California Mental Health Planning Council

Healthcare Integration Committee

Thursday, June 16, 2016
Ontario Airport Hotel
700 North Haven Avenue Ontario, CA 91764
ROOM: Cypress Room
8:30 a.m. to 12:00 p.m.

Time	Topic	Presenter or Facilitator	Tab
8:30 a.m.	Planning Council Member Issue Requests		
8:35 a.m.	Welcome and Introductions	Terry Lewis, Chairperson	
8:40 a.m.	Review and Approve Meeting Highlights	All	A
8:45 a.m.	Brief Recap of April Meeting	Terry Lewis, Chairperson	
9:00 a.m.	Background/History of the HCI Committee and Charter Review	Terry Lewis, Chairperson Robert Blackford, Chair-Elect	
9:30 a.m.	Work Plan Review	Robert Blackford, Chair-Elect	B
10:15 a.m.	Discussion : Work Plan Goal #2 (Explore the health effects of psychotropic Medications on Children and alternatives to medication)	All	
10:45 a.m.	Break		
11:00 a.m.	Review California Health Care Foundation Health Plan Report and update by Catherine Teare, CHCF	Terry Lewis, Chairperson Catherine Teare, CHCF, *Invited*	C
11:30 a.m.	Public Comment		
11:40 a.m.	Next Steps/Develop Agenda for Next Meeting	Terry Lewis, Chairperson	
11:50 a.m.	Wrap up: Report Out/ Evaluate Meeting	Terry Lewis, Chairperson	
12:00 p.m.	Adjourn Committee		

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

Committee Members:

Chair:
Terry Lewis

Chair-Elect:
Robert Blackford

Members:

Cindy Claflin
Josephine Black
Steven Grolnic-McClurg
Vera Calloway
Gail Nickerson
Peter Schroeder
Cheryl Treadwell
Deborah Pitts
Dale Mueller
Peter Harsch
Melen Vue
Daphyne Watson
Patricia Bennett

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

California Mental Health Planning Council
HEALTHCARE INTEGRATION COMMITTEE

Roster

HCI Chair and Chair-Elect:

Terry Lewis, Chair E-mail: tlewis@dmh.lacounty.gov	**Robert Blackford, Chair-Elect** Email: equinerobert@gmail.com

Committee Members:

Josephine Black E-mail: jblack32@cox.net	**Patricia Bennett** **Email:** pbennett@resourcedevelopment.net
Cindy Claflin, Vice Chair E-mail: cclaflin@uacf4hope.org	**Steven Grolnic-McClurg, LCSW** E-mail: SGrolnic-McClurg@ci.berkeley.ca.us
Peter Harsch **Email:** Peter.Harsch@dor.ca.gov	**Vera Calloway** **Email:** veritsca@sonic.net
Dale Mueller, EdD, RN E-mail: dmueller@earthlink.net	**Deborah B. Pitts, PhD, OTR/L, BCMH, CPRP** Email: pittsd@usc.edu
Gail Nickerson Email: Gail.Nickerson@ah.org	**Peter Schroeder** Email: peters@ssl.berkeley.edu
Cheryl Treadwell E-mail: cheryl.treadwell@dss.ca.gov	**Melen Vue** Email: melen@namica.org
Daphyne Watson **Email:** dwatson@mhasd.org	

Staff: Tracy Thompson
MS 2706 P.O Box 997413
Sacramento, CA 95899-7413
tracy.thompson@cmhpc.ca.gov

HEALTHCARE INTEGRATION COMMITTEE CHARTER

ADOPTED 10/17/12

OVERVIEW

The California Mental Health Planning Council (CMHPC) is mandated by federal and state statute to advocate for children with serious emotional disturbances and adults and older adults with serious mental illness, to provide oversight and accountability for the public mental health system, and to advise the Governor and the Legislature on priority issues and participate in statewide planning.

PURPOSE

The purpose of the Healthcare Integration Committee (HCI) is to develop a framework for tracking, addressing, and responding to the multitude of issues resulting from Federal Healthcare Reform that impacts California's mental health system.

The HCI promotes the inclusion of five core elements from the Mental Health Services Act to guide all mental health work:

- Promoting Consumer and Family oriented services at all Levels
- Ensuring Cultural Competence
- Increasing Community Collaboration
- Promoting Recovery/wellness/resilience orientation
- Providing Integrated service experiences for clients and families

MEMBERSHIP

The Committee membership is listed below.

The Chairperson and Vice-Chair will be appointed by the CMHPC Leadership. In the Chairperson's absence the Vice Chair will serve as the Chairperson. Terms will begin with the first meeting of the calendar year, and end with the last meeting of the calendar year.

MEETING TIMES

The Committee meets four times a year, rotating locations in conjunction with the standing meeting times of the plenary and other committees. The Committee meets on Thursday from 8:30 AM to 12:00 PM.

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.

The Chair and Vice Chair hold meetings as needed to plan for the full Committee meetings.

ROLES AND RESPONSIBILITIES

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

- Attend meetings. Speaking on behalf as requested.
- Speak at relevant conferences and summits when requested by the Committee leadership
- Develop 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.

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

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. 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 via email.

DECISION-MAKING

Council and non-council members of 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 using the gradients of agreement. Minority views will be included in the meeting highlights.

MEDIA INQUIRIES

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

SUPPORT

Tracy Thompson, Associate Governmental Program Analyst, tracy.thompson@cmhpc.ca.gov

Healthcare Integration Committee Membership

NAME
Terry Lewis, Chairperson
Robert Blackford, Chair-Elect
Patricia Bennett
Josephine Black
Vera Calloway
Cindy Claflin
Steven Grolnic-McClurg, LCSW
Dale Mueller , EdD, RN
Gail Nickerson
Deborah B. Pitts, PhD
Peter Harsch
Peter Schroeder
Cheryl Treadwell
Daphyne Watson
Melen Vue

Updated 5/10/16

_____ **INFORMATION** **TAB SECTION** **A**

__X___ **ACTION REQUIRED** **DATE OF MEETING** **06/16/16**

MATERIAL PREPARED BY: Tracy Thompson **DATE MATERIAL PREPARED** 05/16/16

AGENDA ITEM:	Review and Approve April Meeting Highlights
ENCLOSURES:	• HCI April Meeting Highlights
OTHER MATERIAL RELATED TO ITEM:	

ISSUE:

Committee members will Review and Approve April 2016 Meeting Highlights.

Healthcare Integration Committee
April 2016 Meeting Highlights
Thursday, April 21, 2016

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

Members Present

Terry Lewis, Chairperson
Robert Blackford, Chair-Elect
Peter Harsch
Steven Grolnic-McClurg
Josephine Black
Deborah Pitts {Via Telephone}
Dale Mueller
Cheryl Treadwell
Melen Vue
Vera Calloway
Gail Nickerson
Peter Schroeder

Others Present

May Farr, CALMHB/C
Matthew Gallagher, California Youth Empowerment Network (CAYEN)
Penelope K. Knapp, M.D.,
{Via Telephone}
Robert Horst, MD and Health Sciences Associate Clinical Professor, UC Davis Department of Psychiatry Medical Director, Sacramento County Child and Family Mental Health {Via Telephone}

Review and Approve Meeting Highlights

A motion made by Robert Blackford and seconded by Josephine Black: The January Meeting Highlights were approved as written.

Abstentions: Peter Harsch

Brief Recap of January Meeting

Clayton Chau, MD, PhD Medical Director, Care Management, Behavioral Health & Provider Continuing Education Health Services, provided a presentation on Utilization and Hospitalization Rates and Mild to Moderate Health Needs for the Medi-Cal population with the LA Health Plan. Dr. Chau advised that neither the state nor the mental health plans are tracking hospital utilization rates. The committee is interested in the following question:

Does the MH plan track who is getting outpatient care through the health plan versus who is getting care through the mental health plan? A follow up letter was sent to the CBHDA. Steven Grolnic-McClurg advised that the Quality of Care External Quality Review report gives hospitalization rates but may not be broken down by low to moderate. This is not an EQRO component. This is a reasonable recommendation that the committee can ask that this data be collected within the EQRO separately if possible.

Catherine Teare, CHCF, provided a brief update. CHCF currently has a consultant that will be mapping out which health plan is carving in and which health plan is carving out and who they are carving out too, and how they are paying for those services. This is directly in line with the committee's goal #3. Teare requested that the committee review this before it is complete. Teare stated that a draft should be available sometime in May 2016.

- Terry Lewis stated that there was a discussion within the Executive Committee for each committee to have no more than 2 items on the work plan.
- Terry Lewis advised that per Executive Committee order the committees are not to contact CBHDA without proper coordination.
- Terry Lewis advised that she would like to request that following question be included within the Data Notebook: *Does your county's health plan have regular advisory meetings that are open to the public. For clarification an Advisory meeting is one in which key behavioral health stakeholders (consumers, advocates and providers) are invited to weigh in on key issues related to behavioral health.* Staff will send this to Linda Dickerson, PhD, Susan Wilson, and Jane Adcock for review.

Panel Presentation: *Health effects of psychiatric medications on Children and Youth and alternatives to medication*

Matthew Gallagher, California Youth Empowerment Network (CAYEN), provided the committee with a moving presentation on his experience as a youth within the mental health system. Mr. Gallagher addressed the following questions put forth by the committee:

1. How much were you able to participate in a shared decision making process?

2. How much were you engaged, especially with your medical doctor?

Mr. Gallagher advised that his treatment plan was very individualized and he felt he was able to consent and participate in every aspect. Stigma was an issue that he dealt with and was a struggle. Early intervention can really work and recovery is possible. Mr. Gallagher is now medication free and is able to manage his illness.

Questions/Comments

- Vera Calloway: Do you feel like your assessment back then was the right one at the time? *Answer:* Assessing a youth who is combative seems impossible to me. I believe that it is protocol to assess a youth before placement but waiting may be prudent. That is a policy change I would recommend.
- Steven Grolnic-McClurg: How do we move towards a system where there is a shared decision making process? This is an important question.
- Matthew Gallagher: My advice to youth in the system is to be as transparent as possible- be honest with their psychiatrist. It is important to me to advocate for all TAY in finding recovery. Basic human needs must be met before a treatment plan can work. Homeless youth need a different approach.
- Peter Harsch: After this experience did you have positive referrals to supportive services wether mental health or education or vocational rehab? *Answer*: After I left the hospital I did not have a discharge plan or any resources. I had my diagnosis and recommended medications with discharge papers indicating I would not cooperate. I should have advocated for an IEP in college but then I must reveal my mental health conditions and stigma is a huge issue.
- Cheryl Treadwell: When the decision was made by you to discontinue medications was there any resistance or recommendations? *Answer*: There came a time where I was on the road to abusing my medication. My Doctor was hesitant but supportive.

Penelope K. Knapp, M.D., Professor Emerita, Department of Psychiatry and Behavioral Robert Horst, M.D., and Health Sciences Associate Clinical Professor, UC Davis Department of Psychiatry Medical Director, Sacramento County Child and Family Mental Health provided a presentation to members on the health effects of psychiatric medications on Children and Youth and alternatives to medication. The following questions put forth by the committee were addressed:

1. What is the current practice for medicating children and adolescents?
2. What is the state of the art for medicating children and adolescents?
3. What issues are facing clinical systems with medication management for children and adolescents?

Penny Knapp: Not everyone who writes a prescription for a child is necessarily a child psychiatrist.

The American Academy of Child and Adolescent Psychiatry has published a number of documents called "Practice Parameters." To create a practice parameter, the Academy convened experts on the topic and spent a year or two reviewing the literature and crafting a document that child psychiatrists and other prescribing people could use to know what is the best approach. One of those is on the prescriptions of medications generally to children and one that is the practice parameters for assessment and management of youth involved in the child welfare system. Dr. Knapp has sent a PDF of this to Cheryl Treadwell. The main emphasis on the approach to treating youth in the child welfare system is on a careful evaluation and their situation and family and developing a broader treatment plan. That is the message that child psychiatrists want to put forward and what we believe in. Medication alone is not enough and won't really change the underlying problems particularly when it is trauma.

In addition, in the state of Texas, a practice parameter for psychotropic medication of foster children has been developed and was published in 2013. Dr. Knapp is an adviser on the current revision of this document. In this revision there was a focus on a number of things:

1. Continue providing good information about the appropriate use of medications for younger children. There is a big concern about pre-school children receiving medication.
2. Continue providing detail on treatment of preschool and young children and to raise the age limit for appropriate prescription of antipsychotic medications to children; the age was 3 and now it has been raised to 5 years old.

In California we don't have a comparable document that focuses on use of medications in children but the DHCS and the DSS Quality Improvement Committee spent a couple of years developing a very thoughtful set of guidelines for treatment with medications for children. That guideline has been published on both websites. Once again, you will see a huge emphasis on adequate evaluation, accurate diagnosis, development of a good treatment plan, and non-pharmacological support.

Questions/Comments

- Steven Grolnic-McClurg: From the child psychiatrist perspective, are there issues or system pressures that have led to prescribing methods for children that may not be ideal? Especially those who do not have family or parents to advocate for them? *Answer:* Dr. Horst advised that the problem isn't really with the Treatment Authorization Request (TAR) process (a form the pharmacies send to insurance companies to ensure payment) but rather with the JV-220 process (Application Regarding Psychotropic Medication). The concern with the TAR process is families not getting medications when they desperately need it. When a dependent child or youth is prescribed a psychotropic medication, it must be approved by the courts. In California, a form called a JV-220 must be filed with the court.

- Vera Calloway: Can you make some recommendation as to alternatives to medications? *Answer:* There is a lot of literature on evidence-based approaches. There is a difference between evidence-based treatment and what we call TAU (Treatment as Usual), some of which would be a treatment alliance and working

together. But for many conditions, evidence-based treatments exist and have been shown to be more effective. A good example of this is a child who has a severe Obsessive Compulsive Condition. Evidence-based approaches to this include desensitization approaches as well as specific medications. Studies have shown that improvement in the brain activity that lead to symptoms occurs after both types of treatment. Both the evidence-based non-pharmacological approach and the medication lead to improvement in the brain function that has led to these symptoms. It is important to use both and it is possible to use the non-pharmacological approach first. Another example of this is cognitive behavioral therapy used for depression. It is our goal to try and train as many providers as possible to use these approaches. There are also evidence-based approaches for treatment for trauma.

- Dr. Horst advised that kids need more access to these evidence-based treatments. Moving around and changing caregivers is traumatic in and of itself. When a child is having mental health issues and development issues related to past trauma, it is extremely important that the child stop being traumatized. Having available evidence-based psychosocial treatment for these children is extremely important. Also, supporting our foster care system and making sure we have good foster parents who are able to manage children with severe behavioral problems. Some children may be prescribed medication because they are at risk for losing placement. We need better access to places that could be supportive and connect with these children. If we are looking at how to improve the system that is the direction we need to move in. Supporting foster families and education. Children need to also have an appropriate school setting.
- Cheryl Treadwell: There was a webinar that was performed by the Evidenced Based Clearinghouse that staff has sent to members which was also a great resource.

Penny Knapp advised that the DSS guidelines are updated annually and re-review the literature to see what is emerging in the state of the art for best practices.

- Dale Mueller: How do you see the role of Psychiatric Nurse Practitioners in medication management? *Answer:* They have an important role to play and they usually are licensed to work collaboratively with a physician to a greater or lesser extent. This brings me to the concept of a team. A person does not have the capacity to do everything that every child needs. A mental health team ideally includes a child psychiatrist but a child psychiatrist ideally works with a team. Within the Medi-Cal specialty mental health clinics that have child programs there is a full team and many things that need to be done for a child are divided between team members. Psychiatric Nurse Practitioners are key members of a mental health team.
- Robert Blackford: In the state of California is there a place where all the prescribing behavior goes into a database where it can be analyzed? Does it prove to be helpful? *Answer:* Yes, it is the Pharmacy Benefits Branch at the DSS. The data is as effective as the analysis. The analysis should do more than just counting the number of prescriptions that are filled and billed. It also should include info on how the child is functioning before, during, and after receiving medications. That requires integrating data that is outside the Pharmacy Benefits Branch. Some of this data would be in the DHCS and some would be at the county mental health plan level and isn't captured in billing data but would be found in chart reviews.

Dr. Horst discussed issues and barriers facing clinical systems with medication management for children and adolescents. An adequate diagnostic evaluation by a qualified child psychiatrist is very important and there are access issues. There is the adherence to establish guidelines that are sub optimal. There is a need for ongoing monitoring that interfaces with primary health care. This can be particularly challenging for foster children. This would also include monitoring of background information. This can be lacking in children in foster care. We need more availability of psycho-social treatment including

family engagement and school support. There is still a stigma to seeing a psychiatrist and this is a huge barrier.

- Dale Mueller: With regards to the cultural and linguistic needs of clients, how is that handled? *Answer*: Sacramento County is required to provide services in the client's native language so we have access to numerous interpreters. We do have specialized provider agencies that work with specific communities as well.
- Robert Blackford: Child Psychiatrists may feel pressured to prescribe for children who are not necessarily mentally ill but are having behavior problems. This can be a source of conflict in the system. *Answer*: You need to take the time to help the child and family understand what they need besides a prescription for medication. This really requires a comprehensive approach. There is an evidence-based approach to treatment for youth with conduct disorder that is effective. This practice is not widely available- some counties offer it and some do not. Every case requires an in-depth look at what is going on.
- Terry Lewis: If you could make one suggestion about impacting policy or this committee's ability to make recommendations what would that be?
    - Dr Knapp advised that the legislature is tirelessly putting forward bills every year; they are mostly put forward by lobbyists but are reviewed by entities. Policy in California is driven by legislation and we have an important job to carefully look at the bills being put forward.
    - Dr. Horst advised that to better help children with mental health needs the answer is not to block access to any kind of treatment. We must increase access to better treatment. There is too much focus and concern on "over treatment" and there is not enough focus on improving access to other types of treatment, stable housing, and better education environments for these children.

- Matthew Gallagher advised that doing a WRAP (Wellness Recovery Action Plan) immediately for youth entering the system would be helpful. Having a peer advocate assigned immediately and improving the stakeholder process. Allowing youth to be a part of their treatment plan as much as possible is extremely important.

Update: Work Plan Goal #3 and #4 Mild to moderate health needs and data around utilization and hospitalization rates for those in the health plans with mild to moderate health needs

Catherine Teare, CHCF, provided a brief update on the consultant with the CHCF that will be mapping out which health plan is carving in and which health plan is carving out, who they are carving out too, and how they are paying for those services. The report will discuss about what the overall structure is (specialty mental health system and non-specialty professional outpatient mental health), what changed in 2014 (side by side chart), what is required as far as coordination, what the MOU requirements are, how administrative structures work, and there is an appendix of background information that includes all-County letters, etc. What is *not* included are actual utilization numbers. We have had conversations with DHCS in terms of collecting and reporting utilizations numbers on mild to moderate services provide by health plans and have not heard anything new on that. We would like to see a plan by plan census of this information. What percentage of Medi-Cal managed care plan members are using the mental health services? Teare advised that she has an upcoming call with DHCS and will be asking this question. There is no way, at this time, to link that to the report but is the next task. Teare advised that a draft should be ready for review by sometime in May 2016.

In 2013 the CHCF created an almanac and have now executed a contract to update this. The almanac includes prevalence data and provider data from a variety of sources. Teare asked that committee members be a part of this process. Teare will send a request to staff.

Questions/Comments

- Steven Grolnic-McClurg: There is a Continuous System Improvement committee within the CMHPC and that may be a good place to bring the request to look over the almanac. I am hopeful that we can continue to strengthen the alliance between the CMHPC and CHCF.
- Steven Grolnic-McClurg: Do you feel it is at the point that it might make sense to recommend that the EQRO reports need to focus on hospitalization rates broken down by low to moderate? This is not an EQRO component. *Answer:* It may be a good time for that conversation. Where do we have the data and where do we not have the data?
- Steven Grolnic-McClurg: It may be a good next step to invite someone from the EQRO to come and present and talk to them about what they are collecting that would be related to mild to moderate benefit, what are their thoughts, and what are they discussing with DHCS at this point? They can also tell us what is and what isn't easily get-able.

Public Comment

No Public Comment at this time.

Next Steps/Develop Agenda for Next Meeting

- Robert Blackford: At the May meeting members need to focus heavily on the work plan.

Adjourn

_x____ **INFORMATION** **TAB SECTION** B

_____ **ACTION REQUIRED** **DATE OF MEETING** **06/16/16**

MATERIAL PREPARED BY: Tracy Thompson **DATE MATERIAL PREPARED** 05/16/16

AGENDA ITEM:	Work Plan Review
ENCLOSURES:	• HCI Work Plan
OTHER MATERIAL RELATED TO ITEM:	

For year 2015/16 the Health Care Integration Committee has been focusing on mild to moderate health needs and data around utilization and hospitalization rates for those in the health plans with mild to moderate health needs in our work plan. As this year comes to a close, the committee is finishing up this project and will begin to focus on a new theme: Explore the health effects of psychotropic medications on children and alternatives to medication. Staff has edited and consolidated the work plan and it is now in front of members for review. As we move forward into this new theme, members will narrow down the focus and discuss what they would like the white paper to highlight.

CMHPC

Healthcare Integration Committee

Work Plan 2016-17

Describe overall goal here	Why is this needed?	How will we know if it is accomplished?	Who is this meant for?
Goal 1: Understand and monitor collaboration/integration between county health plans and mental health plans.	**Rationale:** *MCPs are responsible for the delivery of certain mental health services through the MCP provider network to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder as defined by the current DSM, that are outside of the PCP's scope of practice* *(ACL 13-021)*	**Measure of Success:** A written report and comprehensive list of health plans that are "carving in" and those "carving out via CHCF.	**Target Audience:** Local Mental Health Boards, Counties, Public, Legislature
Objectives	**Action Steps**	**Timeline**	**Leads**
How will we know we are on the right track? Explore Best Practices for the Delivery of Mild to Moderate level of Services. 1. Find what the existing data is around the psychiatric hospitalization rates for members of the managed Medi-Cal health plans. *(Full Council Theme: alternatives to locked facilities*. 2. Create a comprehensive list of health plans that are "carving in" and those "carving out."	How do we get ON the track? • Ongoing Presentations at Meetings. • Literature Review • Ongoing updates Catherine Teare CHCF • Qs to consider: #1: Is it better in places where they are carving in versus carving out #2: Is there any difference in the way the county and health plan have arranged their interactions or meeting schedule which leads integration to work better in certain places.	What gets done by when? • October 2015: Training/Presentation to the CALMHB/C regarding MOU's (Health plans and mental health plans) • (Sent f/u letter March 2016) Ask the CBHDA for a list of entities to request data from. • January 2016: Requested data from DHCS and the Dept of Managed Care: *what is the existing data around the psychiatric hospitalization rates for members of the managed Medi-Cal health plans.* Data not easily accessible. • Late April/Early May 2016: CHCF Contractor document review	By whom? Steven Grolnic-McClurg/HCI Committee Staff Catherine Teare CHCF

CMHPC

Healthcare Integration Committee

Describe overall goal here **Goal 2: Explore the health effects of psychotropic Medications on Children and alternatives to medication**	Why is this needed? **Rationale:** This project will fall under the full council's theme of : *Children and Youth*	How will we know if it is accomplished? **Measure of Success:** Written Report	Who is this meant for? **Target Audience:** Counties, Public, Legislature, Health Plans
Objectives	**Action Steps**	**Timeline**	**Leads**
How will we know we are on the right track? Explore the health effects of psychotropic medications on Children. 1. Research innovative practices counties and mental health plans are doing and alternatives to medications for children. 2. Gather information from Health Plans, County Mental Health, and the youth and family, and a Nurse Practitioner.	How do we get ON the track? Invite a panel to present at the April 2016 meeting • Invite Peter Currie, Health Plan Representative, and possible Nurse Practitioner to June Meeting. • Ongoing research and literature Review *(Child Welfare Indicators Project)*	What gets done by when? • April 2016: Presentation Panel to include • June 2016: Discussion	By whom? Cheryl Treadwell Staff

CMHPC

Healthcare Integration Committee

Describe overall goal here **Goal 3: Support and Monitor California's CCBHC's (Certified Community Behavioral Health Clinics) application development**	Why is this needed? **Rationale:** Increase workforce and access to care	How will we know if it is accomplished? **Measure of Success:**	Who is this meant for? **Target Audience:** Counties, Public
Objectives	**Action Steps**	**Timeline**	**Leads**
How will we know we are on the right track? 1. Advocate for Occupational Therapists as required provider 2. Monitor inclusion of Peer Specialists which is a requirement for CCBHC.	How do we get ON the track? • Continued monitoring via SAMHSA	What gets done by when?	By whom? Staff

_x____	**INFORMATION**	**TAB SECTION**	**C**
_____	**ACTION REQUIRED**	**DATE OF MEETING**	**06/16/16**
MATERIAL PREPARED BY:	Tracy Thompson	**DATE MATERIAL PREPARED**	05/16/16

AGENDA ITEM:	Review California Health Care Foundation Health Plan Report and update by Catherine Teare, CHCF
ENCLOSURES:	
OTHER MATERIAL RELATED TO ITEM:	

The Health Care Integration Committee has been focusing on mild to moderate health needs and data around utilization and hospitalization rates for those in the health plans with mild to moderate health needs in our work plan. Catherine Teare, CHCF, is working with a consultant that will be mapping out which health plan is carving in and which health plan is carving out, who they are carving out to, and how they are paying for those services. The report will discuss what the overall structure is (specialty mental health system and non-specialty professional outpatient mental health), what changed in 2014 (side by side chart), what is required as far as coordination, what the MOU requirements are, and how administrative structures work. There is also an appendix of background information that includes all-County letters, etc. Teare advised that a draft should be ready for review sometime in May 2016. A draft of the report may be available for the June meeting for members to review. The committee has invited Catherine Teare, Associate Director, California Health Care Foundation, to provide an update.