officio capacity when the council is performing its statutory duties pursuant to Section 5772. Such membership shall not affect the composition requirements for the council specified in Section 5771.

5771.3. The California Mental Health Planning Council may utilize staff of the State Department of Health Care Services, to the extent they are available, and the staff of any other public or private agencies that have an interest in the mental health of the public and that are able and willing to provide those services.

5771.5. (a) (1) The Chairperson of the California Mental Health Planning Council, with the concurrence of a majority of the members of the California Mental Health Planning Council, shall appoint an executive officer who shall have those powers delegated to him or her by the council in accordance with this chapter.

(2) The executive officer shall be exempt from civil service.

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(b) Within the limit of funds allotted for these purposes, the California Mental Health Planning Council may appoint other staff it may require according to the rules and procedures of the civil service system.

5772. The California Mental Health Planning Council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:

(a) To advocate for effective, quality mental health programs.

(b) To review, assess, and make recommendations regarding all components of California's mental health system, and to report as necessary to the Legislature, the State Department of Health Care Services, local boards, and local programs.

(c) To review program performance in delivering mental health services by annually reviewing performance outcome data as follows:

(1) To review and approve the performance outcome measures.

(2) To review the performance of mental health programs based on performance outcome data and other reports from the State Department of Health Care Services and other sources.

(3) To report findings and recommendations on programs' performance annually to the Legislature, the State Department of Health Care Services, and the local boards.

(4) To identify successful programs for recommendation and for consideration of replication in other areas. As data and technology are available, identify programs experiencing difficulties.

(d) When appropriate, make a finding pursuant to Section 5655 that a county's performance is failing in a substantive manner. The State Department of Health Care Services shall investigate and review the finding, and report the action taken to the Legislature.

(e) To advise the Legislature, the State Department of Health Care Services, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.

(f) To periodically review the state's data systems and paperwork requirements to ensure that they are reasonable and in compliance with state and federal law.

(g) To make recommendations to the State Department of Health Care Services on the award of grants to county programs to reward and stimulate innovation in providing mental health services.

(h) To conduct public hearings on the state mental health plan, the Substance Abuse and Mental Health Services Administration block grant, and other topics, as needed.

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- (i)** In conjunction with other statewide and local mental health organizations, assist in the coordination of training and information to local mental health boards as needed to ensure that they can effectively carry out their duties.
- (j)** To advise the Director of Health Care Services on the development of the state mental health plan and the system of priorities contained in that plan.
- (k)** To assess periodically the effect of realignment of mental health services and any other important changes in the state's mental health system, and to report its findings to the Legislature, the State Department of Health Care Services, local programs, and local boards, as appropriate.
- (l)** To suggest rules, regulations, and standards for the administration of this division.
- (m)** When requested, to mediate disputes between counties and the state arising under this part.
- (n)** To employ administrative, technical, and other personnel necessary for the performance of its powers and duties, subject to the approval of the Department of Finance.
- (o)** To accept any federal fund granted, by act of Congress or by executive order, for purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.
- (p)** To accept any gift, donation, bequest, or grants of funds from private and public agencies for all or any of the purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.

5814. (a) (1) This part shall be implemented only to the extent that funds are appropriated for purposes of this part. To the extent that funds are made available, the first priority shall go to maintain funding for the existing programs that meet adult system of care contract goals. The next priority for funding shall be given to counties with a high incidence of persons who are severely mentally ill and homeless or at risk of homelessness, and meet the criteria developed pursuant to paragraphs (3) and (4).

(2) The Director of Health Care Services shall establish a methodology for awarding grants under this part consistent with the legislative intent expressed in Section 5802, and in consultation with the advisory committee established in this subdivision.

(3) (A) The Director of Health Care Services shall establish an advisory committee for the purpose of providing advice regarding the development of criteria for the award of grants, and the identification of specific performance measures for evaluating the effectiveness of grants. The committee shall review evaluation reports and make findings on evidence-based best practices and recommendations for grant conditions. At not less than one meeting annually, the advisory committee shall provide to the director written comments on the performance of each of the county programs. Upon request by the department, each participating county that is the subject of a comment shall provide a written response to the comment. The department shall comment on each of these responses at a subsequent meeting.

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- (B)** The committee shall include, but not be limited to, representatives from state, county, and community veterans' services and disabled veterans outreach programs, supportive housing and other housing assistance programs, law enforcement, county mental health and private providers of local mental health services and mental health outreach services, the Department of Corrections and Rehabilitation, local substance abuse services providers, the Department of Rehabilitation, providers of local employment services, the State Department of Social Services, the Department of Housing and Community Development, a service provider to transition youth, the United Advocates for Children of California, the California Mental Health Advocates for Children and Youth, the Mental Health Association of California, the California Alliance for the Mentally Ill, the California Network of Mental Health Clients, the California Mental Health Planning Council, the Mental Health Services Oversight and Accountability Commission, and other appropriate entities.
- (4)** The criteria for the award of grants shall include, but not be limited to, all of the following:
- (A)** A description of a comprehensive strategic plan for providing outreach, prevention, intervention, and evaluation in a cost appropriate manner corresponding to the criteria specified in subdivision (c).
 - (B)** A description of the local population to be served, ability to administer an effective service program, and the degree to which local agencies and advocates will support and collaborate with program efforts.
 - (C)** A description of efforts to maximize the use of other state, federal, and local funds or services that can support and enhance the effectiveness of these programs.
- (5)** In order to reduce the cost of providing supportive housing for clients, counties that receive a grant pursuant to this part after January 1, 2004, shall enter into contracts with sponsors of supportive housing projects to the greatest extent possible. Participating counties are encouraged to commit a portion of their grants to rental assistance for a specified number of housing units in exchange for the counties' clients having the right of first refusal to rent the assisted units.
- (b) – (h)** present additional requirements for the grants.
- 5820. (a)** It is the intent of this part to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.
- (b)** Each county mental health program shall submit to the Office of Statewide Health Planning and Development a needs assessment identifying its shortages in each professional and other occupational category in order to increase the supply of professional staff and other staff that county mental health programs anticipate they will require in order to provide the increase in services projected to serve additional individuals and families pursuant to Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. For purposes of this part, employment in California's public mental health system includes employment in private organizations providing publicly funded mental health services.
 - (c)** The Office of Statewide Health Planning and Development, in coordination with the California Mental Health Planning Council, shall identify the total statewide needs for each

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professional and other occupational category utilizing county needs assessment information and develop a five-year education and training development plan.

(d) Development of the first five-year plan shall commence upon enactment of the initiative. Subsequent plans shall be adopted every five years, with the next five-year plan due as of April 1, 2014.

(e) Each five-year plan shall be reviewed and approved by the California Mental Health Planning Council.

5821. (a) The California Mental Health Planning Council shall advise the Office of Statewide Health Planning and Development on education and training policy development and provide oversight for education and training plan development.

(b) The Office of Statewide Health Planning and Development shall work with the California Mental Health Planning Council and the State Department of Health Care Services so that council staff is increased appropriately to fulfill its duties required by Sections 5820 and 5821.

5845. (a) The Mental Health Services Oversight and Accountability Commission is hereby established to oversee Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act; Part 3.1 (commencing with Section 5820), Human Resources, Education, and Training Programs; Part 3.2 (commencing with Section 5830), Innovative Programs; Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs; and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act. The commission shall replace the advisory committee established pursuant to Section 5814.

(d) In carrying out its duties and responsibilities, the commission may do all of the following:

(12) Work in collaboration with the State Department of Health Care Services and the California Mental Health Planning Council, and in consultation with the California Mental Health Directors Association, in designing a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, including, but not limited to, parts listed in subdivision (a). The California Health and Human Services Agency shall lead this comprehensive joint plan effort.

5848. (d) Mental health services provided pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850), shall be included in the review of program performance by the California Mental Health Planning Council required by paragraph (2) of subdivision (c) of Section 5772 and in the local mental health board's review and comment on the performance outcome data required by paragraph (7) of subdivision (a) of Section 5604.2.

5892. (d) Prior to making the allocations pursuant to subdivisions (a), (b), and (c), funds shall be reserved for the costs for the State Department of Health Care Services, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development, the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to the programs set forth in this section. These costs shall not exceed 5 percent of the total of annual revenues received for the fund. The administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to

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concerns about quality, structure of service delivery, or access to services. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. The amount of funds available for the purposes of this subdivision in any fiscal year shall be subject to appropriation in the annual Budget Act.

5897. (a) Notwithstanding any other provision of state law, the State Department of Health Care Services shall implement the mental health services provided by Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division through contracts with county mental health programs or counties acting jointly. A contract may be exclusive and may be awarded on a geographic basis. As used herein a county mental health program includes a city receiving funds pursuant to Section 5701.5.

(b) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of such mental health services. The agreement may encompass all or any part of the mental health services provided pursuant to these parts. Any agreement between counties shall delineate each county's responsibilities and fiscal liability.

(c) The department shall implement the provisions of Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division through the annual county mental health services performance contract, as specified in Chapter 2 (commencing with Section 5650) of Part 2 of Division 5.

(d) When a county mental health program is not in compliance with its performance contract, the department may request a plan of correction with a specific timeline to achieve improvements.

(e) Contracts awarded by the State Department of Health Care Services, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development, and the Mental Health Services Oversight and Accountability Commission pursuant to Part 3 (commencing with Section 5800), Part 3.1 (commencing with Section 5820), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.7 (commencing with Section 5845), Part 4 (commencing with Section 5850), and Part 4.5 (commencing with Section 5890) of this division, may be awarded in the same manner in which contracts are awarded pursuant to Section 5814 and the provisions of subdivisions (g) and (h) of Section 5814 shall apply to such contracts.

(f) For purposes of Section 5775, the allocation of funds pursuant to Section 5892 which are used to provide services to Medi-Cal beneficiaries shall be included in calculating anticipated county matching funds and the transfer to the State Department of Health Care Services of the anticipated county matching funds needed for community mental health programs.

14682.1. (a) The State Department of Health Care Services shall be designated as the state agency responsible for development, consistent with the requirements of Section 4060, and implementation of, mental health plans for Medi-Cal beneficiaries.

State Statutes - Welfare and Institution Code

(b) The department shall convene a steering committee for the purpose of providing advice and recommendations on the transition and continuing development of the Medi-Cal mental health managed care systems pursuant to subdivision (a). The committee shall include work groups to advise the department of major issues to be addressed in the managed mental health care plan, as well as system transition and transformation issues pertaining to the delivery of mental health care services to Medi-Cal beneficiaries, including services to children provided through the Early and Periodic Screening, Diagnosis and Treatment Program.

(c) The committee shall consist of diverse representatives of concerned and involved communities, including, but not limited to, beneficiaries, their families, providers, mental health professionals, substance use disorder treatment professionals, statewide representatives of health care service plans, representatives of the California Mental Health Planning Council, public and private organizations, county mental health directors, and others as determined by the department. The department has the authority to structure this steering committee process in a manner that is conducive for addressing issues effectively, and for providing a transparent, collaborative, meaningful process to ensure a more diverse and representative approach to problem-solving and dissemination of information.

Health and Safety Code Section 128456.

In developing the program established pursuant to this article, the Health Professions Education Foundation shall solicit the advice of representatives of the Board of Behavioral Sciences, the Board of Psychology, the State Department of Health Care Services, the California Mental Health Directors Association, the California Mental Health Planning Council, professional mental health care organizations, the California Healthcare Association, the Chancellor of the California Community Colleges, and the Chancellor of the California State University. The foundation shall solicit the advice of representatives who reflect the demographic, cultural, and linguistic diversity of the state.

Federal Public Law (PL) 106-310- the MHPC should perform the following functions:	Council Activity	Deliverable
<ul style="list-style-type: none"> Review the State mental health plan required by PL 106-310 and submit to the State any recommendations for modification 	Annual review of CA SAMHSA BG application	Yes
<ul style="list-style-type: none"> Review the annual implementation report on the State mental health plan required by PL 106-310 and submit any comments to the State 	Annual review of CA Implementation Report	Yes
<ul style="list-style-type: none"> Advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems 	Legislative advocacy, Participation on HCR and other issue-specific committees,	No
<ul style="list-style-type: none"> Monitor, review, and evaluate annually the allocation and adequacy of mental health services within the State. 	Workbook Project w/ Local MH Boards	Yes
<p>California Welfare and Institutions Code (WIC) 5514- There shall be a 5-person Patients' Rights Committee formed through the CMHPC. This committee, supplemented by two ad hoc members appointed by the chairperson of the committee, shall advise the Director of Health Care Services and Director of State Hospitals regarding department policies and practices that affect patients' rights.</p>	None yet, new requirement in FY 2012-13 TBL	
<p>WIC 5771- Pursuant to PL 102-321 the Planning Council shall be responsible to fulfill those mental health planning requirements mandated by federal law.</p>		
<p>WIC 5772 - The California Mental Health Planning Council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:</p>		
<ol style="list-style-type: none"> To advocate for effective, quality mental health programs. 	Legislative testimony, Participation on HCR and other issue-specific committees	No
<ol style="list-style-type: none"> To review, assess, and make recommendations regarding all components of California's mental health system, and to report as necessary to the Legislature, the State Department of Health Care Services, local boards, and local programs. 	SAMHSA BG Peer Reviews, Council Meeting to showcase model programs, Legislative testimony	No
<ol style="list-style-type: none"> To review program performance in delivering mental health services by annually reviewing performance outcome data as follows: 	Workbook Project w/ Local MH Boards, SAMHSA BG Peer Reviews,	Yes
<ul style="list-style-type: none"> To review and approve the performance outcome measures. 		

<ul style="list-style-type: none"> To review the performance of mental health programs based on performance outcome data and other reports from the State Department of Health Care Services and other sources. 		
<ul style="list-style-type: none"> To report findings and recommendations on programs' performance annually to the Legislature, the State Department of Health Care Services, and the local boards. 		
<ul style="list-style-type: none"> To identify successful programs for recommendation and for consideration of replication in other areas. As data and technology are available, identify programs experiencing difficulties. 		
4. When appropriate, make a finding pursuant to Section 5655 that a county's performance is failing in a substantive manner. The State Department of Health Care Services shall investigate and review the finding, and report the action taken to the Legislature.		
WIC 5772 - continued	Council Activity	Deliverable
5. To advise the Legislature, the State Department of Health Care Services, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.		
6. To make recommendations to the State Department of Health Care Services on the award of grants to county programs to reward and stimulate innovation in providing mental health services.		
7. To conduct public hearings on the state mental health plan, the Substance Abuse and Mental Health Services Administration block grant, and other topics, as needed.		
8. In conjunction with other statewide and local mental health organizations assist in the coordination of training and information to local mental health boards as needed to ensure that they can effectively carry out their duties.	Coordinate training needs with CiMH and CALMHBDC	No
9. To advise the Director of Health Care Services on the development of the state mental health plan and the system of priorities contained in that plan.		
10. To assess periodically the effect of realignment of mental health services and any other important changes in the state's mental health system, and to report its findings to the Legislature, the State Department of Health Care Services, local programs, and local boards, as appropriate.		
11. To suggest rules, regulations, and standards for the administration of this division.		
12. When requested, to mediate disputes between counties and the state arising under this part.		
13. To employ administrative, technical, and other personnel necessary for the performance of its powers and duties, subject to the approval of the Department of Finance.		

14. To accept any federal fund granted, by act of Congress or by executive order, for purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.		
15. To accept any gift, donation, bequest, or grants of funds from private and public agencies for all or any of the purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.		
WIC 5820 - Each OSHPD five-year WET plan shall be reviewed and approved by the Planning Council.	Participate in OSHPD WET Advisory Committee; Coordinate Council review of 5-Yr Plan	
WIC 5821 - The Planning Council shall advise the OSHPD on education and training policy development and provide oversight for the department's education and training development.	Participate in OSHPD WET Advisory Committee	

Members Present:		
Adam Nelson, MD, Chair	Kathleen Derby, Chair-Elect	
Steve Leoni	Barbara Mitchell	Maya Petties, PsyD
Darlene Prettyman	John Ryan	Daphne Shaw
Staff Present:	Jane Adcock, E.O.	Andi Murphy, Staff
Presenters:	Patrick Miles Stacie Hiramoto Sally Zinman Adrienne Shilton (by phone)	San Mateo Co Behav. Health REMHDCO CAMPHRO CBHDA

- Meeting Commenced at 8:40 a.m., members introduced themselves.

Item #	Issue	Discussion/Options	Action/Resolution	By Whom?	By When?
1.	New Business	AB1424 (Mullen) – should be watched and/or opposed; conflict of interest.	<ul style="list-style-type: none"> • Should be agendized for future meeting with an eye to developing talking points detailing concerns. 	All	July 2015
2.	Committee Work Plan – Next Steps	<ul style="list-style-type: none"> • Rather than ask about IMD usage, would it be easier to track trends on Admin Bed Days rather than on IMDs? • Should we compile the best practices beforehand and ask counties what THEY are doing in a similar vein. • Money and resources are more available in some counties than in others – a statewide survey would ensure we hear from the less 	<ul style="list-style-type: none"> • Amend the survey to reflect existing census when placements were made into IMDs and/or MHRCs for all of the dates. • Suggest going with 2004 in addition to 2009, and 2014 in respect to asking about placements. • Invite a consultant to the July meeting so we can sound out our questions and discuss our intentions. 		July 2015

Item #	Issue	Discussion/Options	Action/Resolution	By Whom?	By When?
		<p>resourced counties.</p> <ul style="list-style-type: none"> A consultant who is knowledgeable about the existing DHCS data sets may help articulate the questions in a way that can be answered by DHCS staff. 			
3.	<p>SB 614 – Should Community Health Workers be included in the bill?</p>	<ul style="list-style-type: none"> CHWs could be used to reach segments of the population that may be resistant to the topic of mental illness or reluctant to disclose. Would Advocacy consider recommending language be included in SB 614 to include CHWs? There is already language including and requiring cultural competency in the language. CHWs would likely not disclose their own psychiatric disability due to cultural norms. 	<ul style="list-style-type: none"> SB 614 is not the vehicle to use for this issue because it is about getting a statewide certification process and mechanism for billing in place. Inserting CHWs into the mix would be confusing and disruptive to the intent of the legislation. CHWs already have a billing mechanism in place. The Committee elects to not support the addition of CHWs into the Bill language. Advocacy would like to work with REMHDCO to support their efforts for greater recognition and use of Community Health workers in the Behavioral Health community. REMHDCO will forward information that can be shared with committee member to shape a plan of action. 	<p>N/A</p> <p>5 ayes/ 2 abs./ 1 no</p> <p>1 abstain the rest ayes.</p>	

Item #	Issue	Discussion/Options	Action/Resolution	By Whom?	By When?
4.	Discussion: Next Steps on Committee Work Plan	Meet in July	Meet in July	All	July
5.	Public Comment	None	N/A	N/A	N/A
6.	WWW/Plan For Next Meeting	Not Addressed	Discuss at July meeting	All	July

A TAB SECTION

DATE OF MEETING 10/15/15

**MATERIAL
PREPARED BY:** Canaan

**DATE MATERIAL
PREPARED** 9/14/15

AGENDA ITEM:	Meeting Minutes from September 9, 2015
ENCLOSURES:	Minutes

BACKGROUND/DESCRIPTION:

Please see the enclosed minutes from the September 9, 2015 meeting.

Members Present:		
Adam Nelson, MD, Chair		
Steve Leoni	Darlene Prettyman	Barbara Mitchell
Daphne Shaw	Arden Tucker	
Staff Present:	Jane Adcock, E.O.	Andi Murphy/Erica Canaan, Staff
Presenters:	Susan Kinoshita, Dilara Boring, Gerald Zipay and Justin Powers, DHCS	

- Meeting Commenced at 11:00a.m, members introduced themselves.

Item #	Issue	Discussion/Options	Action/Resolution	By Whom?	By When?
1.	New Business	<ul style="list-style-type: none"> • Kathleen Derby has stepped down from the Council. 	<ul style="list-style-type: none"> • Agenda item for October and be thinking about a new Chair Elect 	ALL	October 2015
2.	Committee Work Plan - Involuntary Detention Rates & DHCS Data Explained	<ul style="list-style-type: none"> • Committee wanted to see if the MHSA had a positive effect on Involuntary Holds. • IMD's are not collected on the Involuntary Detention Reports. • DHCS reported that there is no flag in the system if a client received IMD services. • Why isn't this data collected? The state doesn't track it because this is something done by the counties. How 	<ul style="list-style-type: none"> • Andi will email out the Involuntary Forms from DHCS to answer some questions in regards to the data and how it's reported. • Barbara will ask Bob what report he used to receive with in-depth information for the county. 		

Item #	Issue	Discussion/Options	Action/Resolution	By Whom?	By When?
		<p>can we get this information from the counties? Some committee members did get this information from their county mental health. CBHDA would be the place to get this information.</p> <ul style="list-style-type: none"> • Can we ask the State to REQUIRE the counties to get this data? • Is there Residential Care Facilities data? DHCS said there are Specialty Mental Health State Budget Data sections that describe Crisis Residential - published on DHCS website – May/November budget supplements. • The data on the holds are incidents, not individuals. • EQRO Report has good information on data but only captures the Medi-Cal portion. • Committee would like EQRO to report out again within the next year. 			
3.	Medi-Cal Coverage and Transgender Services	<ul style="list-style-type: none"> • Jane asked if the Committee would be interested in advocating for the transgender community that the entire transition be covered by Med-Cal. • The committee didn't think this was something that they would want to take the lead on to change legislation, but would consider learning more 			

Item #	Issue	Discussion/Options	Action/Resolution	By Whom?	By When?
		about this and giving possible support.			
4.	Legislative issues/updates	<ul style="list-style-type: none"> 614 is a two year bill 	<ul style="list-style-type: none"> Will be included on October agenda 		
5.					
6.	Public Comment	<ul style="list-style-type: none"> Asked by Jen Burstedt from California Quality Collaborative what ways could we better integrate on the health plan level? Jane referred Jen to our website and to email her directly, that a better committee meeting for her to attend would be Integrated Health Care. 			
7.	WWW/Plan For Next Meeting				

B TAB SECTION

DATE OF MEETING 10/15/15

**MATERIAL
PREPARED BY:** Canaan

**DATE MATERIAL
PREPARED 9/21/15**

AGENDA ITEM:	Legislative Platform
ENCLOSURES:	Legislative Platform – Mandatory Planks

BACKGROUND/DESCRIPTION:

Review the California Mental Health Planning Council's current Legislative Platform for any updates or changes that may need to be made.

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL

LEGISLATIVE PLATFORM

January 2015

Mandatory Planks

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

Discretionary Planks (Require Deliberation & Discussion)

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

C TAB SECTION

DATE OF MEETING 10/15/15

MATERIAL
PREPARED BY: Canaan

DATE MATERIAL
PREPARED 9/14/15

AGENDA ITEM:	Excellence in Mental Health; update on federal legislation and the two proposed Murphy bills
ENCLOSURES:	Excerpts from the DHCS Grant Application for the Excellence in Mental Health Care Act. Two proposed Murphy Bills.

BACKGROUND/DESCRIPTION:

Megan Sussman, a representative from Congresswoman Doris Matsui's office will speak about pending Federal Legislation and the Excellence in Mental Health Care program.

The DHCS application has been submitted and is waiting for approval. (attached)

Below are the links to the various summaries on the two Murphy Bills currently in Federal Legislation.

http://murphy.house.gov/uploads/Latest_Summary_The%20Helping%20Families%20in%20Mental%20Health%20Crisis%20Act.pdf

<http://www.murphy.senate.gov/issues/mental-health>

<http://www.murphy.senate.gov/newsroom/press-releases/cassidy-murphy-introduce-comprehensive-overhaul-of-mental-health-system>

California Department of Health Care Services

Application for the

U.S. Department of Health and Human Services

Substance Abuse and Mental Health
Services Administration

Planning Grants for Certified
Community Behavioral Health Clinics

Request for Applications Number SM-16-001

Catalogue of Federal Domestic Assistance Number: 93.829

Abstract

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

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

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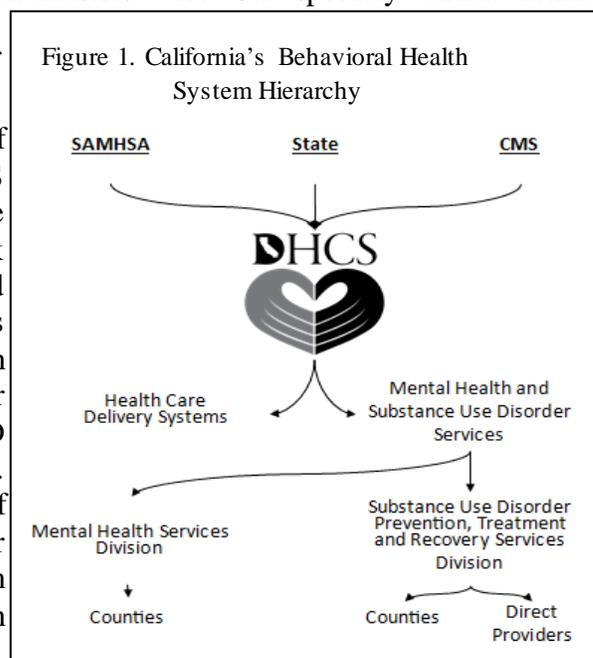
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Project Narrative

Section A-1 Current System Design

Organization of Services

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



Funding

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

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

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

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

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

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

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

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

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

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

Provision of Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section A-2 Prevalence Rates

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

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

25) have the highest rates of any mental illness (AMI¹⁰), serious thoughts of suicide, binge drinking, alcohol dependence, and illicit drug dependence, compared to other age groups. Substance use prevalence estimates by youth age group show that substance use increases with age. Eleventh graders (ages 16-17) have the highest prevalence of alcohol use (33%), binge drinking (22%), and marijuana use (24%) compared to younger youth. Substance use in youth is also much more prevalent in youth who smoke. Research also shows that smoking prevalence is higher among those with behavioral health issues. Nearly half (49%) of the callers to the California Smoker's Helpline self-reported behavioral health issues.¹⁷ Persons with serious psychological distress in California have a smoking prevalence of about 28%, compared to the overall California smoking prevalence rate of about 12%.

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

Demographic/ Characteristic	Prevalence Estimates						
	SMI	SED	SUD or SMI	Substance Dependence or Abuse	Binge Drinking	Alcohol Use	Marijuana Use
Gender¹¹							
Female	5%	8%			11%		
Male	4%	8%			23%		
Race/Ethnicity¹²							
Native American	7%	8%			-		
African American	6%	8%			15%		
Hispanic	5%	8%			19%		
Caucasian	4%	7%			17%		
Age Group							
All Adults (18+)	4% ¹³		22% ¹⁴	9% ¹⁵	23% ⁶	54% ⁶	9% ⁶
Young Adults (18-25)	4%	-		19% ⁶	36% ⁶	58% ⁶	22% ⁶
Youth (12-17)		8%		9% ⁶	6% ⁶	12% ⁶	8% ⁶
Youth (12-13)				3% ¹⁶	5% ⁷	11% ⁷	7% ⁷
Youth (14-15)				8% ⁷	11% ⁷	20% ⁷	15% ⁷
Smoker					64% ⁷		71% ⁷
Non-Smoker					9% ⁷		10% ⁷
Youth (16-17)				14% ⁷	22% ⁷	33% ⁷	24% ⁷
Smoker					68% ⁷		69% ⁷
Non-Smoker					15% ⁷		14% ⁷
Other							
Veterans				3% ¹⁷			
Smoker	28% ¹⁸						

¹⁰ NSDUH definition of AMI is any mental, behavioral, or emotional disorder that met DSM-IV criteria, excluding developmental and substance use disorders. SMI is a subset of the AMI population, including those with AMI, where the mental illness substantially interferes with or limits one or more major life activities.

¹¹ SMI/SED estimates by gender from CA Needs Assessment; binge drinking estimates by gender from BRFSS.

¹² Race/ethnicity estimates for SMI/SED from CA Needs Assessment and binge drinking estimates from BRFSS.

¹³ CA Needs Assessment; NSDUH.

¹⁴ CA Needs Assessment; SUD or SMI service utilization.

¹⁵ NSDUH.

¹⁶ CHKS; grade-level (7th, 9th, and 11th) used as proxy for age groups.

¹⁷ Clients self-reported as veterans in publically-monitored SUD treatment in FY 2013-14.

¹⁸ CDPH; California Tobacco Facts and Figures 2015; estimates for adults with serious psychological distress.

Section A-3 California’s Medicaid State Plan

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

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

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

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

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

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

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

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

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

Section A-4 Nature of the Problem

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

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

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

ER Visits

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

ACHI Days

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

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

Average ACHI Length of Stay

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section B-2 Input from Partners/Stakeholders

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

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

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

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

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

Section B-3 CCBHC Selection

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

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

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

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

Section B-4 CCBHC Service Provision

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

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

PROGRAM REQUIREMENT 1: STAFFING

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

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

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

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

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

PROGRAM REQUIREMENT 2: AVAILABILITY/ACCESSIBILITY OF SERVICES

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

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

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

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

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

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

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

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

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

PROGRAM REQUIREMENT 3: CARE COORDINATION

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

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

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

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

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

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

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

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

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

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

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

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

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

PROGRAM REQUIREMENT 4: SCOPE OF SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PROGRAM REQUIREMENT 5: QUALITY AND OTHER REPORTING

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

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

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

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

CIBHS’ eBHS system has the following design features:

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

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

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

Section B-5 *Evidence-based Practices*

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

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

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

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

Table 5. Evidence-Based Practices Currently Used in California

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

Section B-6 *CCBHC Certification*

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

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

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

Section B-7 *Transition to Implementation*

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

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

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

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

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

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

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

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

Section B-8 *PPS Rate Selection and Justification*

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

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

Section B-9 *Establishment of CCBHC PPS Rates*

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

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

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

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

Section B-10 Participation from Other Organizations

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

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

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

Section B-11 CCBHC Board Governance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section D-2 State Support for CCBHC Performance Measurement Infrastructure

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

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

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

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

Section D-4 Data Collection and Reporting Challenges

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

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

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

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

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

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

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

Section D-5 Preliminary Plan to Construct a Comparison Group

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

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

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

Section D-6 Data Collection Capacity

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

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

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

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

Murphy's Law – The Cassidy-Murphy Mental Health Reform Act will do the following:

Integrate Physical and Mental Health

- Encourages states to break down walls between physical and mental health care systems by requiring states to identify barriers to integration. States would be eligible for grants of up to \$2 million for five years, prioritizing those states that have already taken action. States taking part are eligible with additional federal funds to treat low-income individuals who have chronic conditions or serious and persistent mental illness.

Designate an Assistant Secretary for Mental Health and Substance Use

- Elevates the issue of mental health by establishing an Assistant Secretary for Mental Health and Substance Use Disorder within the U.S. Department of Health and Human Services who will be responsible for overseeing grants and promoting best practices in early diagnosis, treatment, and rehabilitation. The Assistant Secretary will work with other federal agencies and key stakeholders to coordinate mental health services across the federal system and help them to identify and implement effective and promising models of care.

Establish New Grant Programs for Early Intervention

- Establishes a grant program focused on intensive early intervention for children as young as 3 years of age who demonstrate significant risk factors recognized as related to mental illness in adolescence and adulthood. A second grant program supports pediatrician consultation with mental health teams, which has seen great success in states like Massachusetts and Connecticut.

Establish Interagency Serious Mental Illness Coordinating Committee

- Establishes a Serious Mental Illness (SMI) Coordination Committee under the Assistant Secretary to ensure documentation and promotion of research and treatment related to SMI and evaluate efficiency of government programs for individuals.

Establish New National Mental Health Policy Laboratory

- New entity will fund innovation grants that identify new and effective models of care and demonstration grants to bring effective models to scale for adults and children.

Reauthorize Successful Research & Grant Programs

- Reauthorizes key programs like the Community Mental Health Block Grants and state-based data collection. The bill also increases funding for critical biomedical research on mental health.

Strengthen Transparency and Enforcement of Mental Health Parity

- Requires the U.S. Department of Labor, the U.S. Department of Health and Human Services, and the U.S. Department of the Treasury to conduct audits on Mental Health Parity implementation and issue guidance on how determinations are made regarding comparability mental health services and physical health services.

Improve Mental Health Services within Medicare/Medicaid

- Makes critical reforms to allow for patients to use mental health services and primary care services at the same location, on the same day. Repeals the current Medicaid exclusion on inpatient care for individuals between the ages of 22 and 64 if the CMS actuary certifies that it would not lead to a net increase of federal spending.



Tim Murphy

U.S. Congressman for the 18th District of Pennsylvania

The Helping Families in Mental Health Crisis Act of 2015 H.R. 2646

Mental illness does not discriminate based on age, class or ethnicity. It affects all segments of society. The stories are haunting and the numbers are staggering. Nearly 10 million Americans have serious mental illness (schizophrenia, bipolar disorder, and major depression); but, millions are going without treatment as families struggle to find care for loved ones.

To understand why so many in need of care go without treatment, the Energy and Commerce Subcommittee on Oversight and Investigations launched a top-to-bottom review of the country's mental health system beginning in January 2013. The investigation, which included public forums, hearings with expert witnesses and document and budget reviews, revealed the federal government's approach to mental health is a chaotic patchwork of antiquated programs and ineffective policies spread across numerous agencies with little to no coordination. As documented in a recent Government Accountability Office (GAO) report, 112 federal programs intended to address mental illness aren't connecting for effective service delivery and "interagency coordination for programs supporting individuals with serious mental illness is lacking."

While the federal government dedicates \$130 billion towards mental health each year, the so-called "mental health system" is best described by its deficits. To name just a few:

- There is a nationwide shortage of nearly 100,000 needed psychiatric beds.
- Three of the largest mental health "hospitals" are in fact criminal incarceration facilities (LA County, Cook County, and Rikers Island jails).
- Privacy rules that frustrate both physicians and family members generate nearly 8,000 official complaints yearly.
- For every 2,000 children with a mental health disorder, only one child psychiatrist is available.
- The leading federal mental health agency does not employ a psychiatrist.

The Helping Families in Mental Health Crisis Act of 2015, H.R. 2646, fixes the nation's broken mental health system by refocusing programs, reforming grants, and removing federal barriers to care.

Empowers Parents and Caregivers

Breaks down barriers for families to work with doctors and mental health professionals and be meaningful partners in the front-line care delivery team.

Drives Evidence-Based Care

Creates an Assistant Secretary for Mental Health and Substance Use Disorders with mental health credentials within the Department of Health & Human Services to elevate the importance of mental health in the nation's leading health agency, coordinate programs across different agencies, and promote effective evidence-based programs.

Further Refines Mental Health & Substance Abuse Parity

Requires the Assistant Secretary for Mental Health and Substance Use Disorders to make public all federal investigations into compliance with the parity law so families and consumers know what treatment they have rights to access.



Tim Murphy

U.S. Congressman for the 18th District of Pennsylvania

Driving Innovation

Establishes a National Mental Health Policy Laboratory to drive innovative models of care, develop evidence-based and peer-review standards for grant programs. Dedicates funding for the Brain Initiative (Brain Research Through Advancing Innovative Neurotechnologies Initiative).

Improving Transition from One Level of Care to Another

Requires psychiatric hospitals to establish clear and effective discharge planning to ensure a timely and smooth transition from the hospital to appropriate post-hospital care and services.

Fixes Shortage of Crisis Mental Health Beds

Provides additional psychiatric hospital beds for those experiencing an acute mental health crisis and in need of short term (less than 30 days) immediate inpatient care for patient stabilization.

Reaching Underserved and Rural Populations

Advances tele-psychiatry to link pediatricians and primary care doctors with psychiatrists and psychologists in areas where patients don't have access to needed care.

Focuses on Mental Health Workforce

- Requires the Assistant Secretary for Mental Health and Substance Use Disorders to study and recommend a national strategy for increasing the number of psychiatrists, child and adolescent psychiatrists, psychologists, psychiatric nurse practitioners, clinical social workers, and mental health peer-support specialists.
- Includes child and adolescent psychiatrists in the National Health Service Corps.
- Authorizes the Minority Fellowship Program.

Advances Early Intervention and Prevention Programs

- Authorizes, for the first time in federal law, the Recovery After Initial Schizophrenia Episode (RAISE), an evidence-based early intervention program.
- Reauthorizes the National Child Traumatic Stress Network.
- Launches a new early childhood grant program to provide intensive services for children with serious emotional disturbances in an educational setting.

Alternatives to Institutionalization

Incentivizes states to provide community-based alternatives to institutionalization for those with serious mental illness, such as Assisted Outpatient Treatment and other assertive-care community approaches.

Focuses on Suicide Prevention

Reauthorizes the Garrett Lee Smith Suicide Prevention Program, invests in research on self-directed violence and for the first time authorizes in statute the Suicide Prevention Hotline

Advances Integration Between Primary & Behavioral Care

Extends health information technology for mental health providers to coordinate care with primary care doctors using electronic medical records.

Increases Program Coordination Across the Federal Government

Establishes Interagency Serious Mental Illness Coordinating Committee to organize, integrate, and coordinate the research, treatment, housing and services for individuals with substance use disorders and mental illness.

Effective Protection & Advocacy



Tim Murphy

U.S. Congressman for the 18th District of Pennsylvania

Focuses on the rights of individuals with mental illness to be free from abuse & neglect while ensuring access to, and the ability to obtain treatment for serious mental illness.

Fixes the broken grievance procedure by providing an independent pathway so families can once again participate in the protection, care and advocacy on behalf of their loved one.

Increases Physician Volunteerism

Ends the decades-old prohibition on physicians seeking to dedicate time volunteering at community mental health clinics and federally-qualified health centers.