

Advocacy Committee

Thursday, June 18, 2015

Crowne Plaza Burlingame

1177 Airport Blvd.

Burlingame, CA 94010

(650) 342-9200

Room: Plaza III

8:30 a.m. - Noon

Time	Topic	Facilitator/Presenter	Tab
8:30 a.m.	Welcome and Introductions	Adam Nelson, MD, Chair	
8:35	Agenda & Packet Review	Kathleen Derby, Chair-Elect	
8:40	Council Requests/New Business	Adam Nelson	
8:55	Review/Approve May Meeting Summary	Kathleen Derby	A
9:00	Presentation: San Mateo County Behavioral Health Services; IMD Usage - Patrick Miles, Assistant Director, San Mateo County Behavioral Health	Adam Nelson	B
10:00	Break		
10:20	Discussion & Next Steps – Committee Work Plan	Adam Nelson	C
11:00	Discussion: SB 614 – Inclusion of Community Health Workers; Stacie Hiramoto, REMHDCO	Kathleen Derby	D
11:45	Follow-up Discussion /Next Steps	Adam Nelson	
11:50	Public Comment	Kathleen Derby	
11:55	Develop Report Out/ WWW/ Plan for Future Meetings	Adam Nelson	
Noon	Adjourn		

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

Committee Members:

Chair: Adam Nelson, MD

Chair-Elect: Kathleen Derby

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

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

Members Present:		
Adam Nelson, MD, Chair	Kathleen Derby, Chair -Elect	
Carmen Lee	Steve Leoni	Barbara Mitchell
Maya Petties, PsyD	Darlene Prettyman	Daphne Shaw
Arden Tucker	Monica Wilson, PhD	
Staff Present:	Jane Adcock, E.O.	Andi Murphy, Staff
Presenter:	Mary Marx, LCSW	LA County DMH
Others Present:	Theresa Comstock	Napa County MHB

- Meeting Commenced at 8:40 a.m., members introduced themselves, and minutes were approved, (moved Shaw, 2nd Mitchell).

Item #	Issue	Discussion/Options	Action/Resolution	By Whom?	By When?
1.	New Business	CONREP in Ventura, NIMBYism, Pushback, economic and physical threats, people evicted; parents attacked. No place to provide services to mentally ill who have been released. The sites were in Residential neighborhoods and services were to be provided on-site.	Andi to send out synopsis to committee in order to discuss options at May meeting.	All	5/13/15
2.	Refresher: Legislative Process	What is the deadline for submitting proposing legislation? Are Gut and Amend bills sorted by author and available to use to propose legislation?	<ul style="list-style-type: none"> Andi to send out 2015 Leg Calendar and info on Gut and Amend. Create orientation packet specific to Advocacy committee and provide at each meeting. 	Andi	5/13/15 By June
3.	Review of Proposed Legislation	SB 614 Leno Peer Certification SB 11 (Beall) POST MH Training and SB29 (Beall) CEU	<ul style="list-style-type: none"> Support letter sent April 12 continue to monitor Support; request C/FM perspective be 		

Item #	Issue	Discussion/Options	Action/Resolution	By Whom?	By When?
			included in curriculum development and training.		
	Review of Proposed Legislation (Con't)	<p>Ab 1193 (Eggman) Laura's Law AB 59 Waldon</p> <p>AB1194 – Allows past history to determine present danger when evaluating 5150. Intends to standardize across counties definition of " danger". Existing law, AB1424, requires prior history to be considered when deciding on 5150, but it still doesn't work because people aren't forwarding the information.</p> <p>AB 1300 – Ridley-Thomas, LPS and CHA – who can release from an ER hold, etc.</p>	<p>Oppose-Both Counties barriers have been removed already, there is no need to mandate it and based on loss of transparency and protective language of funds. AB 59 Removes protective funding.</p> <p>This law says "history must be considered" but AB1424 (2001) already does this, so oppose based on duplicativeness, and that it does not standardize the language.</p> <p>Lacks clarity on County Responsibility, CPA does not support this. WATCH</p>	Andi	Not stated
	Review of Proposed Legislation (Con't)	<p>AB 848 – Drug and Alcohol</p> <p>AB 858 – Same Day Billing</p> <p>AB 861 – Directs DHCS to apply for Matsui Mental Health grant program to increase Fed Medicaid match from 60 to 90%</p> <p>AB 1025 – Pilot project – Mental health for children in Elementary – multi-tier- 30 schools may be expensive.</p>	<p>Not really a platform issue – watch</p> <p>Support Same Day Billing</p> <p>Support AB 861 – (Check to see if it is for Rapid Rehousing?)</p> <p>Ask Monica N. about it.</p>	Andi	
4.	Info Only: Presentation, LA County IMD Utilization Rates and	Pursuant to previous discussion and planning in respect to the committee work plan, the committee invited LA County to	Consider investigating the correlation between AB109 releases and increase of IMD usage - are the number the same?	All	Discuss at May meeting

Item #	Issue	Discussion/Options	Action/Resolution	By Whom?	By When?
	Social Reinvestment	hear about their programs. (See Appendix for details).			
5.	Discussion: Next Steps on Committee Work Plan	Our task may be beyond the scope of available committee members, and it may be able to use a consultant to gather the data; also DHCS may be able to assist Should the committee consider narrowing the focus further? Should the Committee focus on how many people in IMDs have had previous criminal justice backgrounds?	Discuss at May meeting	All	
6.	Public Comment	Dearth of Board and Care facilities for people on fixed incomes needing shelter and some level of assistance/care.	Send Board and Care report to commenter. Also send to committee members and discuss its inclusion in the overall work plan at the May meeting.	Andi All	May
7.	WWW/Plan For Next Meeting	May - send out Care Home report June: Invite County to talk about AB 109 and IMD beds.	(May) refine work plan, (June) Invite San Mateo.	All Andi	May

LACMHD COUNTY RESOURCES
Alternatives to IMDs
Mary Marx

PRESENTATION SYNOPSIS

LACDMH Continuum of Care

County Wide Resource management (created under MHSA) oversees 2300 beds a day in LA County. Services range from state hospitals to step-down programs and AB 109 clients. It serves as a single access point and gate to all level of care. They have staff of clinicians, psychiatrists, medical director, etc., who participate in a triage process for referrals to all levels of care as well as at the IMD side who consult and refer people back out when ready. 15,000 people annually transition through the service system.

Collaboration occurs between the LA county hospital and the urgent care center are co-located in order to coordinate efficiently. People can self-refer to Urgent Care too, and it does not automatically result in a 5150. They do not need to be Medi-Cal eligible. Another collaboration model is the Residential Bridges program, which includes 6 Peer “Bridgers” who work along with clinical staff to work with IMD step-down programs to identify lower levels of care that are appropriate for the individual.

Los Angeles has received 42 million dollars from SB 82 monies. The County Wide Resources management is responsible for implementing the SB 82 funded projects. Currently, 3 new urgent care centers, 35 crisis residential programs are in development.

Urgent Care centers are designed to offer Crisis Residential-type services; actual Crisis Residential centers are designed to have 30 day stays, Urgent care Centers 10 to 21 days, Crisis Stabilization 3 days. They are right down the street from the County Hospital. People can be dropped off by ambulance, or police, or self-refer. They may be referred from the Emergency room to Urgent Care and occasionally stay in the Crisis stabilization but not necessarily be 5150'd. The Urgent Care site sees about 60 people a day, 12 chairs(?) for adults, and an adolescent unit; about 10,000 people a year.

A recent project was implemented based on analysis of hospital campus and surrounding areas, developing a collaborative of 15 agencies, into a sort of one-stop, to provide multiple interventions on the individuals if desired, including SUD services. Similar to project 50, they demonstrated a cost savings of about \$4700 per person, based on reduction of ER use.

The LACDMH is presently applying for funding for a sort of Acute Diversion model, which diverts out of hospitals, provides longer term “urgent Care” of 10 to 21 days, (more than crisis stabilization, but less than standard Crisis residential or transitional housing).

A few hybrid residential care programs have been proposed for poly-morbid conditions (drug use, physical illness, mental illness) funded through the hospital fund, but has required a complicated licensing process to allow medical services to occur in the residential care homes.

IMD Usage and Alternatives

In 2008-09 LA's IMD bed capacity was approximately 800, of which 45 to 50 beds a day were allocated to court diversion program. In 2010 beds were increased to 1254 and there is still a waiting list of 45 to 50. In 2015 IMDS bed capacity is averaging about 1024, with about a 150 people waiting in hospital beds. This may be partially attributed to the ACA and partially to AB 109 populations, who are screened upon release and referred to the appropriate level of services. Over the last few years, many Incompetent to Stand Trial (IST)s are diverted, through conservatorship, into IMDs with forensic capabilities. LACDMH has been trying to serve them at lower levels of care before resorting to IMDs, but it not always able to do that. For a time, LA County had a state hospital bed count as low as 190, from a high of 500. Now that AB109 has been enacted the number of beds has increased to 235.

Two different models of IMDS - MHRCs and SNF-STPs

LA County uses both MHRCs and SNF-STPs as IMDs. It had tried earlier to develop a program specifically for AB109 populations with high medical needs, and were not quite through the process when it was dropped. It has been resurrected now, due in part to ACA. It contracts with 8 IMDs, 2 in San Bernardino Riverside County, and 1 in San Diego county. The increase of AB 109 releases seems to anecdotally relate to increase of IMD beds, but there is no hard data at this point. LACDMH participates in the CBHDA Forensic committee activities, but nothing concrete has been developed yet in the area of AB 109 and IMD usage.

LA county population has increased by 3% between 2010 and 2014, and the IMD utilization has increased by 25%, - which is due to state hospitals as well as the prison systems. Stepdown Programs were developed – 240 beds initially with MHSA, and now there are about 650, and those step down programs provide very intensive mental health services and augmented supervision which helped reduce the use of IMD beds down to about 775.

**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.

CA Mental Health Planning Council State Statutes

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.

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.

(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.

(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.

(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.

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 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.

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	

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.

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.

INFORMATION

TAB SECTION A

 X ACTION REQUIRED

DATE OF MEETING 6/16/15

MATERIAL
PREPARED BY: Murphy

DATE MATERIAL
PREPARED 5/15/15

AGENDA ITEM:	Approve May Meeting Summary
ENCLOSURES:	May Meeting Summary
OTHER MATERIAL RELATED TO ITEM:	None

ISSUE:

The meeting summary from the May meeting is attached. Please review for accuracy and provide corrections if needed prior to voting for approval.

Members Present:		
Adam Nelson, MD, Chair	Kathleen Derby, Chair -Elect	Carmen Lee
Maya Petties, PsyD	Daphne Shaw	
Staff Present:		Andi Murphy, Staff

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

Item #	Issue	Discussion/Options	Action/Resolution	By Whom?	By When?
1.	CONREP in Ventura, NIMBYism, Pushback, economic and physical threats (Carried over from April meeting)	Discussion: ConReP is now contracted through DSH, which is a change from when Counties controlled the process. County claims that Zoning issued permit “in error” and revoked permit etc.; <ul style="list-style-type: none"> • Has Disability Rights CA been notified? • They represent the individual, not the contractor 	<ul style="list-style-type: none"> • Ventura County MH Director will be apprised of suggestion to contact DRC. • Committee will wait to hear back on whether further action should be considered 	M.P.	6/18/15
2.	Other New Business	AB 861 Maienschein – Language has changed to permissive rather than mandating DHCS to pursue Excellence in Mental Health Grant funding sponsored by Matsui. DHCS has indicated uncertainty as to whether to pursue the grant opportunity	<ul style="list-style-type: none"> • Planning Council to send letter ASAP indicating support for the Grant and DHCS application; cc Representative Matsui, DHCS Director, SAMHSA • Legislative Digest to be sent out periodically 	Andi Andi	6/1/15
3.	Work Plan Modification	Should work plan be modified or narrowed? Potential modifications included the impact of AB 109 populations on IMD usage or whether Board and Care homes could play any role in the alternatives to	<p>OPTION: New Focus As the Advocacy Committee, we should advocate for best practices .</p> <ul style="list-style-type: none"> • What are the Residential Treatment options that are 	All	6/18/15

Item #	Issue	Discussion/Options	Action/Resolution	By Whom?	By When?
		<p>IMDs continuum of care.</p> <ul style="list-style-type: none"> • Original question “Has MHSA created a reduction in IMD usage?” is still the crux of the issue. The two suggested modifications don’t reflect that. • Have not heard back from DHCS on possible/probable data sources • Should we query the IMDs instead? There are 75 registered with DHCS. 	<p>gaining tractions as an alternative to IMDs.</p> <ul style="list-style-type: none"> • Research and develop recommendations on attractive alternatives to IMDs • Query existing IMDs on resident composition, demographics, referral source, etc. <p>Put on June Agenda for additional input.</p>		

X INFORMATION

TAB SECTION D

_____ ACTION REQUIRED

DATE OF MEETING 6/18/15

MATERIAL
PREPARED BY: Murphy

DATE MATERIAL
PREPARED 5/15/15

AGENDA ITEM:	Presentation: San Mateo County Behavioral Health Resources Unit
ENCLOSURES:	None
OTHER MATERIAL RELATED TO ITEM:	None

ISSUE: The Advocacy Committee has invited the Clinical Services Manager of the San Mateo County Behavioral Health Resources Unit to present on the status of IMD utilization in San Mateo County. The following questions were asked to be addressed during the presentation:

1. *What was the total number of placements in IMDs or MHRCs in 2014?*
2. *What was the total number of bed-days in IMDs or MHRCs in 2014?*
3. *How many adults with SMI are served in your county in 2014 regardless of whether placed in IMD's/MHRC's or not?*
4. *What was the number of placements, bed days, and SMI served in 2009?*
5. *Have the changes due to the Affordable Care Act affected utilization?*
6. *What is the demography of long-term care placement? Race-Ethnicity/age group/gender*
7. *Please describe any community programs/services intended to provide appropriate community placements or situations allowing the shortening of IMD/MHRC stays or the replacing of such stays altogether for some.*
 - *Types of services?*
 - *Who provides them?*
 - *How they are funded - e.g. MHSA funded and/or funded through reinvestment from no longer utilized IMD/MHRC bed-days?*
 - *What is the cost of these services?*
 - *Have they expanded, declined, or stayed the same since 2009?*

_____ **INFORMATION**

TAB SECTION C

___X___ **ACTION REQUIRED**

DATE OF MEETING 6/18/15

**MATERIAL
PREPARED BY:** Murphy

**DATE MATERIAL
PREPARED 5/15/15**

AGENDA ITEM:	Committee Work Plan Discussion
ENCLOSURES:	California IMDs Registered with DHCS (from DHCS website) LACDMH Response to IMD Queries
OTHER MATERIAL RELATED TO ITEM:	None

ISSUE:

During the May meeting, committee members continued the discussion from the January meeting on possible work plan modifications based on the complexity and scope of the initial plan and the potential difficulty in obtaining the information needed.

The information received at the April meeting raised the brief consideration of perhaps looking into whether any increases in IMD utilization rates correlated to the increased responsibilities for counties for the Post-Release Community supervision (AB 109) populations. Other information received about the dearth of Board and Care homes also triggered potential discussion on what their roles might play in the continuum of care and how they might tangentially relate to IMD utilization.

Ultimately, committee members refocused the discussion on the original intent of the work plan, which was to determine whether or not MHSA funding had created a reduction in IMD utilization.

There are currently over 70 IMDs registered with DHCS in California (see attached) that could be queried on their resident composition and from where the residents were referred. This may be an option if the data requested from DHCS is not provided. Alternatively, the committee could use the Los Angeles information (attached) as a frame of reference or comparison in respect to what other counties are doing.

As an advocacy committee, the advocacy should focus on the programs that are attractive and successful alternatives to IMDs. Once the best practices are identified, they could be communicated to the Legislature as programs worthy of duplication.

Facilities and Programs Defined as Institutions for Mental Diseases (IMDs) 2014

Please note that this list is not exhaustive, nor does this list relieve county mental health departments of any responsibility to check federal definitions to ensure there are not additional IMDs within their jurisdiction.

Legend:

AP	Licensed by Dept. of Public Health
CRTS	Licensed by Dept. of Health Care Services
MHRC	Licensed by Dept. of Health Care Services
PHF	
STP	Skilled Nursing Facility (SNF) Licensed by Psychiatric Program Dept. of Public Health Certified by
DHCS	
*	

Facility	Address	Program	Licensed Beds	STP Beds
7th Avenue Center	1171 Seventh Avenue, Santa Cruz, CA 95062	MHRC	99	N/A
Alpine Treatment Center	2120 Alpine Boulevard, Alpine, CA 91901	MHRC	113	N/A
Alvarado Parkway Institute BHS	7050 Parkway Drive, La Mesa, CA 91942	AP	66	N/A
Atascadero State Hospital	PO Box 7001, Atascadero, CA 93423	AP	1275	N/A
Aurora Behavioral Healthcare Santa Rosa, LLC	1287 Fulton Road, Santa Rosa, CA 95401	AP	95	N/A
Aurora Charter Oak	1161 East Covina Boulevard, Covina, CA 91724	AP	134	N/A
Aurora Las Encinas Hospital, LLC	2900 East Del Mar Boulevard, Pasadena, CA 91107	AP	118	N/A
Aurora San Diego	11878 Avenue of Industry, San Diego, CA 92128	AP	80	N/A
Aurora Vista Del Mar Hospital	801 Seneca Street, Ventura, CA 93001	AP	87	N/A
BHC Alhambra Hospital	4619 Rosemead Boulevard, Rosemead, CA 91770	AP	97	N/A
BHC Fremont Hospital	39001 Sundale Drive, Fremont, CA 94538	AP	96	N/A
BHC Heritage Oaks Hospital	4250 Auburn Boulevard, Sacramento, CA 95841	AP	125	N/A
BHC Sierra Vista Hospital	8001 Bruceville Road, Sacramento, CA 95823	AP	120	N/A

Facility	Address	Program	Licensed Beds	STP Beds
California Psychiatric Transitions	9226 North Hinton Avenue, Delhi, CA 95315	MHRC	98	N/A
Canyon Manor Rehabilitation Center	655 Canyon Road, Novato, CA 94947	MHRC	89	N/A
Canyon Ridge Hospital	5353 G Street, Chino, CA 91710	AP	106	N/A
College Hospital	10802 College Place, Cerritos, CA 90701	AP	187	N/A
Community Care Center	2335 South Mountain Avenue, Duarte, CA 91010	SNF/STP	167	120
Cordilleras Mental Health Center	200 Edmonds Road, Redwood City, CA 94062	MHRC	68	N/A
Country Villa Merced Behavioral Health Center	1255 B Street, Merced, CA 95343	SNF/STP	96	96
Country Villa Riverside Healthcare Center	4580 Palm Avenue, Riverside, CA 92501	SNF/STP	120	120
Crestwood Behavioral Health Center	6700 Eucalyptus Drive, Suite A Bakersfield, CA 93306	MHRC	55	N/A
Crestwood Behavioral Health Center	1425 Fruitdale Avenue, San Jose, CA 95128	MHRC	98	N/A
Crestwood C.E.N.T.E.R.	295 Pine Breeze Drive, Angwin, CA 94508	MHRC	54	N/A
Crestwood Center - Sacramento	2600 Stockton Boulevard, Sacramento, CA 95817	MHRC	54	N/A
Crestwood Manor - Vallejo*	115 Oddstad Drive, Vallejo, CA 94589	STP	99	37
Crestwood Recovery and Rehabilitation		MHRC	60	N/A
Crestwood Wellness Recovery Center		SNF/STP	99	99
Crestwood San Diego MHRC		MHRC	42	N/A
Del Amo Hospital		AP	166	N/A
Department of State Hospital - Coalinga		AP	1500	N/A
Edgemoor Geriatric Hospital		AP	192	N/A

Facility		Program	Licensed Beds	STP Beds
Gateways Hospital and Mental Health Center		AP	55	N/A
Gladman		MHRC	40	N/A
Golden Living Center (San Jose Care and Guidance)		SNF/STP	110	110
John Muir Behavioral Health Center		AP	73	N/A
Kedren Community Mental Health Center***		AP	72	N/A
La Casa Mental Health Rehabilitation Center		MHRC	190	N/A
La Paz at Paramount		SNF/STP	173	136
Landmark Medical Center		SNF/STP	95	95
Langley Porter Psychiatric Institute		AP	67	N/A
Laurel Park		STP	43	43
Loma Linda University Behavioral Medicine Center		AP	89	N/A
Meadowbrook Manor		SNF/STP	77	77
Metropolitan State Hospital		AP	1254	N/A
Morton Bakar Center		SNF/STP	97	97
Napa State Hospital		AP	1362	N/A
Newport Bay Hospital***		AP	34	N/A
Ocean View Psychiatric Health Facility (Collaborative Neuroscience Network,		PHF	20	N/A
Olive Vista Behavioral Health		SNF/STP	120	120
Pacific Shores Hospital***		AP	30	N/A
Patton State Hospital		AP	1287	N/A
Penn Mar Therapeutic Center DBA San Gabriel Valley Penn Mar		SNF/STP	45	45

Facility		Program	Licensed Beds	STP Beds
Resnick Neuropsychiatric Hospital at UCLA		AP	74	N/A
Royale Health Care Center, Inc.		MHRC	80	N/A
Sacramento County Mental Health Treatment Center		PHF	50	N/A
San Diego County Psychiatric Hospital		AP	109	N/A
San Francisco Mental Health Facility		MHRC	47	N/A
Shandin Hills Behavior Therapy Center		SNF/STP	65	65
Sharp Mesa Vista Hospital		AP	149	N/A
Sierra Vista Hospital		SNF/STP	116	116
St. Joseph's Behavioral Health Center		AP	35	N/A
St.Helena Hospital Center For Behavioral Health		AP	61	N/A
Sutter Center For Psychiatry***		AP	73	N/A
Sylmar Health and Rehabilitation Center		SNF/STP	208	208
Tarzana Treatment Center		AP	60	N/A
The Pathway Home		CRTS	34	N/A
View Heights Convalescent Hospital		SNF/STP	163	99
Villa Fairmont Mental Health Center		MHRC	99	N/A
Vista Behavioral Hospital		AP	68	N/A
Vista Pacifica Center		SNF/STP	108	108
TOTALS		Total Beds	12787	1791

California Mental Health Planning Council Presentation

1. What was the total number of placements in IMDs or MHRCs in 2014? *See table*

IMD Days	2009	2014	Difference between both years (increase)
IMD bed days	15203	16102	899
Subacute bed days	12592	17637	5045
Total # of	67	76	90

Total of 1054 MHRC and IMD beds.

2. What was the total number of bed-days in IMDs or MHRCs in 2014? *See table*

3. How many adults with SMI are served in your county in 2014 regardless of whether placed in IMD's/MHRC's or not? **MHSA CSS plan there were about 97,000 served and for PEI 14,000. DMH served approximately 220,000 a year, but that includes children. The Department converted their electronic records system during this time, so we are unable to provide a total number.**

4. What was the number of placements, bed days, and SMI served in 2009? *See table*
SMI served in 2009 is about 125,000 (18+)

5. Have the changes due to the Affordable Care Act affected utilization? **Yes, it has increased a demand for services in all levels of care**

6. What is the demography of long-term care placement? Race-Ethnicity/age group/gender
These numbers reflect those placed in CRM facilities (Subacute & IMD's).

The IMD's and Subacutes are approximately made up of 64% males to 37% females.

Age Range	Tay (18-	Adult (26-	Older Adult	Total
Male	14%	77%	9%	64%
Female	9%	80%	11%	36%

Example: At the Subacute & IMDs, 26% of the male population is Caucasian.

Race	Caucasian	African	Latino	Asian	Native	Other
Male	26%	31%	34%	7%	0%	5%
Female	33%	35%	25%	10%	0%	3%

7. Please describe any community programs/services intended to provide appropriate community placements or situations allowing the shortening of IMD/MHRC stays or the replacing of such stays altogether for some.

- Types of services? **Stepdowns, FSP, FCCS, Crisis Residential, Outpatient, Wellness Centers**
- Who provides them? **Contract providers with DMH and directly operated clinics**
- How they are funded - e.g. MHSAs funded and/or funded through reinvestment from no longer utilized IMD/MHRC bed-days? **MHSA funded, there was no decrease in state hospital and IMD beds.**
- What is the cost of these services? **See table**

Program types	Cost per
Crisis Residential	\$40
Stepdowns	\$14
FSP	\$5
FCCS	\$38.3
Outpatient	\$2
Wellness	\$8.6

- Have they expanded, declined, or stayed the same since 2009? **Crisis Residential stayed the same. There was an increase in Stepdown beds, FSPs, Wellness, and Outpatient programs.**

_____ **INFORMATION**

TAB SECTION D

 X **ACTION REQUIRED**

DATE OF MEETING 6/18/15

**MATERIAL
PREPARED BY:** Murphy

**DATE MATERIAL
PREPARED 6/5/15**

AGENDA ITEM:	Inclusion of Community Health Workers in SB 614 Language
ENCLOSURES:	REMHDCO –Background info and proposed language change for SB 614 (Leno) Article: Medicaid Will Allow Reimbursement for Community Health Worker Preventive Services!
OTHER MATERIAL RELATED TO ITEM:	

ISSUE: REMHDCO would like the Advocacy Committee to consider the following information and entertain adding its support to REMHDCO’s proposed amended language for SB 614. This will include Community Health Workers in the proposed legislation of approved providers. Please see attachments for additional information.

If the Advocacy Committee agrees that Community Health Workers should be included in the SB 614 language, it will present its findings and rationale to the entire Planning Council at the General Session as part of its report out.

The US Bureau of Labor Statistics offers this Standard Occupation Classification (SOC) description:

21-1094 Community Health Workers

Assist individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the communities that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs. Excludes "Health Educators" (21-1091).

Illustrative examples: *Peer Health Promoter, Lay Health Advocate*



REMHDCO

Racial and Ethnic Mental Health Disparities Coalition

REMHDCO's Proposed Language Regarding SB 614 (Leno)

June 1, 2015

SB 614 (Leno) provides for certification of "Peer Support Specialists" in order to provide mental health support services to consumers and family members and that their services could be reimbursed by Medi-Cal. REMHDCO had and continues to hold, a "Support if Amended" position on the bill.

On May 4, 2015, REMHDCO offered concept language for SB 614 (Leno) that would remove our concerns and allow us to support the bill. We currently have a "Support if Amended" position.

In order to ensure underserved communities receive equitable services that were culturally and linguistically appropriate, REMHDCO seeks language for the bill that would clearly *allow Counties to utilize "Community Health Workers" in lieu of "Peer Support Specialists"* when necessary.

Background

Originally, REMHDCO had proposed that "Community Health Worker" be included in as a category for "Peer Support Specialist". The bill already provides for three categories of "Peer Support Specialists": 1) Adult peer support specialist 2) Family peer support specialist and 3) Parent peer support specialist. (A youth peer support specialist category may be added.)

However, the proponents of SB 614 made clear that they were just "following the language outlined by CMS" and did not want to do anything to jeopardize their approval of certification for Peer Support Specialists in California.

REMHDCO members found out that the category *Community Health Worker* is already defined (see attachment) and their services have been approved for Medi-Cal reimbursement by CMS or the federal Centers for Medicare and Medicaid Services.

What REMHDCO put forth is merely the option for Counties to utilize “Community Health Workers” in lieu of “Peer Support Specialists” when it is appropriate or needed to ensure culturally and linguistically appropriate services to our underserved racial and ethnic communities.

Why Community Health Workers?

REMHDCO supports all the categories of Peer Support Specialists but also recognizes that many consumers and families in underserved racial and ethnic communities may be better served by *Community Health Workers*. Community Health Workers can perform the same or similar services as Peer Support Specialists (although they may or may not have mental illness themselves or mental illness within their families.)

Community Health worker will encompass more specific language used in different cultural communities like Natural Helper in Native American communities or Promotores in Latino communities. These “*peer cultural models*” are the models that work and that are preferred as noted in the population reports of the California Reducing Disparities Project. However, these peer cultural models would not be honored in the current language of SB 617 of what constitutes a peer specialist, even though there is evidence that these peer cultural models are the interventions that would improve engagement and reduce disparities for diverse populations.

Community Health Worker will also honor different cultural meanings of wellness and mental illness beyond the DSM. As stated by the U.S. Surgeon General’s Report of 2001 and other documents examining the reduction of disparities, many diverse communities suffer from misdiagnosis as their conditions are not listed in the DSM. Many people from diverse communities do not engage in the behavioral health system of care so many would not fit the description of “peer” as defined by the current language. Furthermore, due to transition, cultural, and linguistic barriers, it is often difficult to identify and support “Peer Support Specialists,” as opposed to community health workers specifically trained to serve this population with regard to their mental health condition, cultural background, and linguistic preferences.

The bill as written would leave out services to people who are already underserved and could increase disparities for diverse communities.

Medicaid Will Allow Reimbursement for Community Health Worker Preventive Services!

To engage the service, you first need a physician or other licensed practitioner. Read more below:

Community Health Worker (CHW) Health Disparities Initiative partners -- have you heard about the CMS ruling announced last month? The Centers for Medicare and Medicaid Services (CMS) created a new rule which allows state Medicaid agencies to reimburse for preventive services provided by professionals that may fall outside of a state's clinical licensure system, as long as the services have been initially recommended by a physician or other licensed practitioner. The new rule for the first time offers state Medicaid agencies the option to reimburse for more community-based preventive services, including those of CHWs. The rule goes into effect on January 1, 2014.

The announcement of the CMS ruling marked a wonderful moment in time, providing a new opportunity to recognize and advance the role of CHWs! We encourage you to begin discussions with your own national, state and local networks to see how you can contribute to the conversation about reimbursement for preventive services provided by CHWs in your state. Please see below for the actual ruling and links to the relevant sections.

The new rule now states,

"(c) Preventive services means services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law to—

1. Prevent disease, disability, and other health conditions or their progression;
2. Prolong life; and
3. Promote physical and mental health and efficiency."

The citation for the ruling is:

Medicaid and children's health insurance programs: essential health benefits in alternative benefit plans, eligibility notices, fair hearing and appeal processes, premiums and cost sharing, exchanges: eligibility and enrollment; final rule.

Centers for Medicare & Medicaid Services. 78 Fed Reg 42160 (July 15, 2013). The relevant section is, "a. Diagnostic, Screening, Preventive, and Rehabilitative Services (Preventive Services) (§ 440.130)" (paragraph citation: 78 FR 42226)