STAKEHOLDER RECOMMENDATIONS FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

PRESENTED TO

THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES AND ITS COUNTY PARTNERS

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CiMH Staff

Sandra Naylor Goodwin, PhD, MSW
President and CEO
California Institute for Mental Health

Alice J. Washington, BA
Associate
California Institute for Mental Health

ADPI Staff

Victor Kogler
Executive Director
Alcohol and Other Drug Policy Institute

Consultants

Eric Douglas, Senior Partner and President, Leading Resources, Inc.

Leslie Tremaine, EdD, Emeritus County Mental Health Director

Rama K. Khalsa, MFT, PhD, Mental Health Director, Santa Cruz County

Contact

California Institute for Mental Health
2125 19th Street, 2nd Floor
Sacramento, CA 95818
Phone (916) 556-3480
Fax (916) 556-3483
Fax (916) 556-3478
www.cimh.org

About the Cover

We chose this artwork by Lillian Bond because it represents a path we hope to travel in partnership. A quote from this report states it clearly, “There is much work to be done and creative approaches will be necessary for California to optimize its health care delivery system.”

Table of Contents

Stakeholder Recommendations for Mental Health and Substance Use Disorder Services

I. Introduction

In 2012, the California Department of Health Care Services (DHCS) retained the California Institute for Mental Health (CiMH) and the Alcohol and Drug Policy Institute (ADPI) to develop stakeholder-informed guidance for addressing critical mental health (MH) and substance use disorder (SUD) services. The purpose was to identify the critical public policy and/or funding issues in California's community-based MH and SUD systems, and to help DHCS develop short- and long-term goals to guide it and its partner counties in their administration of these services.

The project consisted of four phases:

A. Gathering information and data.

B. Establishing priorities for further development.

C. Creating workgroups to identify and make recommendations on priority issues.

D. Developing the final report.

A. Gathering information and data: The project began with information and data gathering through focus groups, interviews and written responses to questions. The list of organizations and individuals that provided data (along with the questions posed) is in Appendix B. In addition, a focus group was established that included various state agencies. The data gathered is in Appendix C.

B. Establishing priorities for further development: In the next phase, CiMH and ADPI convened discussions with DHCS, the Department of Alcohol and Drug Programs (DADP), the California Mental Health Directors Association (CMHDA), and the County Alcohol and Drug Program Administrators' Association of California (CADPAAC) to develop concurrence on the initial set of priorities. As a result of this meeting, the project team prepared a report on the top-ranked priorities and distributed it to stakeholders for review and comment. Stakeholders provided comments via email and then met on October 24, 2012, in-person and via a webinar. More than 80 people participated.

C. Creating workgroups to make recommendations on priority issues: On October 25, 2012, representatives from the state and the counties met to review the feedback and to decide which issues to assign for further analysis. In determining the final set of topic areas, the state and county representatives used the following criteria:

- Do realistic solutions exist? Is there a potential for early wins, for success?
- Does it offer an opportunity to clarify roles and responsibilities at state and county levels?
- Is it within the state and/or the counties' ability to control and address?
- Is it important to consumers and family members?

County and stakeholder input tended to cluster around a set of seven overarching topic areas. To adequately manage the number of topics and large volume of county and stakeholder input with a reasonable degree of consensus and sufficiently outlined by stakeholder input, a staff workgroup identified the issues and recommendations. For more complex topics, further stakeholder involvement augmented a staff workgroup. Evaluation, outcomes and accountability, and finance and operations topic areas were developed with additional stakeholder involvement.

1) Evaluation, outcomes, and accountability

Most stakeholder groups raised this topic as

an area of considerable concern because of the number of organizations involved and overlapping efforts. Because of the level of concern that this issue generated, a staff and stakeholder work group developed the issue and its related recommendations. The resulting issue paper is in Appendix A. The list of work group members is in Appendix B.

2) Financing of mental health and substance use disorder services

   Numerous stakeholder interviews raised this topic. A staff and stakeholder work group was established due to the complexity of the topic. The resulting issue paper is in Appendix A. The list of work group members is in Appendix B.

3) Coordination and integration of primary care and mental health and substance use disorder treatment

   Integration of MH and SUD treatment and primary care arose in the context of health care reform and the changes needed to service structure. Given the substantial information gleaned from stakeholder interviews, a staff workgroup addressed this topic area. The resulting issue paper is in Appendix A.

4) Reducing administrative burden

   Administrative burden was an issue, primarily because the service delivery system and related administrative requirements have not been reviewed in many years. A staff workgroup examined this topic area. The resulting issue paper is in Appendix A.

5) State and county roles and responsibilities

   The recent state-level reorganization of community MH and SUD services, as well as changes underway due to the 2011 Realignment and federal health care reform, are seen by stakeholders as creating both needs and opportunities to clarify state and county roles and responsibilities in programs, and fiscal oversight and direction of MH and SUD service systems. A staff workgroup explored this topic area. The resulting issue paper is in Appendix A.

6) Workforce skills and capacity

   Stakeholders expressed concern that the workforce for both the MH and SUD treatment systems is insufficient to meet current needs, much less the demand for increased services under health care reform. Further, the SUD workforce is lacking in standardized certification and licensing. There is considerable concern about the ability of uncertified or licensed staff to work in a managed care system. A staff workgroup explored this topic area. The resulting issue paper is in Appendix A.

7) Organizational capacity of substance use disorder service providers

   Stakeholders felt that the state's SUD system faces 2014 with significant structural limitations. With notable exceptions, the SUD service system in California is composed of many small independent non-profit organizations. Many of these SUD providers have limited administrative, staffing, and financial resources to make the transition to managed care and Medi-Cal insurance billing systems. A staff workgroup researched this topic area. The resulting issue paper is in Appendix A.

D. Development of the plan: These seven issue papers were distributed for public review and comment with a web-based survey from December 18 to 21, 2012. A total of 70 completed surveys

were received. A stakeholder meeting was held on December 21, 2012. Participants took part in person, via webinar, and by conference call. The stakeholder comments were analyzed and the issue papers revised accordingly. The revised versions were sent to the state and county representatives for review, and a meeting of state and county leaders was held on January 3, 2013. Subsequently, project staff began work on a final report.

Much more work needs to be done, and creative approaches will be necessary for California to optimize its health care delivery system. This document and series of recommendations provide a solid framework that the state, counties, and all MH and SUD stakeholders can use as a basis for working together on issues of common concern and importance.

II. GOALS, STRATEGIES, AND ACTIONS

These recommendations for MH and SUD services are organized around three goals:

1. Strengthen the overall delivery system for MH and SUD treatment and prevention services;
2. Support a coordinated and integrated system of prevention and care for MH, SUD, and medical care; and
3. Facilitate a coordinated method for data collection and evaluation of outcomes that helps ensure excellence in care and improved outcomes for individuals, children, families, and communities.

Each goal is infused by the over-arching core values of:

- Person-centered care
- Wellness, recovery and resiliency
- Cultural inclusion and competency
- Stakeholder communication and engagement
- The Triple Aim: Better health for populations, better care for individuals, and reduced cost through improvement.

This document contains strategies and actions related to each goal. Strategies are the broader initiatives required to achieve each goal. Actions are the specific

work necessary to achieve the strategy. These strategies and actions are drawn from the work groups and stakeholder feedback and are further amplified in the issue papers in Appendix A.

GOAL 1: Strengthen the overall delivery system for mental health and substance use disorder treatment services.

Background: The 2011 Realignment has shifted the burden of financial risk for Drug Medi-Cal (DMC) and MH entitlement programs to the counties. Counties assert that they cannot sustain this risk without having greater authority to manage these programs, particularly for DMC. This includes the authority to contract with service providers of proven quality and effectiveness. A robust implementation of parity for existing MH and SUD treatment services and for the benefits provided under the Medi-Cal optional expansion will provide quality and cost-effective services under the new care management framework. Parity will also ensure continuity of care across Covered California plans, Medi-Cal and other insurance programs. Stakeholders wanted to restructure the DMC program so that benefits and administration would be consistent with other MH and SUD services. It is also important that evidence-based practices are used to shape the care system to meet the needs of all persons including underserved populations (ethnic groups, older adults, children, and LGBT groups, and others). Achieving this goal and its related strategies will allow the state, counties and direct service providers to use limited resources in the most efficient way possible to produce optimal benefits to clients, families, and communities.

Strategy 1: Pursue solutions to provide counties with greater flexibility to manage fiscal and program risks.

Actions:

1) Provide counties the authority and tools to contract with high-performing, financially responsible providers in order to provide cost effective services that produce good clinical outcomes.
2) Pursue a variety of program and federal revenues solutions ranging from state plan amendments, waivers and changes to statute and regulation.
3) Provide relief for counties from funding formulas that unduly constrain their resources[1].

Strategy 2: Develop a process for the state and counties to define roles and responsibilities to manage shared financial risk

Actions:

1) Determine where authority lies for which types of decisions. Determine the extent to which discontinuities exist between authority, responsibility and financing, and where legislation, regulations, or new models are needed.
2) Fund small counties according to a formula that a) recognizes the unique fiscal and service delivery context of small and isolated service systems, and b) addresses increases in utilization, caseload growth, and cost increases.

Strategy 3: Develop financing strategies for Medi-Cal and other funding sources (e.g., the Substance Abuse and Mental Health Services Administration Block Grants) that are aligned with positive outcomes and best practices for MH and SUD.

Actions:

1) Develop methodologies and conduct pilot programs for pay-for-performance methods including case rates.
2) Develop recommendations for reimbursement for Medi-Cal services provided to clients in a county where they do not reside.

[1] For example, under-spending of 2011 Realignment funds can result in a dollar-for-dollar loss in federal Substance Abuse Prevention and Treatment Block Grant funds

Strategy 4: Develop a joint state and county strategy to advocate for behavioral health treatment parity in health care.

Actions:

1) Gather the data needed to document the case for parity to health plans.
2) Assure consistency of coverage between MH Medi-Cal, DMC, and the alternative benefit plan coverage for the optional expansion population.
3) Advocate for access to essential health elements for MH and SUD clients, including wellness, chronic disease management, and preventive care.
4) Support national advocacy efforts to achieve designated status for federally qualified behavioral health centers.

Strategy 5: Simplify federal billing, reimbursement, cost reporting, and administrative processes to reduce costs, improve efficiency, and return funds to direct care.

Actions:

1) Simplify federal billing structures and reimbursement processes for Medi-Cal in both the MH and SUD systems.
2) Provide counties with flexibility to establish rates for SUD treatment similar to MH Medi-Cal contracts with providers.
3) Develop a unified cost report system similar to the single cost report used by hospitals for Medicare.

4) Increase the efficiency and accuracy of the Medi-Cal Eligibility Determination System.
5) Reduce barriers to Medi-Cal eligibility through a simplified enrollment system.
6) Improve efficiency and timeliness of state and county MH and SUD contracts.
7) Develop a standard template contract for counties to use with providers of MH and SUD Medi-Cal services.
8) Develop standardized provider certifications for MH and SUD contracted providers.
9) Remove barriers to exchange of electronic health records and coordination of care.
10) Request the federal Centers for Medicare and Medicaid Services (CMS) to not require submission of a Medicare claim before billing Medi-Cal when the service is clearly not a covered Medicare benefit.

Strategy 6: Develop a coordinated plan to ensure an adequate and trained workforce to ensure access to care when needed, where needed, at all stages of life.

Actions:

1) Work with the Office of Statewide Health Planning and Development (OSHPD) to develop a long-range plan to enhance the MH and SUD workforce in terms of numbers, as well as geographic access and cultural competence.
2) Create a single-certification body for SUD counselors within state government.
3) Establish appropriate peer and family certification standards.
4) Enhance telehealth infrastructure and related training to serve underserved areas.
5) Promote distance learning to enhance education and training opportunities for workforce in underserved communities and remote areas.
6) Expand loan-forgiveness programs.
7) Promote outreach and incentive programs to attract more individuals to the field (Example: the Title IV-E Program in Social Services).
8) Create mechanisms for adding returning veterans with experience, training, and education in MH and SUD treatment to the California workforce.
9) Support incentives for cross training of staff in MH, SUD, and physical healthcare so that new models of integration are spread throughout the field.
10) Advocate for the addition of marriage and family therapists, and SUD-certified counselors as billable providers in Federally Qualified Health Clinics (FQHCs).
11) Adopt the national psychiatric rehabilitation credential as a new type of MH practitioner.

Strategy 7: Increase business capacity for substance use disorder provider organizations to avoid loss of clinical and program capacity in the face of major system changes.

Actions:

1) Consult with the California Primary Care Association and the California Council of Community Mental Health Agencies on the models they use for shared administrative support and capacity.
2) Identify resources to help SUD providers develop shared business functions through business partnerships, administrative service organizations, or other means.
3) Support legislation to enable MH and SUD providers to participate in federal meaningful use data funding to provide additional resources to build this capacity.

4) Work with foundations to fund joint planning efforts to develop new business structures.

Strategy 8: Create an ongoing forum for state and county leaders to tackle issues and develop strategies for system improvement.

Actions:

1) Develop the forum and focus it initially on the management and implementation of these recommendations.

GOAL 2: Develop a coordinated and integrated system of care for mental health, substance use disorder treatment and medical care.

Strategy 1: Identify best practices and key principles of integrated care.

Actions:

1) Form a service coordination and integration task force to review current promising models and identify principles and practices for effective approaches.

2) Disseminate the information through various distribution channels and through training and technical assistance.

Strategy 2: Enhance flexibility for counties to implement different models.

Actions:

1) Reduce financing barriers and create financial structures to support integration of care.
2) Reduce administrative barriers to integration of care and coordination between providers.
3) Create integrated site certification standards for community health clinics and SUD Medi-Cal outpatient treatment sites.
4) Provide SUD prevention services at (or aligned with) primary care sites in traditional settings, as well as at school sites and community-based health homes.

Strategy 3: Develop the workforce needed to support coordinated and integrated care.

Actions:

1) Create incentives for cross training of the MH, SUD, and primary care workforces.
2) Explore credential and certification options for peer and family counselors, and care managers. (Note: prior work has been done on this topic by the California Association of Social Rehabilitation Agencies and Working Well Together.)
3) Build on current ongoing efforts to define and implement core competencies for SUD prevention staff.
4) Support expansion of programs like the UCLA International Medical Graduate (IMG) program bringing bilingual medical staff to California.

Strategy 4: Develop a joint certification for MH and SUD service providers and sites.

Actions:

1) Create a special workgroup to review and recommend a set of organizational certification standards for outpatient, day treatment, and residential programs.

Strategy 5: Create an ongoing forum for state and county leaders to tackle issues and develop strategies for coordination and integration of care. (Note: For related actions, see Goal 1, Strategy 6.)

GOAL 3: Create a coordinated method for data collection and evaluation of outcomes that helps to ensure excellence in care and improved outcomes for children, families, and communities.

Strategy 1: Develop a comprehensive, statewide data-driven measurement system that supports evaluation, accountability, and quality improvement

Actions:

1) Identify and allocate resources critical to the success of this project.
2) Establish a task force to help develop the strategy and set the stage for implementation.
3) Research and identify all required measurements, outcomes, and data for both treatment and prevention services.
4) Review current work by state organizations, counties, and other entities to determine areas of agreement, duplication, and gaps.
5) Clarify the unique roles and responsibilities of the range of governmental organizations and other entities that are involved in evaluation efforts across the state.
6) Develop a measurement system that builds on existing work and recommends deletion of duplicate or unnecessary work.

Strategy 2: Implement a comprehensive, statewide data-driven measurement system.

Actions:

1) Identify near- and long-term objectives and specify roles and responsibilities.
2) Determine the readiness of participants to meet the near-term objectives, including technology systems and data element reporting structures, and arrange technical assistance as needed.
3) Work with partners and all stakeholders to ensure the continued scalability and utility of the system over time; make recommendations for modification as needed.

Strategy 3: Create an ongoing forum for state and county leaders to tackle issues and to oversee the work of the measurement system. (Note: For related actions, see Goal 1, Strategy 6.)

III. APPENDICES

Appendix A contains the issue papers that summarize stakeholder input and discuss in more depth the recommended strategies and actions.

The issue papers are presented in the following order:

1) Evaluation, Outcomes, and Accountability
2) Financing of Mental Health and Substance Use Disorder Services
3) Coordination and Integration of Primary Care and Mental Health and Substance Use Disorder Treatment
4) Reducing Administrative Burden
5) State and County Roles, and Responsibilities
6) Workforce Skills and Capacity
7) Organizational Capacity for Substance Use Disorder Service Providers

Appendix B contains the list of stakeholders and organizations interviewed as part of the planning process, along with the members of the work groups.

Appendix C contains interviews with stakeholders who participated, which illuminates the views of specific organizations and interest groups.

Appendix D contains the executive summaries of each of the California Reducing Disparities Project Reports (Native Americans; Latinos; Asian/Pacific Islanders; African Americans; and Lesbian, Gay, Bi-sexual, Transgender, Queer and Questioning).

Appendix E contains parity recommendations made by the California Coalition on Whole Health.

Appendix A

1) Evaluation, Outcomes, and Accountability
2) Financing of Mental Health and Substance Use Disorder Services
3) Coordination and Integration of Primary Care and Mental Health and Substance Use Disorder Treatment
4) Reducing Administrative Burden
5) State and County Roles, and Responsibilities
6) Workforce Skills and Capacity
7) Organizational Capacity for Substance Use Disorder Service Providers

ISSUE PAPER 1

Evaluation, Outcomes, and Accountability

A. Description of issue area

California's public behavioral health system does not currently have a comprehensive, efficient, and functional measurement strategy that ensures the routine collection and use of data in the MH and SUD treatment systems. There are multiple excellent evaluation and measurement efforts currently underway, but they are not coordinated into an overall system. For example, the DHCS collects data (Client Services Information, Full Service Partnership data, client satisfaction, and Medi-Cal utilization and cost data); the Mental Health Services Oversight and Accountability Commission is developing a framework for evaluation and contracts with UCLA for evaluation services; the California Mental Health Services Authority (a county joint powers authority) has developed a framework for evaluation of statewide prevention and early intervention projects; the External Quality Review Organization collects Medi-Cal performance data; CiMH collects data on children's evidence-based practices and has developed a palette of measures approach; and many counties have developed their own approaches for local evaluation and quality improvement. Together, these efforts attempt to measure client access to care, the experience of care, service quality and effectiveness, outcomes, quality of life, disparities and the benefit of prevention work. However, because these existing efforts are not part of a coordinated data collection, evaluation, and accountability strategy, California continues to lack a comprehensive statewide picture of system performance and the effectiveness of services. This makes demonstrating accountability to all appropriate state and county entities, and stakeholders difficult if not impossible.

B. Analysis of stakeholder feedback

Below are core themes that resulted from an analysis of the expressed comment and concerns:

- Concerns about quality of life, wellness, resiliency, and recovery for clients/consumers and families who have behavioral health challenges should drive the process of quality improvement, evaluation and accountability;
- The specific behavioral health care needs of children, youth, and families must be addressed;
- Evaluation efforts should be coordinated (not duplicative), add value, and efficient; they should not unnecessarily expend human and monetary resources needed for direct care;
- The Affordable Care Act (ACA) and the recent DHCS assumption of the Department of Mental Health (DMH) and DADP functions provide real opportunities to streamline and improve services;
- All data needs to be timely and understandable, and specifically include information related to cost offsets and how to maximize the potential of the ACA design for California, as well as to provide the legislative and executive branches of government, and others, with useable information about MH and SUD policy and budget;
- Data and evaluation must also support ongoing quality improvement efforts at client, program, county, and statewide levels;
- The unique/distinct roles and responsibilities of a range of governmental and non-governmental organizations/groups/entities involved in evaluation efforts need to be clarified;
- State-of-the-art information technology systems are essential for collecting, storing, retrieving, and analyzing data using technology;

- Dedicated funding to support a new, comprehensive measurement strategy and implementation is necessary so that it is commensurate with the amount of work required for proper data collection, management, and reporting.

C. Recommendations

These are the specific recommendations that emerged from stakeholder interviews and input in this issue area:

1. Develop a comprehensive system that supports evaluation, accountability, and quality improvement.

A task force of relevant entities should be formed to develop an efficient comprehensive, statewide, data-driven measurement plan for a strategy that supports evaluation, accountability, and quality improvement efforts that together help to ensure excellence in care, improved outcomes for clients, children, families, and communities. This plan should not be static; changes and modifications will be required based on the additional learning that will inevitably come from the implementation process over time.

Prior to developing the plan, the task force should research all necessary and required measurements and outcomes. The task force should also review and thoroughly understand the evaluation work currently under way to determine areas of agreement and congruence, and to identify instances of duplication as well as gaps. The plan should build on existing work and recommend deletion of duplication or unnecessary work. The measurement strategy should:

- Support ongoing improvement in quality of care and prevention;
- Support performance-based evaluation of clients as well as population outcomes; and
- Demonstrate accountability to all appropriate state and county entities, and stakeholders.

It is also important that this plan and strategy carefully address the following concerns: wellness, recovery, and resiliency; cultural and linguistic issues, including challenges related to threshold languages; underserved, un-served, and inappropriately served populations; and the need to focus on the entire life span (i.e., infants, children, youth, adults, older adults).

The measurement and evaluation strategy should address current and future state and federal requirements under the ACA, and it needs to be timely to add value to the field. Additionally, data collection should be supported by electronic health records, registries, and integrated with billing and other data-driven administrative functions.

The measurement and evaluation strategy will require resources to both develop and to implement. These resources should be identified and allocated for the work to proceed, and be successful. The task force will require expert consultants in a variety of fields, and it will require staff work if it is to succeed with this challenging task.

D. Conclusion

The clear consensus from representatives of state entities and stakeholders is that California needs a comprehensive, efficient, functional measurement strategy that ensures the routine collection and use of data in the behavioral health services systems, primary care-behavioral health integrated programs, as well as in MH and SUD prevention and early intervention processes.

ISSUE PAPER 2

Financing of Mental Health and Substance Use Disorder Services

A. Description of issue area

Financing policy under the CDSS 2011 Realignment is still evolving at the state and county levels. Revenue earmarked for MH and SUD services is deposited into a single behavioral health subaccount locally. However, each program area has Medi-Cal entitlement programs (DMC and specialty MH) that place counties at risk for financing growth driven by caseload increases and inflationary factors.

Program structure and operation are changing as counties investigate or implement models for integrated care with concomitant implications for new relationships among county MH and SUD departments, health care providers, community-based service providers, and stakeholders.

In under a year, the ACA will, through Covered California and the Medi-Cal optional expansion Alternative Benefit Plan, bring major changes in financing methods (e.g., pay for performance) and business practices to counties and their contract service providers.

B. Analysis of stakeholder feedback

The bulk of stakeholder input on the area of program finance concerned realignment, management of DMC, and managing risk, particularly related to the DMC and Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements. As further noted in this report, the implementation of parity and the ACA's expansion of Medi-Cal eligibility were also of concern. Finally, county and stakeholder comments underscored the opportunity for DHCS, with its new authority for MH and SUD programs, to take a fresh look at financing and administrative policy. A representative sampling of what we heard from stakeholders follows.

1. DMC and realignment

- We need to address how the EPSDT entitlement will be equally protected across the state.
- Numerous issues related to MH financing must be addressed. Mental health funding, the administration of funding, and enforcement of regulations need to be compatible with principles of recovery, client-centered treatment, and desired client and system outcomes.
- Important issues related to financing children's behavioral health services and entitlements, specifically EPSDT, must be examined.
- Realignment dollars not only play a role as match for federal funds in DMC, but are also a factor in the Maintenance of Effort formula for the Federal Substance Abuse Prevention and Treatment block grant. Stakeholders felt that these were conflicting demands on the same revenue pool.
- The challenges of the service delivery in the smallest counties should be considered in all finance-related decision making. Large counties contain rural areas with similar challenges that are in need of similar consideration.

2. Parity and equity

- We should think about quantitative and qualitative issues in terms of the implementation of the Wellstone-Domenici Mental Health Parity and Addition Equity Act of 2008. Behavioral health is oftentimes subject to a higher level of scrutiny in terms of medical necessity.
- To help bring MH and SUD services up to an equitable position with primary care in financing requires Congress to enact Federally Qualified Behavioral Health Center legislation and to provide funding to match what FQHCs now have. The state should support the efforts of the National Council for Community Behavioral Healthcare and other groups advocating for this legislation.
- Stakeholders want more information about the state budgeting system to better understand financial interconnections between departments and to identify where possible savings could occur.
- The concept of parity should extend to the equity of resources across primary care, MH, and SUD service systems.

3. Financing strategies

- The state should standardize MH and SUD fiscal systems, including budgeting, cost reporting, and billing formats and requirements. This should be done within the broader context of reducing and simplifying state-imposed administrative burdens. Among other benefits, this would permit the redirection of provider staff time to client services.
- DHCS should establish a structure encompassing a set of priorities for SUD that looks at all the revenue sources within the SUD system, as well as SUD-related costs in health care.
- The state and counties should determine the specific roles that each will play to oversee, monitor, and assure financial accountability.
- The state should clarify DHCS's role with regard to Mental Health Services Act (MHSA) accountability.

4. New approaches to purchasing MH/SUD services

- Funding should incentivize successful interventions that are cost-effective and result in high levels of customer satisfaction, and not base such interventions on the volume of service units or exclusively on the establishment of medical necessity.
- Fiscal incentives should be established for providers who can document that the interventions they provide to clients are directly related to improvements in health and quality of life, thereby indicating effectiveness of services.
- The costs of the interventions that lead to improvement need to be documented so that cost-effectiveness can be measured. Measures should document the extent to which services are compatible with the needs, circumstances, and preferences of the population they are intended to reach, and reflected in consumer satisfaction.
- The state should develop a policy for creation of a single administrative billing structure for MH, SUD, and primary care.
- Counties should have the option and authority to implement pay-for-performance reimbursement methods in provider contracts.

C. Recommendations

Interviews with key informants, workgroup discussions, and stakeholder input identified four major areas of focus: 1) manage DMC and MH realignment, 2) provide parity for DMC and MH and SUD benefits in the Medi-Cal optional expansion, 3) develop an overall approach and strategy for program financing, and 4) establish effective policy and processes for purchasing services.

1. Manage Drug Medi-Cal and Mental Health Realignment

The 2011 Realignment has shifted the burden of financial risk for DMC and specialty MH services from the state to counties. Counties cannot sustain this risk without additional funding to obtain new tools to manage the DMC program, including managing the provider network.

Additionally, in order to provide cost-effective services that produce good clinical outcomes, it is critical that counties have the authority to contract only with high-quality, financially responsible providers. Limited local resources must be allocated to services of documented effectiveness.

A variety of solutions should be considered, ranging from state plan amendments, federal waivers, and changes to statute and regulation.

Desired outcomes:

- Counties are able to manage service quality and client access.
- Counties can manage costs and risk under realignment.
- Counties are able to meet local needs with a minimum of administrative burden, whether originating from federal, state, or local government.
- The state and counties can maximize federal financial participation in Medi-Cal by taking advantage of tools such as federal waivers or state plan amendments to restructure the program.
- Counties have the ability to build a prudent reserve in their realignment accounts without incurring a maintenance of effort liability under federal block grant requirements.
- Counties will have an efficient cost-based federal reimbursement structure that aligns with the certified public expenditure obligations that have been transferred to local government.
- Administrative and indirect cost obligations are minimized to preserve realigned sales tax revenues for direct services to covered beneficiaries.

2. Provide parity for both DMC and Medi-Cal optional expansion benefits

Implementing and enforcing the requirements of the Wellstone-Domenici Mental Health Parity and Addition Equity Act of 2008 for MH and SUD services is essential if behavioral health is to be adequately addressed in the health care system. This means comprehensive coverage for the spectrum of MH and SUD services with an array of treatment options equivalent to those available in primary care.

Counties are constrained under realignment in their ability to finance the broader range of benefits that parity would seem to require. If parity is not implemented across the board for all MH and SUD services, a bifurcated benefit will result in discrimination against some beneficiaries and services. In addition, resource equity must exist across primary care, MH, and SUD services.

Desired outcomes:

- Parity exists among primary care, MH, and SUD services. Mental health and SUD are at primary care levels in terms of financing and the range of treatment options available. Parity exists on a non-quantitative basis, as well.
- Implementation of the parity recommendations made by the California Coalition on Whole Health[2].
- Parity analysis should look at all the dollars (MH, SUD, and primary care) spent on MH and SUD services and clients. This includes the Substance Abuse Prevention and Treatment Block Grant.
- Identify where the greatest gains can be made in terms of improved health outcomes and reduced cost, and rationalize the distribution of funds across the primary care, MH, and SUD systems.

3. Develop an overall strategy and approach for program financing

Traditional methods of financing SUD services (e.g., monthly cost reimbursement contracts supported by block grant funding) will change under health care reform. Realignment has changed the landscape, and health care reform will call for more accountability (i.e. pay for performance).

DMC realignment funding for the smallest counties is not adequate. In some cases, inequities occur in the distribution of DMC realignment funds to larger counties as well. This needs to be addressed so that clients all across the state have equal access to quality care. In addition, the EPSDT entitlement needs to be protected across the state.

Carving in DMC services may ultimately help advance the goals of health care integration, but the financing of these services should remain carved out until full parity is achieved. For now, the carve-in/carve-out issue should be on the back burner, until we get parity and the particulars of the Medi-Cal optional expansion are settled.

Because of the dissolution of the DMH and DADP (pending legislative approval) and their reorganization within DHCS, stakeholders are hopeful that the opportunity exists to start with a fresh look at financing strategies and methods. The state and counties have an opportunity to create financial incentives for continuing care and long-term care for chronic SUD conditions, as well as linkages with primary care and attainment of good health outcomes. Good financing strategies are not just a matter of moving money but also a means to achieve desired system goals and good health outcomes.

Desired outcomes:

- The vision and strategy addresses both MH and SUD systems.
- More money is in realignment to realistically fund services and not compromise access, quality, and outcomes.
- Small counties are adequately funded.
- Clients, children, youth, and families have access to an adequately funded system of care.
- DHCS develops a comprehensive vision statement that addresses the adequacy of funding for MH and SUD services, and considers the impact of MH and SUD on the primary care system.

[2] See Appendix E.

- The state budgeting process is more understandable for stakeholders, and cross-departmental funding impacts are more apparent.
- The financing strategy does not perpetuate silos among MH, primary care, and SUD services.
- DHCS has a federal advocacy strategy for MH and SUD services. This would, for example, address issues such as federally qualified behavioral health centers, parity, the future of the Substance Abuse Prevention and Treatment Block Grant, as well as waivers and other agreements with CMS.

4. Establish effective policies and processes for purchasing services

DHCS will have options for the design of state and county financing mechanisms; for example, continued fee-for-service, capitation, pay-for-performance, or other models.

DHCS will also be in a position to issue guidance or direction for the county-provider relationship. A similar range of options will be available for local-level provider reimbursement – per-member per-month, case rate or other bundled reimbursement, pay for performance, and other methods. Selection of provider payment methods could also be a county option.

Standardization of billing and other fiscal systems is important as long as it does not mean forcing SUD billing, budgets, and cost reports inappropriately into a MH or primary care framework. Lack of standardization in fiscal systems keeps MH and SUD locked into silos. Just as we work toward integration of patient care, we should be moving toward integration of billing and the reporting of fiscal, patient and encounter data across primary care, MH and SUD services.

Desired outcomes:

- Standardization of reimbursement mechanisms for providers across counties that are compliant with Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR, Part 2 confidentiality regulations. Utilize lessons learned from the dual-eligible pilots.
- County reimbursement of providers is aligned with outcomes. This is a phased process considering all the other changes on the horizon. The system has metrics on which outcome-incentivized reimbursements can be based.
- A preferential reimbursement for evidence-based practices.
- Funding policy permits a balanced combination of standardization and innovation.
- Savings in primary care (e.g., overnight stays, emergency department visits) that are produced by MH and SUD services are reinvested in the MH and SUD system.
- Multiple services in the same day are reimbursable.
- DHCS recognizes rural and small county issues in financing and service delivery.
- The county-of-service vs. county of residence issue in Medi-Cal reimbursement is resolved.

D. Conclusion

Summarizing the input from all groups, the desired outcome is to use limited resources in the most efficient way possible to produce optimal benefit to clients, families, and communities. This means California will have:

- Identified and viable mechanisms for financing growth in DMC and specialty MH under realignment.
- A robust implementation of federal parity rules for MH and SUD in the alternative benefit plans for the Medi-Cal optional expansion population. Adequate financing is needed to support quality services utilizing evidence-based practices and cost-effective program oversight by counties. Parity will also ensure continuity of care across Covered California and Medi-Cal Alternative Benefit Plan programs.
- A restructured DMC program in which benefits and administration are consistent with other MH and SUD services.
- A strategy for managing the federal Substance Abuse Prevention and Treatment Block Grant Maintenance of Effort requirements and a plan for complementary financing of SUD treatment, utilizing both Medi-Cal and block grant funds.

ISSUE PAPER 3

Coordination and Integration of Primary Care, Mental Health and Substance Use Disorder Services

A. Description of issue area:

Across the country a major theme in discussions on health care reform is the value of greater integration and coordination of care for people with multiple areas of need. Research has shown, for example, that depression is one of the top 10 conditions driving medical costs, and that 49 percent of Medicaid beneficiaries with disabilities have a psychiatric illness. Similar findings have been documented for the prevalence of SUDs and their impact on health care costs, as well as the value of effective integration and coordination of care. Studies have also shown over many years that the prevalence of co-occurring MH and SUD needs is very high, with impacts on overall health care costs and outcomes. Enhancing service linkages among MH, SUD, and physical health care has been described overall as crucial in achieving the Institute for Healthcare Improvement's Triple Aim of improving population health, reducing and controlling costs, and improving the experiences of patient care.

A wide range of stakeholders identified cross system service integration and coordination as an essential area for further development. DHCS as the key state agency responsible for many elements of MH, SUD, and physical healthcare service is seen as positioned to play a very positive role. DHCS can provide leadership to support development of coordinated and/or integrated models, in partnership with counties and a range of primary/health care organizations. Such integration and new models needing to address both MH and SUD co-occurring disorders (COD), as well as integration between primary and physical health care, and more specialized MH and SUD services.

Integration and coordination improvements can lead to better outcomes to care for clients, including children and youth, and older adults. Integration and clinic-based care are valuable in addressing the crucial issue of reducing health disparities for underserved populations, as well as for vulnerable populations, such as individuals who are chronically homeless, and those involved in the criminal justice system.

Overall, the recommendations break out into two major areas: (1) service models, and (2) needed supports. Described below are some of the key questions highlighted for each area, along with a summary of recommendations for each.

B. Analysis of stakeholder feedback

Service models and delivery system design: Stakeholders indicated that excellent work has been taking place in developing a range of effective models at the state, local, and national levels. They have focused on co-occurring MH and SUD services, as well as integration of physical health care and behavioral health. Some of this work has targeted specific sub-populations, as well as testing new service configurations, workflow models, clinical roles, and system features. California is seen as being able to take advantage of this work and to build upon learned successes to move ahead in enhancing service integration, supporting principles and best practices. Because of diversity in California, many different models and delivery systems will be needed.People cited innovative and effective service innovations between MH and SUD and various health care plans and providers in numerous counties. State organizations have also been active in working on new approaches to care, including the California Primary Care Association (CPCA),

Issue Paper 3 – Coordination and Integration of Primary Care, Mental Health and Substance Use Disorder Services *(continued)*

County Health Executives Association of California, CiMH, and others. Even with the change, stakeholders want to strengthen recovery values and systems of care provided by the MH and SUD services. The target populations cited that could particularly benefit from such developments included older adults, children and families, and underserved ethnic minorities.

The key questions raised by stakeholders were:

- How can relevant principles, evidence-based and promising service models for both COD and for integration of primary care and MH and SUD services best be identified and supported jointly by key state and county leaders in primary care, MH, and SUD?
- What kinds of state-level policy work might best reflect new service-related visions, values, and principles that underlie many of these models? How can the state's program policy role enhance current local innovative pilots and development? What are the best ways to communication new ideas and structures?

Barriers and needed supports: A wide range of stakeholder comments were made on the numerous barriers to coordination and integration. In some cases, it was recognized that the reorganization of services now under DHCS creates valuable opportunities for positive action. In other cases, federal changes taking place as part of ACA similarly could open up new options and reduce barriers. It was also noted that some local areas had developed "smart" operational approaches that helped (at least on an interim basis) to address these barriers, and warranted possible review and sharing with other areas.

The major areas seen by stakeholders as needing attention to reduce barriers and enhance supports in the overall area of financing and administration are outlined in the questions below:

- What are the key financing-related barriers that need to be overcome to promote integration? How might financing incentives and supports best be identified and developed for true integrated care that reinforces outcomes, not just visit volume? If providers see funding lost as a result of new models of care, they will resist making necessary changes, so how can alignment of finances reinforce implementation of best clinical models? (Note: This work needs to be closely tied to the findings and recommendations of the MH and SUD financing workgroup, as outlined in Issue Paper 2. Stakeholders recognized that enhanced funding and range of services covered by Medi-Cal would be crucial to successful integration.)
- What are the possible barriers and support needs in the area of information technology, and data systems and current data reporting requirements, such as the Client and Service Information system for MH, the DADP California Outcomes Measurement System, OSHPD data, and California Health Interview Survey? How might these be reduced, consolidated, or used more efficiently for better care coordination and integration? Can work telehealth include infrastructure and training to assist small/rural counties that may lack information technology resources and infrastructure supports? How might current limitations on exchange of information (e.g. federal HIPAA limits regarding SUD information) best be addressed to enhance treatment coordination in real time, as well as health planning?

- What kinds of dissemination, training/education, and workforce initiatives are needed to ensure support for the vision and practices of integrated services? How can training for both MH and SUD, and health care staff help promote effective business and services practices, as well as to enhance collaboration and team approaches at agency and provider levels? What is currently being done to disseminate any of these models being tested, and how can such efforts be improved or scaled for greater impact? What kind of approaches may be needed to serve as "incubators" to develop and evaluate new models as needed? Documentation of the barriers in these various pilots is critical to working on administrative barriers.
- The worlds of primary care and behavioral health services, as well as MH and SUD services, have been in separate silos for many years, with key differences not only in financing, structures, data requirements, training, and staffing, but also in "cultures." One of the questions raised in stakeholder interviews is, "How can we best create a shared culture that allows staff and programs to develop needed common values and understanding?"
- What other administrative actions might be needed to support these system improvements? How might opportunities in the ACA help support integrated care? How can DHCS and others advocate for federal simplification in health care reform to help reduce silos for funding and care models? What regulatory or other administrative barriers may exist, and how might these be identified and addressed? What other types of feasible regulatory and/or administrative actions might be needed to overcome barriers and support integration?

C. Recommendations

***Service models*:** Overall it is recommended that:

- DHCS and counties work together to form a coordination/integration task force. It should include DHCS, CMHDA, CADPAAC, CiMH, and ADPI, as well as other relevant state primary care related organizations (e.g. CPCA and County Health Executives Association of California) and representatives from other key stakeholder groups. Actions would include review of current knowledge on (1) promising models in various counties/systems; (2) national resource information on best practice models for both COD and integration of primary care, and MH and SUD services; and (3) changes in other states in which successful practices are showing solid results. Input is needed from key groups working on health disparities, such as the Racial and Ethnic Disparities Coalition, to identify recommended practices for underserved or special needs groups (e.g., the California Reducing Disparities Project recommendations, included in Appendix D). Supported models should include cultural and linguistic competence. A recommendation was made that the task force review the Katie A. settlement agreement document (CDSS/DHCS Core Practices Model) now under development for relevant material for work with children and families. It was also recommended that key safety net organizations, social services, education, and child welfare be included, as needed, to help ensure appropriate attention to the crucial social determinants of health. Stakeholders cited work done by CPCA as well as CiMH's current Learning Collaborative in this area as key sources. These could provide much of the material and support for this service model review.

Issue Paper 3 – Coordination and Integration of Primary Care, Mental Health and Substance Use Disorder Services *(continued)*

- Building on positive and promising work in California and other states, highlight common principles and elements of effective programs and practices. These could serve as guidelines for agency-level planning of models and practices of integration, as well as practitioner-level practices. They would reflect bidirectional collaborative models with enhanced MH and SUD screening for clients as well as treatment options for those in need. The health care needs of persons now served in specialty MH and SUD services should also be a target for unique models. These core principles would then be used to support such work, reflecting overall service system values and taking into account the local diversity and variations in structural environments (e.g., FQHCs, rural areas, and county operated health plans). Stakeholders felt that such work should always build on system principles of person-centered care and reflect recovery values. Using these program guidelines, the state and local partnership could foster collaborative approaches to planning and new service efforts. Review of similar guidelines in Maine, Arizona, Connecticut, Oregon, as well as existing federal and California-specific integration work, could serve as helpful guides.

Barriers and needed supports: Stakeholders had many recommendations on barriers and needed supports in the areas of financing, information technology and exchange, workforce staffing needs, and other administrative actions. Overall it was recommended to identify and coordinate specialized workgroups as needed to further develop these technical recommendations and implement them when feasible. In many cases, existing groups are already working in these areas and should be used to avoid duplicative efforts. These action areas are outlined below:

- Financing: It is recommended that a specialized workgroup be created to provide options on possible fiscal incentives, as well as financing and billing barriers to integrated care models. This group could recommend strategies to address them. The fiscal issues identified in interviews with stakeholders as well as in previous studies on this topic:
  a) Identify possible limitations on payments for same-day billing for physical health and MH services (or same day MH and SUD services), especially within FQHCs. Such limitations may hinder practices, such as a warm hand off between health and behavioral health providers as a common feature of best practice models. Options for change should be recommended with impacts.
  b) Develop recommended reimbursement mechanisms for key elements in integrated, coordinated health, behavioral health, and co-occurring MH and SUD services, such as substance use and depression screening, care coordination, consultation with (and without) the patient present, motivational interviewing, team-based care, and use of unlicensed support staff. These could include case rates, shared risk, and other creative approaches, as long as they support best practices for integration and outcomes.
  c) Develop a financial plan to support telehealth infrastructure and training to increase access for integration and coordination in rural areas, and for underserved populations.
  d) As part of review of reimbursement methods, examine adequacy of current rate structures for key services relevant to integration, and consider possible overall cost-effectiveness of any targeted rate increases or incentive systems. For example, some health plans pay for electronic notes exchanged across providers, which supports the additional time required for coordination.

Issue Paper 3 – Coordination and Integration of Primary Care, Mental Health and Substance Use Disorder Services *(continued)*

e) Examine feasibility of expanding performance-based contracting and/or payment mechanisms for integrated services, providing incentives through payment for outcomes rather than fee-for-service volume-based set ups.

f) Develop financial models that allow and support use of SUD-certified staff or peer wellness coaches.

g) Examine possible use of expansion of the FQHC scope of service requirements as a means for inclusion of billing for MH services and SUD services within health clinics.

h) Research possible new uses of federal block grant funds for COD services, and for the integration and coordination of primary care, MH, and SUD services; research other possible federal or foundation special funding opportunities; create a data bank of such information on resource development for local use.

i) Consider possible amendments in the state Medicaid plan, if needed, to enable a broader range of services and providers, consistent with identified best practices.

j) Examine, with Mental Health Services Act Oversight and Accountability Commission involvement, the options for highlighting integrated and coordinated primary care, MH and SUD services, and co-occurring disorders services models as potential areas of focus for future innovative projects funding under the MHSA.

k) Work with the counties participating in the dual-eligible pilot program to examine learning regarding: effective fiscal strategies for enhancing integration, and offer financial and consultation options for adoption as pilots expand in outlying years.

l) Review existing resource materials (e.g., the June 2011 CiMH Financing Integrated Care toolkit and other similar administrative guides) to identify other possible strategies and actions needed.

- Information technology, information sharing, and data-related issues: Using other expertise as needed, the financing workgroup described above could be charged with exploring these information- or data-related issues and developing further these broad areas of recommendations:

a) Review current work on health information technology at the state and local levels and across provider organizations. Look at barriers and opportunities to promote shared records and integrated treatment planning. Review examples at the local level where health information systems are working well as part of integration models. Based on this review, recommend any possible changes in current policies and procedures, legal clarifications, as well as needed training, toolkits, technical assistance or other supports for using information systems to enhance integrated services;

b) Based on this review, define possible priorities for use of any available state funds for health information technology, and develop guidance and resource information on other possible sources of funding for local development.

c) Clarify current status of HIPAA issues, especially in the SUD area; review any state laws and regulations that may add unnecessary barriers; recommend actions to eliminate or minimize such barriers, including federal advocacy if needed.

d) Promote policies for collection of uniform patient demographics, services, costs, and other variables potentially needed for future systems-level planning and evaluation. Determine how to align with state and local measurement, evaluation, and quality assurance work to support accountability and continuous quality improvement for integrated services (this area should be coordinated with any evaluation workgroup).

- Workforce staffing needs and barriers: Convene a workgroup, including CMHDA, CADPAAC, ADPI, CiMH, OSHPD, and DHCS representatives, as well as other key stakeholder groups, to review and develop further the workforce recommendations relevant to integrated care from interviews. This work group could build on valuable resources from CiMH, ADPI, CPCA, the California Association of Social Rehabilitation Agencies, foundations, and others already involved in such training, tool kits and technical assistance. (Note: See related Issue Paper 6 on workforce skills and capacity.)

  a) Tasks for this work group include: defining core competencies to guide curriculum development, encouraging cross training among MH, SUD, and health provider agencies, including possible continuing education requirements; using materials and resources developed at the federal level in these areas; targeting MHSA Workforce Education and Training, and technical assistance funds in this area.

  b) This group could then review and recommend further work needed to strengthen or expand dissemination efforts for the practice, principles, and models identified above. This may include strategies for use of "incubators" or early adopters, who could then serve as training sites for other areas at earlier adoption stages.

  c) Addition of marriage and family therapists and SUD counselors to FQHCs as billable providers would use an existing workforce to enhance integration in the clinic setting. This will require work (in conjunction with other workforce and finance efforts outlined in this report) to assure that these providers are able to bill for their services. Without the ability to bill, it will be difficult to add these critical providers to the FQHC environment, which serves many communities of high-risk and underserved patients.

- Other opportunities to support integration:

  a) Stakeholder recommendations that DHCS consider adoption of health home models as one of the options available under ACA, per guidelines in November 2011 letter from CMS. DHCS may wish to ask the integration workgroup recommended here to work with them to review this option as it could support the vision of integration MH, SUD, and primary care.

  b) Consider how the upcoming behavioral health services plan in follow up to the behavioral health needs assessment (as required by the 1115 Waiver – Bridge to Reform) may present opportunities to implement any of the recommendations highlighted here that promote integration.

  c) Some stakeholder groups also requested that DHCS and others consider action to advocate at the federal level for congressional action to adopt the designation of Federally Qualified Behavioral Health Centers at parity with FQHCs.

d) The experiences of the County Medical Services Program behavioral health pilots may also suggest some areas of further administrative action needed; the integration workgroup suggested here could review the findings of the recent evaluation as well as confer with affected counties for recommendations.

e) The technical work group described above could also develop a single set of site certification requirements for Medi-Cal, which include MH, SUD, and primary care services in a single site. Currently different requirements are making colocation difficult. This would be particularly helpful for outpatient care and care management services.

D. Conclusion

The consensus among stakeholders supported the development of a more comprehensive, coordinated, and integrated continuum of MH, SUD, and primary care services, promoting "whole health," and improving outcomes and cost effectiveness for people with multiple physical health, MH, and SUD needs. These services need to reflect and build on the solid recovery values and community support service strengths of the MH and SUD systems, ensuring a seamless client service experience through "smart" operational structures across systems where needed. Such development requires reducing key fiscal and administrative barriers, as well as assuring supports, as needed, to enhance the development of effective models of coordination and integration. The vision is to create a diverse range of innovative local responses that move toward a vision of "whole health" for all Californians.

ISSUE PAPER 4

Reducing Administrative Burden

A. Description of issue area

Over the last decade the percentage of funding and staff resources spent in administrative functions in MH and SUD (at the state and county levels as well as for service providers) has increased significantly, eroding the funding available for direct care and programs. It was widely recommended there be a review of many current administrative systems and costs, followed by identification of alternative approaches that maintain accountability and reduce costs. The ACA and the advent of electronic medical records and more sophisticated business tracking systems provide an opportunity to take a fresh look at billing and claiming, cost reports, Medi-Cal eligibility, data reporting requirements, certification and licensing, legal processes and contracts. Based on feedback from stakeholders at all levels, many requirements and duties have been added without letting go of older outdated or duplicative administrative and data requirements.

B. Analysis of stakeholder feedback

Stakeholders felt opportunities existed for improving efficiency and reducing duplicative, complex administrative requirements on many fronts. There was a shared view that mission "creep" (in an effort to meet needs for accountability and legislative changes) has led to a complex maze of administrative requirements that cost significant staff time and dollars, but often did not achieve the goals intended. A variety of policy studies have been done in this area, and other states have taken on the task of restructuring and reducing duplicative administrative, fiscal, and data systems. Many states have been successful in getting help from consultants familiar with federal requirements. All stakeholders felt that it was a good time for re-assessment and that as many dollars as possible should be spent on meeting client and family care needs in a cost-effective way.

C. Recommendations

The proposed administrative improvement areas would need coordination, resources, legislative support, and partnerships to be successful. The vision for each area of improvement is articulated with background and suggested processes to move forward are discussed.

1. Create a standardized and simplified methodology for provider reimbursement and billing.

Similar to primary care, the state needs to create standardized methods for provider reimbursement and billing for MH and SUD services. It is important that clinics are able to provide and bill for both medical care, and MH and SUD services without burdensome requirements. Current MH Medi-Cal and DMC billing systems are very complex, with different rates, codes, and lock-outs, making it very difficult and expensive for providers to master. Stakeholders noted that for providers who serve multiple counties, standardization and a minimum level of computer billing capacity are important. Many counties cannot accept electronic claims and require providers to use cumbersome data entry of claims on a variety of software systems, adding to cost and confusion. Many services are not ever covered by Medicare, so it seems unnecessary to go through a complex billing process just to get an obvious denial and then bill Medi-Cal. There was a strong desire to have the state advocate with CMS to eliminate this unnecessary billing requirement, which creates costs and waste that could go into care.

Recommended process: Create a county-state workgroup to review current billing and reimbursement systems, and develop an incremental change process. Build on HIPAA standard claiming formats, transaction codes, and standard rates. Set a goal of creating a simplified billing system with federal and state approvals by December 1, 2014. It is important to note, based on advocate feedback, that changes in billing systems do not eliminate the entitlement nature of the Medi-Cal benefit, including EPSDT for youth. It was also noted that greater standardization for billing and outcomes could benefit the system in terms of tracking the "state wideness" issues.

2. Create a unified cost reporting system.

The state should create a unified cost reporting system, similar to that used by hospitals for Medicare, instead of the current plethora of cost reports with different structures and methodologies for MH specialty care, DMC, federal block grants, MHSA, and categorical funds. Doing so would make it easier to communicate how funds are spent to the community as well as legislators, and it could allow comparison across counties. It would allow a complete picture of how counties are spending state, federal, local, and special funds across their systems of care in MH and SUD. If MH and SUD services are part of an FQHC under prospective payment, then the funds should be part of that existing cost report, not a second or third additional cost report. A unified cost report similar to the hospital Medicare cost report does not eliminate the need to track costs down to program level, and it would be helpful to have clear definitions for classification of costs and distribution of administrative overhead. A unified cost report could also be combined with the Client and Service Information system and California Outcomes Measurement System data to look at costs for specific programs and special populations within them using demographic categories.

Recommended process: State and county partners could review existing requirements and policy goals linked to the cost reporting systems. They could consider this process incrementally starting with a unified cost report for MH and SUD services. Collaborate with CMS to minimize audit risks. As needed, seek one-time funds to supplement current resources to create this unified cost report and get technical assistance. Consider in the design cost reporting requirements that add value to policy makers and program planners related to return on investment and total costs. Set a long-term goal of looking at cost offsets in physical health, criminal justice, and foster care to evaluate the business case of investment in MH and SUD services. Another long-term goal would be a single-cost report, for FQHC and non-FQHC safety net clinics, particularly for those providing primary care, and MH and SUD services. A unified cost report system would need to coordinate with the proposed finance activities.

3. Simplify Medi-Cal aid codes and enrollment and eligibility systems.

The complexity of the current Medi-Cal system with more than 160 aid codes and complex eligibility systems has long been an area of desired change. Many policy papers have been written on the need to reduce the number of aid codes and the complexity of the current eligibility and enrollment systems. To ensure all California citizens get timely access to Medi-Cal and care, a simplified system would be a powerful asset.

Recommended process: In partnership with the state and local social services departments and the California Legislature, utilize the ACA-required eligibility changes to reduce the administrative burdens and costs on local social services departments and the Medi-Cal program. Identify and encourage easier-to-use enrollment systems with online access. The ACA provides an opportunity to take a fresh look at this issue. A timeline that is aligned with ACA legislation should be developed to complete this process.

Given current computer systems, it will take multiple years to implement fully, but the vision should be created by 2014 when millions of new patients will be added to the Medi-Cal program.

4. Improve care and quality using health information technology.

There are currently many data collection requirements, including MH services data in the Client and Service Information system, SUD data from the California Outcomes Measurement System, claims data, cost report data, and multiple special databases to meet a large range of data and business requirements. Rather than continuing to add new requirements, it is important to ask some key questions: "Is this data already collected in some current data reporting requirements?" "How could current data systems be modified to meet this new need?" Adding new stand-alone requirements increases administrative costs and takes dollars away from care.

Recommended process: Seek legislative support for financial resources for one-time technical assistance as needed. Form a team with local representatives and state quality representatives to set priorities and document current data collection systems. Other states have used special technical resources to help reduce duplicate data collection and increase the number of databases that can exchange information by program or client. States have also reduced duplicate and repetitive evaluation and outcome gathering methods that take clinical staff time away from care and add more administrative costs and complexity. Working with the federal government through the Office of National Coordinator for Health Information Technology and CMS, identify new approaches to gathering critical data. All stakeholders were interested in maximizing their investments in technology and evaluation to see what works, for what cost, and how best practices can be replicated and shared across the field of MH and SUD care. This work should be coordinated with the recommendations in the evaluation, outcomes, and accountability section of this appendix (Issue Paper 1).

5. Create standardized and combined (for dual diagnosis treatment) MH and SUD organizational certification and licensing.

There is a strong desire to create Medi-Cal certification systems for outpatient, residential treatment, and day programs that serve patients with both MH and SUD issues. These programs would more easily allow for blended funding and care. Simplification and compatibility of requirements would lead to better programs and client outcomes. A similar approach would benefit children's programs for youth with MH and SUD treatment needs.

Recommended process: County staff members who deal with DMC organizational requirements could develop a set of proposed changes for DHCS to review and discuss. Also, to create true systems of care and efficient allocation of limited dollars at the local level, stakeholders recommended that the state delegate to counties responsibility for certification of their DMC-funded contract providers (similar to MH Medi-Cal). This delegation in MH has been effective and allowed for both support and monitoring of care from the contract providers. The county committee would provide to DHCS a joint proposal on this area for review and discussion. Work on this issue should be coordinated with service integration activities and vice-versa.

6. Establish a single certification entity for SUD counselors.

The state should establish a single certification entity for SUD counselors who do not have master's level or higher clinical licenses. This would greatly benefit the field and reduce current confusion and career tracks. There are too many complex conflicting systems currently.

Recommended process: The county with stakeholder input could provide a set of recommendations to the state on this issue. Providers would be willing to pay credential fees if they allowed for more billing options with Medi-Cal and other insurance. Thus, funding could be possible for this process through approved certification programs with clear criteria set by the state. In a December 2012 stakeholder meeting, stakeholders mentioned that New York and other states have systems that seem to work well. The goal would be to have SUD certification recommendations for the state by June 2014.

7. Simplify and streamline state and county contracts.

Current processes are very expensive and labor intensive for MH, SUD, and public health. Avoid full state and county contracts for every small program area. Since counties are legally an arm of state government under the California Constitution and therefore different from other legal entities, a more streamlined system may be legally possible. In the current system, state and county contracts for each individual program are going back and forth throughout the year and are rarely final before the end of the fiscal year.

Recommended process: This project would be ideal for a committee composed of representatives of the County Supervisors Association of California, CMHDA, CADPAAC, the County Health Executives Association of California, the County Counsel Association and state staff to identify best options and obtain legislative support if changes are needed to the legal processes between the state and counties related to funding of services. The committee could consider a biannual umbrella evergreen contract with annual rate and allocation updates that could be approved by the state as part of the budget and local county boards of supervisors. A proposed timeline could be developed by the joint committee to study this issue and recommend an approach that saves money, staff time, and provides clarity and accountability as required by state law. State and local legal input would be part of the process.

8. Develop a patient- and provider-friendly system for sharing MH and SUD clinical information across all current clinical care providers.

Individual should be able to insist that their doctors and clinicians coordinate care, avoid drug interactions, and support a unified care plan with patient input. Currently there are many barriers to this vision. It is critical to share medication and lab information for basic safety and effective treatment. The goal would be to access information in real time to support quality of care. The benefits of this effort would be great in terms of care quality, avoiding drug interactions, and achieving a holistic approach to care and wellness. The challenge is that federal and state legal changes are needed. Legislation is important to clarify the "rules of the road" in this area according to board members from Cal eConnect, an organization established to set up information exchange rules and infrastructure throughout California.

Recommended process: Establish a workgroup with stakeholder and state representatives to coordinate with federal policy efforts in this area as well as with Cal eConnect and the Office of National Coordination for Health Information Technology. This goal and issue is not unique to California, and a broader approach is needed. Recommendations need to consider privacy, evidence-based practices, and coordination across primary care, and specialty MH and SUD providers. Given this complexity and the technical issues for exchange of health information, a reasonable goal would be to accomplish this within three years using existing state and federal efforts as well as advocacy. The issue paper on integration of services contains related recommendations.

D. Conclusion

Stakeholders share a vision of efficient administrative systems that meet clinical as well as administrative needs for accountability, quality, fiscal integrity, and planning. The potential benefits of administrative streamlining are great. It is time for a re-evaluation of historical approaches. The challenge is the time and resources needed to do a competent and effective job of "revamping" historic systems and structures to meet the needs of the future. To make the most of the integration of MH and SUD services into DHCS, however, a "rethinking" of current systems and structures is needed. Fortunately, the ACA does require and support a thoughtful review of many of these areas, and to achieve optimal health for Californians with the ACA, it is important to spend funds wisely on both care and administrative supports.

ISSUE PAPER 5

State and County Roles and Responsibilities

A. Description of issue area

Recent state-level reorganization of MH and SUD services, as well as changes underway due to the 2011 Realignment and to federal health care reform, are seen by stakeholders as creating both needs and opportunities to clarify state and county roles and responsibilities in program and fiscal oversight and direction of MH and SUD service systems. Some of the key issues raised included:

- Defining and communicating what can be expected of DHCS and other state agencies in MH and SUD program and financing oversight;
- Deciding how best to meet needs for system-wide leadership in policy development, planning, program and fiscal monitoring, and accountability;
- Dealing with the disparate administration and financing of major components of the system to maximize coordination and reduce risks of fragmentation;
- Defining and communicating to stakeholders the roles of DHCS and other state departments and organizations now involved in MH and SUD;
- Achieving accountability for the overall performance of the various systems and funding streams;
- Identifying key continuing and/or new roles in this changing climate for county level MH and SUD leadership and direction;
- Assuring in the context of realignment that counties are able to balance appropriate local flexibility and direction with needed assurances for statewide access and quality standards; and
- Assuring effective structures for joint local and state decision-making to deal with rapid and ongoing climate of change across a wide range of issues.

B. Analysis of stakeholder feedback

DHCS roles and responsibilities: Stakeholders described a climate of uncertainty and a need for greater clarity about how DHCS can be expected to carry out its new roles in the shift away from long standing roles of DMH and DADP as lead state agencies. The other changes taking place at both the state and federal levels in financing and policy increased this sense of uncertainty. Major areas of stakeholder feedback regarding DHCS roles focused on the following issues:

- What kind of leadership role should DHCS play as lead state agency for MH and SUD in key areas, such as program and financing oversight, system policy direction, and planning? How should we define expectations of DHCS in MH and SUD services and financing?
- Given the importance of active stakeholder inclusion, how can changing DHCS roles best be delineated and conveyed to stakeholders?

Coordination of roles with other involved state departments and organizations: Stakeholders expressed concerns regarding fragmentation and challenges presented by the recent re-organization of state-level roles involving multiple agencies in MH and SUD services management functions, such as licensing, certification, and state hospital management. These changes added to on-going perceived needs for coordination at the

state level with other agencies crucial to assuring collaborative systems of services for children and for adults with MH and SUD needs (e.g., education, criminal justice, social services, aging, housing, employment). Stakeholders felt overall that it would be important for DHCS to play a strong role in assuring such coordination and communications, providing clarity wherever feasible to local entities and to stakeholders on how these roles would be optimized, and coherence and alignment achieved as needed to guide MH and SUD work at all levels. Major areas of stakeholder feedback regarding such state-level coordination are as follows:

- How can the roles of DHCS and other state departments and organizations with statutory responsibilities for MH and SUD best be coordinated? Where should DHCS exercise leadership in this process?
- How can DHCS help create a climate for collaboration with other state agencies involved in services that are a part of a broader system of care approach to MH and SUD needs?

County roles and responsibilities: Stakeholders agreed it is crucial in any work on role definition and clarification that county MH and SUD authorities are positioned to carry out strong roles that are essential to assuring adaptation to the tremendous variability across California cities and counties, as well as tapping the unique strengths of such local systems through effective consultation models in state decision making. The optimal roles for counties overall are ones that meet broad state and federal mandates, and systems policies while respecting counties as partners and allowing for local variability in approaches and priorities. Stakeholders believed that finding this balance requires on-going work in a climate of consultation, communication and collaboration. Major areas of stakeholder feedback regarding county roles addressed the following areas:

- What are some of the key areas in which counties should have a lead role?
- How can a climate of real partnership best be developed between counties and DHCS? What are some key areas in which that kind of consultation is most needed to set reasonable policies and directions in the current challenging climate of change?

C. Recommendations

Below are recommendations based on stakeholder feedback in the major areas of DHCS roles and responsibilities, coordination with other state agencies, county lead roles, and state and county collaboration.

DHCS roles and responsibilities: DHCS leadership as the lead state department for MH and SUD should focus on the following key areas:

1) DHCS's role should focus in part on developing plans to enhance the overall credibility of MH and SUD services through demonstrating strong performance accountability. Involve counties and other key stakeholders in planning the best way to enhance credibility and accountability. Areas mentioned as foci for DHCS attention included getting information from local systems and providers as needed to assure reporting that demonstrates clear results or outcomes of services, and efficient and effective use of funds, especially of dedicated funds.
2) Respondents also recommended DHCS focus on ensuring compliance with key mandates, including but not limited to: regulations and standards for program quality, access and availability for all

services, including those in the Specialty Mental Health Medi-Cal Plan, appropriate availability and use of grievance and appeal procedures, use of least-restrictive environments in compliance with Olmstead, and assurance of key child and family service entitlements and mandates, such as those identified in the Katie A. settlement. It was recommended that DHCS and others, as appropriate, prepare a background paper that incorporates significant current activities in areas such as the department's Strategy for Quality Improvement in Health Care, and the Mental Health Services Oversight and Accountability Commission FY 2013-14 Annual Update Instructions for MHSA, as well as an inventory of applicable federal and state laws and regulations, as a guide in this compliance work.

3) Respondents recommended DHCS carry out program oversight roles in a manner that takes into account the related need to streamline such systems and to reduce any administrative burden that could detract unnecessarily from investing funds in direct services. (Note: See related issue papers Reducing Administrative Burden [Issue Paper 4], and Evaluation, Outcomes and Accountability [Issue Paper 1].)

4) DHCS should prioritize providing clear and timely guidelines, regarding new or changed performance expectations and administrative procedures, geared to help providers perform well and be successful and compliant in meeting requirements. This communication is seen as needed to help clarify the types of services that can be provided by whom and, where needed, with the indicators of medical necessity. Such clear and timely communications can help DHCS show strong leadership and oversight while helping to reduce mistrust and confusion for providers and local authorities. Such efforts could also help ensure timely claims processing, payments, taking into account local and provider needs for time to change systems and to maintain cash flow. Some felt that the Short-Doyle II claims payment system was an example of the negative impact of a state agency's lack of effectiveness in these kinds of key administrative roles.

5) DHCS's role also should include strengthening and integrating data systems as needed to assure better system wide data availability and information flow, more user-friendly data systems, and clear reporting. It was also suggested that the state play a role in providing support for small counties and rural areas in enhancing local systems as needed to be part of these improvements.

6) Another important recommended role is that DHCS provide clear policy direction and planning for health care reform and related new directions. The development of such policy and planning should be done in consultation with counties and other key stakeholders. The work needs to address at a minimum strong behavioral health benefit designs and coverage plans, assurance of parity, review and determination of key new and enhanced financing models, support of needed service enhancement and development strategies, and addressing crucial workforce needs. Such policy development clearly ties into other business planning issue areas as well as other major planning activities (e.g., the 1115 waiver's behavioral health services plan, Duals project, and Health Benefit Exchange work). Stakeholders strongly recommended that such policy work take advantage of new integration opportunities while maintaining proven strengths and key values for recovery and use of alternatives to hospitalization, as well as for prevention and early intervention services. It was also recommended that attention be given as well to longer-term planning that goes beyond near-term budget cycles.

7) Another key role involved providing a strong advocacy voice for the MH and SUD fields. This advocacy would include, for example, efforts to leverage federal funds, working with the California Legislature and administration to sustain and enhance available state funds, assuring cost offsets and savings due to MH and SUD services are returned to the field, playing a role in areas such as public education regarding the potential for recovery and stigma reduction regarding MH and SUD. It was also recommended that DHCS demonstrate clearly that MH and SUD are equally represented and given priority in the administration of health care services and in future delivery of health care. This advocacy was also needed to help ensure provision of a full array of treatment and rehabilitation services by insurers and payers. This strong advocacy would help in addressing some stakeholder concerns about the visibility and priority given to MH and SUD services potentially being diminished in this reorganization.

8) A key recommendation dealt with DHCS leadership in addressing health disparities, dealing with underserved groups, and enhancing cultural responsiveness of services. Among the underserved groups needing focus are underserved cultural and ethnic groups. Part of this leadership would include continuing to require strong cultural competence planning by local systems and to offer technical assistance to areas with high indicators of disparities. Also mentioned were special needs populations such as aging adults, stressed families and single parents, and those with dementia, traumatic brain injury, and autism.

9) An important DHCS role cited by stakeholders is to model the needed engagement and inclusion of counties and other key stakeholders in decision-making and planning processes. This modeling of inclusion and partnership approaches is needed to help build a climate of greater trust and to enhance the potential for "smart" coalitions that could provide a more unified voice and better advocacy for the overall MH and SUD field in current wider discussions of health care and state funding priorities. In addition, stakeholders felt it would be important to assure open, clear communications with a wide range of stakeholders on appropriate role expectations for DHCS as a key state agency level leader. This emphasis on such active communications regarding roles was seen as helpful in establishing trust with stakeholders. It may be useful to review information regarding roles via regional forums and targeted meetings to assure clarity.

Coordination of roles with other state departments and organizations involved in MH and SUD services: Below are the recommendations from stakeholders regarding the actions needed to assure effective cross-agency coordination and to minimize risks of fragmentation with those agencies that share statutory responsibilities for MH and SUD:

1) DHCS should work closely at the state level with other key entities now directly involved in MH and SUD service management functions to develop possible memorandums of understanding (MOUs), joint plans and policies, shared administrative procedures, and other means of cross-departmental coordination. Those named included the Department of State Hospitals regarding state inpatient facilities, Department of Public Health and others as needed regarding cultural competence and health disparities work; Department of Social Services and others as needed regarding licensing and certification functions; OSHPD regarding workforce issues; and DADP for non Medi-Cal SUD issues. Work would also be needed from the Mental Health Services Oversight and Accountability Commission and the California Mental Health Planning Council, especially regarding MHSA support, oversight, and consistent direction. Other recommended state-level areas of focus for DHCS

leadership in service coordination included work with the Insurance Commissioner on parity, as well as continuing close engagement with the Health Benefit Exchange regarding finalizing and implementing coverage plans for Health Care Reform. Stakeholders noted that the state departments listed above could be encouraged to join DHCS in direct interactions as needed with CMHDA and CADPAAC to help assure effective communications with county-level leadership, as well as in other venues for stakeholder communications. Also reflected in input was the need for close coordination with the Department of Social Services as needed to ensure compliance with key Katie A. requirements.

2) Some stakeholders expressed concerns regarding the reorganization of responsibilities for MH and SUD facility licensing and certification. It was recommended DHCS advocate for these functions, as related to MH and SUD 24-hour facilities, be under the same authority and not split among separate state departments, and that they be staffed by people familiar with MH and SUD treatment settings.

3) It was recommended that DHCS also engage in close work with criminal justice agencies to help enhance planning and resource development work related to better meeting the MH and SUD needs of people involved with the criminal justice system. New opportunities were also cited for DHCS to work in conjunction with criminal justice on pursuing expanded Medi-Cal coverage for some criminal justice-involved individuals, as well as evaluating jointly the impact of MH and SUD services on AB 109 populations.

4) Another area in which collaborative efforts for DHCS will also be crucial is in working with all state agencies and other partners involved in primary care to create a climate for collaboration among primary care providers (e.g., FQHCs, county clinics) and county MH and SUD services. Collaboration with education and social services agencies involved in systems of care for children is seen as especially needed in light of Katie A. settlement requirements, as well as the changes in responsibilities for services to special education students.

County roles and responsibilities: Stakeholders overall recommended that counties play a strong lead role in the following areas:

1) It was recommended that counties be acknowledged as continuing to have the lead role and responsibility for setting local fiscal priorities for services, as long as such priorities are within the broader "container" of state and federal mandates. Developing at the state level, some "county option" services for enhancing basic service packages such as DMC could also support this local ability to set fiscal priorities.

2) Stakeholders also felt counties should have the lead role in deciding who becomes a DMC provider. Changes as needed should be made to align current practices and policies with this expectation in order to help counties manage the risk of DMC funding in realignment as well as to assure the quality of providers.

3) Stakeholders felt counties needed to have a strong say in determining program models that best fit their local needs and resources, as long as such models meet basic state requirements and standards. Clear standards, developed with local input, would support counties being able to carry out that role effectively. This variability would allow local areas, for example, to ensure the ability to meet the needs of special groups within their areas as part of addressing disparities. Within the context of a clear fiscal framework, program standards and measures of performance, counties would then be

able to take the lead in innovations at the local level to reach statewide service goals.

4) It was recommended that counties have the clear lead and responsibility for engaging local stakeholders in planning and priority setting. Clear and reasonable state policies and standards for such local engagement were seen as sufficient to provide a foundation and climate of accountability within which local areas could then be allowed to vary in how such requirements were met.

State and county collaboration: Stakeholders also strongly recommended the development of new structures for state and local collaboration, as needed, across a wide range of areas in an environment of rapid change:

1) Stakeholders recommended that work take place to develop new partnership structures and forums for collaboration that reflect and help to create new norms of consultation and collaboration between counties and DHCS. Discussions with CMHDA and CADPAAC could be productive in developing the broad outlines of such models, with clear delineation of when and how communications take place, the kinds of issues most productive for consultation, the key players to be involved, and the norms and practices for dealing with areas of disagreement, and strong differences in perspectives.

2) One key area seen as important for such ongoing dialogue is developing longer-term fiscal models to move forward in various areas of the post-realignment and health care reform worlds. Examples of such fiscal policy included: "To what extent should local MH and SUD systems be primarily safety nets, "Kaiser-like" plans, or a "smart" hybrid? How can adverse selection risks involved in these choices best be handled? How can private coverage plans and those for Medi-Cal populations best be aligned to avoid two-tiered systems? What options may exist for pay for performance systems? How can the needs of those who will remain uninsured after 2014 best be met? How can the state and counties sustain services to the Medi-Cal optional expansion population after federal financial participation begins to decrease? How can such financing models best take into account the needs of special groups whose needs cross areas, such as those with autism, dementia or traumatic brain injuries? How can other areas of cross-system financing be optimized and any cost offsets clearly due to behavioral health services best be re-invested?"

D. Conclusion

The consensus is that stakeholders seek enhanced clarity, coordination, and functionality of state and county roles and responsibilities to assure needed system-wide accountability, leadership and advocacy for both MH and SUD in a manner that capitalizes on both local and state strengths.

ISSUE PAPER 6

Workforce Skills and Capacity

A. Description of issue area

Looking ahead to the 2014 expansion of Medi-Cal and commercial insurance coverage, there are not enough MH and SUD providers (especially those providing Medi-Cal services) in California to ensure timely, appropriate access to care. Rural and frontier areas have particular challenges in having enough access to programs and providers, as do special needs patients who are often homebound, isolated, or have barriers to care in terms of language or culture. There is already a significant lack of providers from diverse backgrounds who are culturally competent. The aging and retirement of baby boomers from the workforce will exacerbate the challenges of having enough qualified providers. New clinical providers, particularly for Medi-Cal beneficiaries, are needed to ensure timely access to needed care and optimal health outcomes.

Besides quantity and the geographic distribution of providers, the workforce needs training and experience with new models of care embedded in the "patient-centered medical home" to ensure solid clinical outcomes and meet the needs of culturally diverse populations. The lack of culturally trained and linguistically skilled providers contributes significantly to health disparities and problems with both access and effective treatment. To address these needs, innovative new approaches are required with new career ladders and support systems for individuals interested in providing care in both MH and SUD treatment and care management.

Mental health and SUD services, provided within primary care medical homes, would help reduce stigma and improve coordination, but new models and training are needed. This is due to the fact that current workflows and business models in primary care and behavioral health are very different. Conflict and operational problems will occur, unless this is faced head-on with new delivery models, training, and planning.

In addition, new models of recovery have shown the value of utilizing peer counselors and family educators as part of an optimal system of care for individuals with disabilities and special needs. These skill sets need to be utilized and acknowledged with a certification structure in the MH service delivery as part of an optimal workforce for the future. All disciplines should practice at their fullest scope(s) and new disciplines should be developed for additional scope, skill sets, and impacts.

B. Analysis of stakeholder feedback

Stakeholders raised many concerns related to workforce capacity, access, and skills. The first set of issues relate to licensing and certification of existing and potentially new types of providers and various strategies to increase access to these providers. The second set of issues relate to learning new skills and new program models, particularly for underserved populations. Five policy papers on this topic are included in Appendix D to this report with a summary of recommendations.

Beyond shortages and skills, there are also unique issues within the SUD field, which has a primarily peer recovery-oriented workforce with limited options to bill Medi-Cal. Few services are billed to Medi-Cal outside of the County Medical Services Program system because the current Medicaid plan for California does not include them. In addition, there are multiple certification agencies with no clear accountability system linked to state authority. This is an area for recommended change and more accountability,

particularly if individuals are going to be part of a workforce billing Medicaid. (Note: Related issues and recommendations are contained in the issue papers on financing [Issue Paper 2] and administrative burden [Issue Paper 4].)

Mental health workforce challenges include both licensed and unlicensed staff resources. Some licensed staff members are not fully utilized, such as marriage and family therapists in FQHCs. Best practice rehabilitation and recovery models require more peer and family care managers and support staff. Work has been going on for some time reviewing options for unlicensed individuals who might be able to earn certification to become a core part of the workforce. The California Association of Social Rehabilitation Agencies, Working Well Together, and CiMH have been working with a broad group of stakeholders to look at these issues. The MH workforce needs a standardized peer and family certification program similar to Georgia or other states for recovery and support services. These entry-level certifications also would allow more access to underserved community members as part of the core workforce.

C. Recommendations

The recommendations are organized in two areas: 1) Add to the available workforce through a variety of strategies, including licensing and certification changes; and 2) provide the needed training, education, and critical skill-building, especially to serve under-served populations. OSHPD has statutory authority for workforce development in the MH field and should take the lead in working with stakeholders on these recommendations for both MH and SUD workforces. OSHPD is also developing a five-year plan and will be engaging stakeholders to discuss needs.

1. Expand the available workforce.

Stakeholders recommended that OSHPD build on existing work in this area by UCLA, MHSA Workforce Education and Training, Working Well Together, and CiMH, CADPAAC, and others. OSHPD should be given resources to organize a workgroup to review and prioritize recommendations for expanding the MH and SUD workforce with a special focus on Medi-Cal and underserved populations.

Some options suggested by stakeholders for improvement are listed below:

a) Consider promotion of incentives like the Title IV-E program in social services to attract more individuals to the field. Title IV-E is a federal program in which social workers in training can have their costs paid for if they work for three or more years for social services after graduating. This is used by child and adult protective services at the local level to attract new students to this important work.

b) Support continuation and expansion of loan forgiveness programs. Loan forgiveness programs have proven their effectiveness in hiring and retaining workers in underserved areas in the public MH system. For example, the Mental Health Loan Assumption Program offers up to $10,000 in loan repayment in exchange for a 12-month service obligation in the public MH system. This program has been particularly important in recruiting psychiatrists and other professionals to public-sector services and low-income populations.

c) Consider how to add returning veterans with MH and SUD treatment and crisis experience to the California workforce. Partner with the U.S. and California Departments of Veterans Affairs on this review. Consider changes in certification or licensing to give veterans credit for education, training, and experience towards degrees and certifications.

Issue Paper 6 – Workforce Skills and Capacity *(continued)*

d) Expand skills of existing licenses and certifications commonly used in healthcare to meet MH and SUD needs, such as psychologists, marriage and family therapists, social workers, psychiatrists, psychiatric MH nurse practitioners, medical assistants, pharmacists, registered nurses, nurse practitioners, physician assistants, and occupational therapists. Use distance learning to keep skills and add education to those in remote areas or already working full time.

e) Access to psychiatric medication management is a major challenge that has been addressed in other states through expanding programs for psychiatric nurse practitioners and adding to the scope of practice for psychologists with special additional training. Cross training with primary care providers who can prescribe is also strongly supported.

f) The MH and SUD workforce must be culturally diverse and have capacity and training to meet the needs of special populations in the broad sense. Consider special outreach to high school and community colleges to foster career paths.

g) Consider addition of paraprofessional health navigators with roots in underserved communities who can work as part of clinical teams and do outreach, engagement, care management, and support services.

h) Consider options to add marriage and family therapists and SUD-certified counselors as billable providers in FQHCs to help address new Medi-Cal needs in clinic environments. Currently only psychologists and licensed clinical social workers can bill in an FQHC environment. This would require legislative changes. In addition, same-day services for behavioral health and primary care is an obstacle to adding these services in an FQHC setting and doing "warm handoffs" between primary care and behavioral health.

i) Building on existing telehealth efforts, consider grant support for telehealth for MH and SUD assessment and treatment in remote areas. This would be for equipment as well as training and infrastructure. Telehealth systems using existing state, private, and federal efforts could be prioritized for frontier and rural access. Consider financial support for hub institutions like the University of California, Davis, and Loma Linda University in Loma Linda, California, to build infrastructure and support additional training for rural and remote areas.

j) The state did an excellent job expanding nursing programs at community colleges and other state-funded educational institutes and should consider similar strategies for the MH and SUD workforce. Some of the programs also included extra supports, such as transportation and child care supports and funding for tuition and other expenses for low-income students.

k) Using work from CiMH, Working Well Together and others, consider how to add peer and family caregiver MH certification standards similar to those in other states.

l) Create a single state-approved certification for SUD counselors without graduate degrees as discussed in detail in the administrative burden area (Issue Paper 4). This was discussed with the Department of Consumer Affairs Board of Behavioral Sciences, which preferred to not handle licensing or certification for those without master's degrees. Options for a unified accountable certification process should be considered.

2. Provide the needed training, education, and skill-building.

Mental health and SUD workforces will need training and education in new models of integrated community care. Language, cultural competence and awareness of unique needs of different communities are essential skills in which training and development of new staff resources are critical.

a) Consider emerging best practices in partnership with the CPCA, CMHDA, and CADPAAC to evaluate best practices for different models of primary care, MH and SUD joint service delivery. The recommendations would include identifying barriers, recommending options that do not sacrifice billing, client care, or create audit problems. The Institute of Healthcare Improvement and other quality institutions have been working on these models. It is not just access that is needed; it is quality systems organized in partnership with patient-centered medical homes.

b) Once new models are identified, training of the workforce is needed. Consider using MHSA training funds, education institutions, distance learning options, and new continuing education requirements for clinicians and doctors to get updated training in the field for integrated treatment and best practices.

c) Modernize the current SUD service models and structure with the best science, including looking at successful harm-reduction models with good outcomes for challenging costly groups such as public inebriates.

d) Consider the California Reducing Disparities Project's cultural recommendations related to how the workforce could be changed or trained to address the challenges of serving special populations and cultural groups. There is a summary of these recommendations in Appendix D.

D. Conclusion

In summary, stakeholders voiced strong recommendations to increase the numbers of program staff in both the MH and SUD workforce and strengthen the workforce with new skills. The quality and quantity of the MH and SUD workforce must meet the needs of new enrollees in California, including underserved populations. The workforce across MH and SUD, and physical health all need specialized training in new service models and best practices. It is also critical that paraprofessionals with community cultural competency be added to the workforce in new and creative models to reduce health disparities.

ISSUE PAPER 7

Organizational Capacity for Substance Use Disorder Service Providers

A. Description of issue area

National statistics indicate that only 10 percent of the people who seek treatment are able to get it. The state's substance use treatment and prevention system faces 2014 with significant structural limitations. The SUD service system in California has many small independent non-profit organizations. Many of these SUD providers have limited administrative, staffing and financial resources to make the transition to managed care, Medi-Cal, and insurance billing systems. Stakeholders noted that some of the MH local non-profit organizations are also struggling with similar issues.

Many small providers have limited depth in fiscal and computer systems to do electronic billing, establish electronic health records, track clinical and program outcomes, and meet many standard managed care and insurance requirements. There is a serious risk of failure and loss of clinical capacity at the community level if these providers cannot successfully transition to new program models and administrative requirements. The ACA and related legislation is a major change for the field and requires planning and support. Many of the smallest organizations serve diverse, low-income communities in high-risk areas. They are often the only SUD resources available to these communities. Attrition within this group will exacerbate disparities in treatment access and outcomes.

In the smaller counties, the non-profit sector is limited or absent entirely. In many cases, services are provided by county staff, and the concerns relating to small providers apply to small counties as well.

B. Analysis of stakeholder feedback

There is significant concern about the ability for non-profit providers with limited administrative capacity to become organizations with capacity to function effectively in the world of managed care, electronic billing, and electronic health record systems. Funding for high-level administrative skills is not available within most non-profit SUD agencies to make this complex transition. Yet the loss of already inadequate treatment capacity at a time it is critically needed would be a major setback for the field. This is even more important with criminal justice reform and the ACA.

Using the non-profit community clinics as an example of organizations that have successfully transitioned, there were a number of recommendations made to foster similar success for SUD agencies. External funding, such as foundation funds, federal grants, and organizational leadership at the state and county levels, as well as the federal Health Resources and Services Administration, the California Primary Care Association, and the National Association for Community Health Centers supported some of these transitions. If similar models can assist SUD providers to make this transition, it would greatly benefit the field and preserve essential local services.

Stakeholders also suggested that SUD providers in the California Council of Community Mental Health Agencies be included for unified strength of advocacy around policy issues, funding, and technical support. Other options for sharing the costs and expertise involved in billing, contracts, and business functions included developing one or more Administrative Service Organizations across the state to support small

non-profit providers. This approach preserves the virtues of smallness and personalization, but joins these with the efficiency of a robust administrative and billing organization.

Individual physician practices have also been evolving into groups to cope with major business needs related to managed care contracts, billing, and computer software systems. This has led to more organized systems of care, as well as stronger business systems for medical practices. For example, instead of each office buying and implementing an electronic medical record system, multiple practices shared the cost. Another example is a billing clearing house processing electronic claims and posting electronic payments.

Finally, MH contractors have generally also evolved into coalitions or larger entities to manage similar administrative demands. Some of these strategies employed in MH, such as group purchasing of "back office" services, staff sharing, and other alliances (short of a formal merger) could benefit the small non-profit SUD service providers.

C. Recommendations

The following recommendation emerged from the input from stakeholders:

1. **Encourage non-profit organizations to join together in coalitions, networks and/or partnerships.**

   These coalitions or partnerships can be used to create and support critical business functions of the organizations. The coalitions and partnerships should be used to purchase computer hardware and software capacity, legal and technical resources for billing, contracting, and labor negotiations, as well as to plan in regional ways to fill gaps in care, evaluate outcomes, and obtain contracts.

   - Consult with others who have made this transition, such as CPCA in the community clinics and private medical practices and foundations, MH contractors, and others.
   - Support creation of umbrella legal entities to enhance the capacity of SUD providers.
   - Provide resources for consultation and facilitation of decision making. These resources will be needed at the local level to explore and plan for new partnerships and structures. State and county advocacy with foundations and federal government for some of these one-time supports is important.
   - Ideally these recommendations would be completed in a time frame that would permit consideration as part of various federal, state, local, and foundation funding cycles.

D. Conclusion

There was an important consensus that SUD non-profit providers need technical assistance and one-time funding to make the transition to more robust administrative systems. These transitions can be achieved through regional coalitions, partnerships, administrative service organizations and umbrella organizations.

Appendix B

Stakeholders and organizations interviewed as part of the planning process, along with the members of the work groups

Stakeholders

Stakeholders include the following mental health and substance abuse organizations:

California Association of Addiction Recovery Resources

California Association of Alcohol and Drug Program Executives, Inc.

California Association of Alcoholism & Drug Abuse Counselors

California Association of Health Facilities

California Association of Marriage & Family Therapists

California Association of Social Rehab Agencies

California Council of Community Mental Health Agencies

California Hospital Association

California Mental Health Directors Association

California Mental Health Planning Council

California Network of Mental Health Clients

California Primary Care Association

California Youth Empowerment Network

CLAS Technical Assistance

County Alcohol & Drug Program Administrators' Association of California

DAC – Aging Constituent Committee

Disability Rights California

Kingsview

Mental Health America

Mental Health Services Oversight & Accountability Commission

National Alliance on Mental Illness, CA

National Health Law Program

Native American Health Center

Pacific Clinics (Asian & Pacific Islanders)

The Racial and Ethnic Mental Health Disparities Coalition

Telecare

UCLA ISAP

United Advocates for Children & Families

Vet to Vet

Working Well Together

California Association of Local Mental Health Boards and Commissions

County Medical Services Program

Government representatives

DHCS Business Plan
Evaluation Work Group Roster

Steering Committee

Name	Affiliation
Sandra Naylor Goodwin, PhD	CiMH
Renay Bradley, PhD	MHSOAC
Neal Adams, MD, MPH	CiMH
Wayne Clark, PhD	Monterey County
Richard Van Horn	MHSOAC Mental Health America, LA
Stephanie Oprendek, PhD.	CiMH
Cricket Mitchell	CiMH
Stephanie Welch, MSW	CalMHSA
Sarah Brichler	CalMHSA
Will Rhett-Mariscal	CiMH

Work Group

Name	Affiliation
Larry Poaster, PhD	MHSOAC
Renay Bradley, PhD	MHSOAC
Karen Stockton, PhD	Modoc County
Wayne Clark, PhD	Monterey County
David Pilon, PhD, CPRP	Mental Health America, LA
Ryan Quist, PhD	Riverside County
Jessica Cruz, MPA/HS	NAMI CA
Tom Trabin, PhD, MSM	Alameda County
Lily Alvarez	Kern County
Poshi Mikalson, MSW	LGBTQ, MHA of No. Cal
Steve Maulhardt	Aegis Medical Systems, Inc.
Mark Bryan	Yolo County BH
Dan Walters	Kern County BH
Bev Abbott	Telecare
Michael Gardner	CMHPC
Andi Murphy	CMHPC
Darren Urada	UCLA

DHCS Business Plan

Finance Work Group Roster

Name	Affiliation
Jim Irwin	Substance Use Services, Fresno County
Jason Kletter, PhD	BAART Programs
Albert Senella	Tarzana
Dennis Koch	Fresno County
Bill Manov	Santa Cruz County
Tom Renfree	CADPAAC
Larry Poaster, PhD	MHSOAC
Mike Geiss	Mike Geiss Consulting
Tom Sherry	Sutter/Yuba County

Appendix C

Interviews with stakeholders who participated, which illuminates the views of specific organizations and interest groups

DHCS Business Plan
October 2012
All MH Interview Responses

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
Lack of transparency and accountability that funds allocated are spent on those most in need. Complex funding silos that do not facilitate integration Adequacy of funds -some counties not allocating funds for the indigent population, no mechanism developed to bill counties for FSP patients receiving short term hospitalization in psych beds, no mechanism for general acute care hospitals to bill for ER MH services rendered to county MH patients being warehoused due to lack of appropriate placement options. Uniform billing forms for use across the programs Inconsistent application of medical necessity criteria	Inability to communicate using electronic means to determine eligibility across programs - we can't integrate until we can communicate Wide and at times inappropriate variation is the application of the LPS, 5150 involuntary care laws Lack of adequate and accurate data on individuals served and services received Clear identification of county responsible for individuals receiving service out of their host county Lack of public safety coordination- County MH/SUD, law enforcement, Emergency transportation providers and hospitals	Network adequacy and establishment of a set of core services each Medi-Cal managed care plan must have - for example 24/7 crisis services Work force, adequacy and scope of practice maximization Privacy laws which impede communication between/amongst providers and clinicians and the plans Identification of point organization when an individual is using MH and/or SUD and/or physical health services	Only evidence based metrics should be used Hospitalization and readmission frequency should include both inpatient (med/surg and psych) and outpatient ED utilization when used a measurement of reducing utilization Measures should be readily available to the public and supported with an adequate data base and reporting by the counties for all individuals they serve regardless of funding source To my knowledge the current data is perceived as inadequate due to under reporting, inaccurate reporting, and misinterpretation of the data. Data should be collected consistently across counties on the realigned prison population, individuals committed to state hospitals, jails, and hospital ER usage to determine if the county system is adequately designed to serve the Medi-Cal population	
Framework for funding future programs under the MHSA. Continuing IMD exclusion for Medicaid funding.	Establishing a workable process that allows for true integration of necessary mental health and substance abuse disorder services within the same	Staff training and competency in recognizing substance abuse and the relationship to mental health. Cultural backgrounds of clinical staff vary and staff may	Recidivism within the system – It was suggested that Los Angeles County may have systems in place (MIS) where coding could be modified or added to track	It would be important to bring groups representing consumers and others to the table. Such groups include the County Conservators, Protection and

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
Ability for counties to sustain current funding levels given that realignment has already been stretched beyond any reasonable limit. Ancillary funding and responsibility to provide for the physical health and medication needs of Medicaid beneficiaries within the IMD setting still remains unclear.	treatment setting (i.e. Acute psych, MHRC, LTC STP, or IMD). Recommend establishing or funding intensive drug counseling and related programs within these settings as opposed to separate treatment for substance abuse disorders that exacerbate or are connected to mental health diagnoses. Establishing a workable process that provides for true integration of the above services with the physical health and other psycho/social needs of the patient/resident. Lack of follow-up in the community after discharge.	not be aware or recognize drug abuse (such as use of marijuana (smell)) within the treatment setting. Recommendations include developing required in-service training and formal certification programs in substance abuse recognition and treatment. Concern for the impact of AB 105 (the early release program) on capacity and treatment. Sufficient funding for AB 105	this. Additionally, it was also suggested that LA County's MULTNOMAH assessment tool could also be used.	Advocacy, NAMI, and CAMI to name a few.
Adequate funding base to insure access and quality $ to get care when needed and not just at the highest levels of hospital/ER EPSDT changes with schools and realignment need close monitoring/leadership to prevent problems/set backs State leadership in general needs to continue over key financial, evaluation, policy, licensing, program issues so each county not left to do themselves/not cost effective	State leadership needed similar to past partnership on issues with DMH Joint licensing of SUD & MH programs and facilities with SDMC Rehab options to allow for treatment of dual diagnosis and also more financial stability Workforce: Particularly look at creating Peer certification standards statewide to add peers at all levels, youth, family, adults, older adults Role differentiation and	Review licensing requirements in MH and AOD to improve integration for facilities and programs & allow AOD services under Rehab Option Review and change scopes of practice and types of certified and licensed practitioners to meet needs of patients and evidence based practice including peer certification programs, do not try to reinvent wheel county by county Use innovation experience of	Need 3 Levels of Evaluation/ tracking to achieve success: 1. Quality of Life surveys to see what is making a difference at ground level 2. System indicators to track system effectiveness and access 3. Program and intervention/care services evaluation of effectiveness/outcomes Also, Consumer/family/advocate participation in planning, policy,	Leadership at state to role model this value Use Planning Council Definitions of meaningful involvement of Consumers/stakeholders (see attached) Evaluation tools and indicators, MHSIP not that helpful, consider Quality of Life and satisfaction tools statewide, not county by county Do not leave out Transition Age youth where early interventions and treatment critical

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
and can create problems particularly in small counties with limited resources Maintain spirit of transformation with MHSA funds, not just using to replace cuts, preserve prevention and innovation funds With health reform, will insurance plans have adequate MH and SUD treatment and rehab? Will service array be different from Medi-Cal coverage creating two tier systems? Concern that criminal justice realignment needs to fund treatment and case management for individuals returning with MH and SUD histories (AB 109); if all $$ going to jail beds, POs, and police then there is a major problem and more tragedies will happen Add Substance Abuse treatment services to Rehab Medi-Cal Option to expand access, range of services, financial stability Realignment and fall tax measure, critical services at risk, need back up plans	teamwork between Planning Council and Oversight and other stakeholder groups needed Access to Medi-Cal data for quality analysis for client outcomes over time and across systems; data fragmented at local level even within counties Recognition of the Planning Council as a resourceful government entity with value to the system of care	MHSA to share best practices of what works Support evidence based practice and quality initiatives including those for underserved populations Review methods of education and best practices when using psychotropic medication with children, particularly vulnerable children in the foster care system; Support continued research on medication and treatment outcomes as understanding of the brain/body expands and improves/ role model always striving for improvements in care	programs State leadership on these issues to avoid waste, duplicate efforts at county level Timely accurate data so outcomes work has real value to those in the field and making policy, not just another administrative burden	
Establishing clear policies on reimbursement for providers Ensuring meaningful scope of	Increasing cultural and linguistic competency of plans and providers	Improving care coordination Increasing preventive care and effective management of stable	Survey and track the number of culturally and linguistically competent providers	Department keeps a record of recommendations presented by consumers, families and stakeholders and either adopts

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
coverage in public and private health plans to comply with mental health parity requirements Ensuring effective monitoring and enforcement of mental health parity requirements at the state level Maximizing state leveraging of federal funding opportunities	Improving consumer outreach and education to ensure understanding of enrollment and benefits Encouraging provider capacity building through alternative treatment methods (e.g., telemedicine) Prioritizing the need to align resources to address health care disparities among ethnic and linguistic groups Overcoming obstacles that prevent diagnosis, treatment and coverage for high- need populations – i.e. homeless, I.V. drug users – with dual diagnoses	populations to prevent relapse	Track readmissions for inpatient treatment of severe mental illness and addiction	those recommendations or provides explanations and rationales for recommendations it declines to adopt
Ensure funding adequacy overall for MH Ensure through funding process that a two tiered system isn't developed i.e. MHSA intensive services but less availability if not funded by MHSA Need for adequate funding under public safety realignment for MH and SUD services	Primary issue should be early and sustained engagement of stakeholders in all stages (including how to design planning processes, planning program development, oversight.) How meetings are conducted is also crucial – formats needed to be welcoming, there needs to be follow up and feedback loop , a climate of respect Laos a major overall need to ensure that under new realignment DHCS develops a system of county accountability. DHCS will need to set criteria	There is a need for robust quality improvement processes to ensure use of best practices DHCS needs to work closely with DPH re major issues of cultural competence and disparities – this involves more than ensuring people get "in the door"; access is necessary but not sufficient to ensure good outcomes	Develop and support data/evaluation systems that truly meet needs for both oversight and analysis. E.g. we need to be able to get breakdown on services provided by funding source, locations, and recipients. These data systems and info sharing need to be more user friendly Data in user friendly formats also needed re grievances and appeals need also to know more than that a grievance was resolved "favorably" – what really happened?	Measures needed to help us know stakeholder involvement is sustained beyond the planning stage

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
	and exercise oversight as required to ensure basic and consistent expectations re service availability/quality/program standards, procedures for grievances and appeals, etc.? Similarly need for Medi Cal regs that set statewide standards in terms of quality, due process protections, access, use of least restrictive environments, availability of peer supports , service adequacy etc. Also assure via policy and other mechanisms a strong stakeholder process and issue resolution processes for MHSA ; overall maintain the MHSA regs and other mechanisms to ensure county accountability for services using these funds Policies need to retain LPS protections Policy work will be needed to coordinate licensing and certification work in light of current split across departments ECT policies and requirements need to address use outside state hospitals and to provide for assurances re safety and due process in other settings			

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
	Take advantage of opportunity to enhance coordination with public safety in reducing "revolving door" for people in and out of correctional facilities			
Adequate funding base, no SMAs More flexible funding, less silos, more outcome focused Simplification of billing/funding systems, Medi-Cal eligibility, claiming & cost reports(wasted resources due to complexity) Enhanced rates for rural areas particularly for psychiatry and professional shortage areas(like Medicare) Funding for housing and supports, no one gets better on the streets, funding important for not just traditional treatment, but also for critical ancillary supports to insure access to food, clothing, shelter, etc. Systemic analysis needed for $ in system and across systems – health, criminal justice, social services. Innovative pilots needed for high users across systems Evaluate total financing of	Workforce development needs strong $ and policy support Need to work licensed employees to top of scope of practice and use more medical assistants and health workers and AA credentials to meet patient demands/needs Consider expanded scopes of practice Look again at San Antonio for workforce issues and flexibility as well as nurse delegation act of Oregon, staff need to be able to float between programs and be used in flexible ways to be cost effective and meet needs of consumers/family Break down joint treatment barriers so services for those with addiction and MH needs Interventions that are **evidence based** need to be promoted: housing, medication with recovery milieu, no street drugs = increase stability and success for SMI in community	Expand drug service options to be more like rehab option in MH True support for telemedicine in rural area and tele-mental health with continuity of care to insure access even in remote areas Track best practices and research to have best interventions and see how financial systems align to create incentives to do best practice (never stop trying to improve More training options for best practices and for getting graduate education in MH Need legislation to have true health record inter-operability, rigid and conservative legal fears stopping coordination of care for MH and SUD client needs with physical health	MHSA measures good, especially the 5 core measures, Standardized family and consumer satisfaction survey instruments statewide Use Electronic medical records to look at outcomes/best practices across system and within organizations. Do quality studies with funded providers.	Representation on all policy and program planning committees Fund services of value to these groups even if Medi-Cal not reimbursed Statewide use of consumer and family satisfaction surveys done regularly (at least annually) data compiled and shared publically

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
services versus just silos, (consider model used in San Antonio Texas which supports cross system planning and analysis and interventions) Support flexible financing systems which support MH and SUD integration into Primary care but retain core services for SMI and SED with specialty providers who can meet intensive needs of disabled/conserved	Move to a continuum of clinical options with medical homes, not all or nothing with FSP model Create true systems of care with accountability and client/family focus (current system too fragmented, wastes money, categorical $, too many organizations with different focuses makes coordination difficult, need true data sharing across legal entities and seamless exchange, HIPAA making things worse, not better in terms of coordination between providers			
Fund Native American tribes/urban agencies directly without going through contractors (i.e. counties, large mental health/substance abuse agencies, etc.) as contractors restrict how funding is used without regard to cultural competent services.	Enter into agreements directly with Native American tribes/urban agencies. There are over 100 tribes in CA that are federally-recognized and are sovereign nations.	Native American CRDP "Native Vision" Native American AOD Project "Healing Circle"	What is their cultural competency level? What steps are being made to improve it? How have counties reached out to Native communities?	Support funding and/or resources for Native American tribes/entities community that is culturally competent and engaging. Please visit the web ink to the recent Native Vision Report, especially the Recommendations section. http://www.nativehealth.org/content/publications
Priorities (focusing especially on children's services) Ensure adequate funding at the local level, with accountability as needed to ensure it is allocated appropriately per relevant entitlements .Mandates must be met and required services provided even if initial allocation	The action oriented approach used by DHCS to move quickly using policy letters/directives rather than lengthy processes via regs has often been helpful in assuring timely and targeted action (although it bypasses the regulatory and public input process requirements under the APA). The key will be also	Currently fragmented structures (often along funding source lines) drive divisions that are unproductive – this should be examined and improved One example is of children that cross multiple systems (e.g. child welfare and mental health); Another e.g. is where parents of	Great need for better data matching across systems especially re services outcomes. We need to know more than numbers of slots or programs Expand the kinds of new forums to enhance quality improvement work across areas; EQRO data	

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
of funding has been expended – fiscal limits don't change obligations for entitlement services to be assured. Concur with Steinberg's office re need for greater MHSA accountability and assurances that local systems are not replacing base funding with resources intended for growth Adult services historically seen as receiving greater levels of funding and there is need to assure appropriate attention to the needs of children. Need to pay special attention to risk of erosion of resources for children/youth involved in other systems (e.g. special education services), to maintain the investments needed in MH services and coordination of funding with other agencies responsible for the same children (e.g. child welfare). The DHCS business model seen as more clear re accountability and this may be helpful for MH and SUD services	ensuring transparency and clarity in directives as well as opportunities for input and engagement to help improve the quality and relevance of needed policy work. Such clear and broad communication will be needed to help ensure consistent information and understanding of requirements across state departments, counties and providers /entities. Be clear about expectations and policies re issues that cross departments, developing co-governance structures with shared policies at the state level to model needed coordination and shared responsibility MOU's at the state level can also help create clarity re responsibilities at the state level.	children in the child welfare or juvenile justice systems have co-occurring disorders of their own) – there is need to serve the family in a more holistic and integrated or coordinated manner In Medi-Cal, the state needs to ensure accountability at all levels for MH Plans- shouldn't sacrifice needed state authority and consistent application of the rules statewide, or accept excessive local divergence	Ensure accountability at the state agency level, especially for DHCS in managed care area. Need to be sure DHCS has the bandwidth and capacity to do more than just pass the capitation on to plans through contracts and more plan accountability to ensure that key requirements don't fall thru the cracks in major initiatives like transfers from Healthy Families or mandatory managed care enrollment for SPD's . This focus on accountability is crucial in a time with so many changes and such complexity. It is also important to be both selective and clear in setting up stakeholder processes so information sharing and feedback are meaningful d but strategically planned and critical information is shared at critical junctures in a timely way The work done by TAC to examine needs in the MH and SUD systems is crucial and very rich; this needs to be used and mined	
Substance Abuse and Mental Health Funding Silos (particularly under health care reform) Drug Medi-Cal billing limitations	Disparities in serving underrepresented groups Lack of integrated plan	Funding silos Limited array of services (i.e. intensive to wellness centers)	Client recovery goals More reasonable funding flexibility	Increased family involvement, particularly from those in underserved groups Attendance at meetings,

DHCS Business Plan
October 2012
All MH Interview Responses

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
Fear that Medicaid will tum into a block grant model (political environment) Medi-Care limits in billing mental health	Uneven allocation of resources Workforce development (How will we have enough staff to serve individuals who are anticipated to be eligible for Medicaid or purchasing insurance on the exchange?)	Lack of affordable housing Ensuring that interpretation or other services that are clinically appropriate for ethnic communities are billable to Medicaid/Medicare	Increased penetration rate of service usage by counties	sessions
How do we move away from the priority being providing services that match Medi-Cal and put the priority on providing services that consumers/family members and the community want? Will DHCS encourage counties to continue PEI programs and expand PEI programs when the funding requirement is gone?	How will DHCS develop and model a community stakeholder process for itself and the counties? How do we ensure that DHCS works in partnership with community stakeholders – not just county and CMHDA staff and other government partners – regarding all aspects of the Work Plan including planning, development, oversight, etc.? An effective issue resolution process must be developed by DHCS. How will DHCS ensure that local and statewide stakeholders are involved in holding counties accountable to the MHSA? How will DHCS protect, enforce, and publicize the County Cultural Competence Plan Requirement reports? Cultural competence and reducing disparities is not just for the Office of Health Equity in the CA Dept. of Public Health –	How are we ensuring or increasing the number of bi-lingual and bi-cultural providers? How do we continue creating and fostering PREVENTION programs, as opposed to just CSS programs? How do we incorporate traditional cultural practices along with present day clinical programs and approaches? How can we get counties to fund community-defined or community-based programs and approaches to treatment? How can we get counties to understand and then act on the fact that many (most?) evidenced-based practices have not been tested on adequate numbers of people from underserved communities?	Regarding cultural competence and reducing disparities, the County Cultural Competence Plan Requirements should be kept as it left the DMH, and used “as is” to measure both effectiveness and goals. Individual focus groups with specific underserved communities OR interviews with specific community leaders, cultural brokers or mental health providers from ECBO’s should be done for more quality assurance pieces. These should not be done with county staff in the room. The contacts should be obtained by asking groups outside the county staff, in addition to asking the ESM/CCM. What rate did the county reduce disparities	

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
	how will DHCS encourage, monitor, and enforce these requirements? How will DHCS promote "transformation" and culture change within itself to be able to administer the MHSA effectively? How ill DHCS promote transformation and cultural change within the counties?			
Employment assistance Money management/budget Ability to pay for housing (rent/mortgage) Transportation assistance to/from medical appointments Drop-in centers in the community	Non-professionals to help veterans (shared experiences) Female professionals/facilitators to talk with female veterans	Mental health issues Substance abuse issues	Peer support groups Peer facilitators trained by professionals who have similar experiences	Consumers who return for services on a consistent basis and are actively participating
Funding for Parents, family members, caregivers and youth to be able to attend conferences, trainings and events that are mental health related. There is a need for funding for respite care for parents who are raising children with mental health challenges.	AB 823 California's Coordinating Children's Council Prop 63 Continuation of funding for PEI programs State certification for Parent Partners/Family Advocates Continuing of Mental Health services in schools	Inclusion of Parents within the clinics and on the clinical teams Certification of Parents as Parent Partners/Family Advocates making the certification a new hire training requirement Trainings to support and empower parents as Parent Partners in the workforce and as parents of children with mental health challenges.	Put resources in as many languages as possible Distribute the resources to the rural and underserved areas. Resources need to be taken (walked) into these communities. Engage all cultures in all processes and decisions in their communities.	

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
			Town hall meetings or focus groups with the understanding that they will receive the outcomes of these meetings.	
Protecting the MHSA as a dedicated funding source for mental health. Assuring that the structure of Realignment provides that MH and SA funding does not compete with other local priorities for social services or corrections programming. Assuring that DHCS supports the 1915(b) mental health waiver and that it supports services that are recovery oriented such as a 16 bed MHRC, social supports, peer provided services, and supported housing and employment. Addressing the issue of funding for IMD ancillaries. Addressing the significant underfunding of substance use disorder treatment. The Medicaid expansion population will need access to the same array of services available to the current Medi-Cal population so that we don't create a two tier system: services should be provided	The licensing function for mental health needs to continue to support recovery oriented programming such as MHRC's and provide timely, clinically informed oversight and monitoring. Need for leadership from DHCS on MH issues because functions and roles are now spread out over multiple State offices. Assuring that the essential health benefit not only addresses parity, but also includes the necessary social and community based supports that reinforce recovery. This includes crisis and other residential services, and long term rehabilitation services. The Department needs to continue to provide leadership on workforce development issues so that the increasing shortage of mental health professionals due to the implementation of the ACA can be addressed. The Department should pursue enhanced Medicaid funding	Supported employment is not a robust part of most ACT/FSP programs and counties are not able to fund dedicated positions that meet Evidence-Based Practice supported employment fidelity standards (see Dartmouth Psychiatric Research Center, http://www.dartmouth.edu/~ips/page19/page21/files/se-fidelity-scale002c-2008.pdf). DHCS could assist by partnering with Department of Rehabilitation (DOR) and reinforcing the need to support persons with Serious Mental Illness at the local level. Substance use treatment is still largely siloes due to financing and policy separation at the State level and the requirements of 42 CFR. The Department could provide leadership here to reinforce the integration of services for true co-occurring treatment. As the Dual Eligible pilots are implemented and expanded, it is critical that the local plans continue to be required to work closely with county mental	Need 3 Levels of Evaluation/ tracking: 1. Quality of Life surveys to see what is making a difference at ground level 2. System indicators to track system effectiveness and access 3. Program and services evaluation of effectiveness/outcomes Consumer/family/advocate participation in planning, policy, programs important State leadership on these issues to avoid waste, duplicative efforts	

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
based on clinical need.	under Section 2703 of the ACA – and include Community Mental Health Centers and a robust Person Centered Health Home as a model. Healthcare integration cannot mean the replacement of the recovery model with the medical model and only funding traditional services. SMI individuals need additional community based social supports to achieve good overall health.	health to assure that care is coordinated, the full spectrum of recovery oriented services for Seriously Mentally Ill Adults and Seriously Emotionally Disturbed children is provided, and that assertive engagement and monitoring of services is provided so that clients are not underserved. In addition, the pharmacy benefit and formulary must be carefully coordinated to assure continuity of care. The Department needs to continue to reinforce and support the value of Evidence Based and promising practices, including Integrated Dual Diagnosis Treatment (IDDT), motivational interviewing, Assertive Community Treatment, supported employment and housing, peer support services, the PIER model for early detection and intervention for the prevention of psychosis, etc.		
Determine how best to sustain and protect the funding already in MH and SUD services, using the principle that "dollars need to follow the consumer". This means keeping funds in direct services areas that continue to benefit consumers as directly as possible. Also ensure through careful tracking that funding	MH and SUD communities are seen as separate; greater solidarity and collaboration are needed to strengthen a common voice and ensure service effectiveness Health disparities across a range of groups need to be addressed effectively. Assure equitable	Peer supports are crucial. Provide a clear and consistent career ladder for peers in SUD and MH services so they can advance beyond lower level/poorly paid positions. These successes are important in demonstrating the potential for recovery and are helpful as well in fiscal advocacy as described	See above re measuring health disparities Also important to measure improvements in quality of life at community level (across both MH and SUD)	

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
from various sources maintains baseline levels without erosion or redirection of savings until baseline levels are assured Ensure fiscal support for peer services as effective element in systems of care. This also gives peer advocates a direct stake in advocating for service system funding in synch with other providers. It is important to help create/support consumer coalitions that can have an effective voice in advocacy for programs and policies. The stories and successes of peers are effective in driving funding and we need to get those messages out Diversify funding to find some alternatives in addition to tax dollars like Prop 63 that fluctuate with overall economy and hence destabilize supports. When the economy is down tax dollars are diminished but the service needs are actually higher for MH and SUD services- we need stable supports to respond to these needs Ensure the appropriate use of private insurance as first payor wherever feasible (e.g. with autism) ; monitor and take advantage of parity requirements to ensure this sue	access as well as improvements in health status/quality of life. Make addressing the current disparities clear state priorities and ensure accountability for meeting those policy priorities through effective measures.	above. See above re services that respond effectively to the needs of a diverse population		

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
of private insurance helps to support the service system				
Making sure the benefit package is good, but still affordable for exchange Insuring solid implementation of parity and enforcement by Insurance Commissioner Planning for the 10% by putting savings into a reserve? Go full board on early intervention/prevention on Medicaid during 3 years with no match to keep folks out of hospitals and in homes and natural settings, think about interventions and financial structures incentives to keep providers motivated to achieve these goals, important to make sure all legislators get message the public wants good healthcare, republicans resisting change saying to wait for election, governor concerned about long term solid budget and fiscal planning Support other concerns of CMHDA and CADPAAC	Time to consider some legislation on assault weapons MH treatment access and early identification/reflecting on Colorado Keep health reform moving forward Support better integration with Medicare Promote programs like the County Organized Health Systems Support use of technology to improve coordination of care, patient's right to insist on coordinated care Support use of technology for telemedicine to remote areas including MH and SA Medi-Cal aid code simplication for enrollment	Look at evidence based medical care and treatments, push system to stay up on best practices and have Medicaid plan evolve with it Consider ways to expand work force and training and scopes of practice that insure better access	Need concrete outcomes that folks understand, add value to the field, not just for academics Keep administrative costs reasonable in design Try to get health and social services to use systems that are really able to talk to each other without spending a fortune to program	
There is a lack of clarity regarding what services are provided to which clients using what funding sources. We need better clarity regarding the	SUD services provision is limited and seen as out of date in many cases. We need a more robust discussion of evidence based practices in SUD and	We need to work on provider capacity development especially in SUD area Cross disciplinary training is also	As described in fiscal area above there is a significant need for better/more accessible outcome and performance data across all funding streams. It now is too	Stakeholder involvement needs to be more robust, so consumers and other key stakeholders are seen as equal partners. This means not simply input or

DHCS Business Plan
October 2012
All MH Interview Responses

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
"building blocks" of these diverse funding streams and how they are used. More clearly delineating funding streams at the Federal, state and local level , and how they are being used will improve accountability and transparency/credibility This clarity will allow us not only to be more accountable, but also to identify/take better advantage of missed opportunities to enhance funding, draw down Federal funds, and more effectively integrate where appropriate.	opportunities for expansion/improvement It will also be important to ensure broader in depth understanding of how Drug Medi Cal works Determine how best to use SAMHSA funds for MH and SUD services in more coordinated manner especially to better address co –occurring MH and SUD disorders In MH there is a need to meaningfully engage a broader range of stakeholder's service system review and development. This involves trust building and more open communications, using the kind of greater fiscal and data transparency described in area 1 above to help in trust building. Trust depends on openness; this greater trust will in turn enhance the quality of policy development work by bringing in key participants This type of "mapping" has been done in segments of the health area with assistance from some key foundations. Such more definitive data analysis work in MH can better drive a shared policy development process and foundation	needed with health care providers, to take down the walls and assure skills for needed service integration and improved outcomes	hard to get that info. This need will be especially evident in dealing with Medi Cal managed care. It may be helpful to look at how for example to provide incentives to encourage outcome reporting. IT development will be crucial but we also need less costly ways to collect/report/analyze data e.g. data repositories as being developed by OAC. The EQRO data and reports also should be more broadly shared/used. Cross system data will be crucial to help do populations based evaluations	involvement in initial stages, but ongoing substantive partnership

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
	This type of comprehensive convening of systems working with children is needed especially in the area of children's services, given the complexity of EPSDT funding and the cross system service needs and involvement of children/families. We also need to address how better to integrate MH and SUD services with primary care, addressing key barriers such as FQ issues at the state level. We need open discussion on involuntary commitment , LPS criteria and use of hospital beds We need more effectively to address health disparities especially for Latinos and Southeast Asians – concrete and short term goals regarding core MH disparities should be targeted for action oriented work			
1. We need to work with DHCS and other key agencies to reduce the often burdensome, unnecessary and inefficient complexities in system procedures and requirements. These have raised administrative costs without adding value to the system. Compliance and accountability can be achieved	1.We need to address changes in our fiscal, evaluation and program models to respond to challenges/opportunities of HCR, Realignment and budget pressure. The need for such changes is particularly evident for example in dealing with: -Primary care integration (e.g. are we a Kaiser type system, a	1. As indicated above in policy area we need to ensure support for system of care principles and practices, with administrative requirements aligned well with these models. This might mean for example: -Greater flexibility for SUD partners in team based care -Continuation of specialty teams	1.As with fiscal procedures simplification/streamlining in reporting requirements is needed and feasible without loss of accountability. Requirements can be jointly reviewed to reduce inconsistencies/ fragmentation across systems as well as to ensure greater clarity. The focus can be on how to help	

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
in other less burdensome ways. 2. Similarly new systems need to be developed that streamline claiming and fiscal processes for counties and providers, assuring more timely payment and reasonable cash flow. 3.Any changes in such administrative procedures need to be made in consultation with counties and key stakeholders, and information about such changes needs to be openly and clearly shared. Attention is also needed to the development of related IT and other infrastructure for complying with state requirements (with appropriate attention to the special needs of smaller counties) 4. Tied in to the first policy issue above, we need to work together to help prepare new payment models for the post HCR /post realignment environment. This may involve dealing with earlier issues such as same day services limitations, coordination with FQ requirements, Drug Medi Cal limitations, and overall lack of needed SUD funding	safety net or hybrid? key policy question re county roles raises issue of adverse selection if we remain solely in safety net role under capitation models) -AB 109 (including link to waiver/LIHP) -Co-occurring disorders -Uninsured individuals after 2014 -Special needs populations that fall between the cracks e.g. autism, traumatic brain injury, dementia 2.We need through these changes to assure ongoing support for basic system of care principles and rehabilitation approaches that have been so effective in our work i.e. don't throw out what works as we adapt to new environment 3.We have opportunities for new models of more inclusive decision making in emerging environment with key roles for counties as well as for other major stakeholders. "Smart" coalition development as well as new structures for decision making can be developed and supported in policy 4.Throughout all of this work reducing disparities also needs to be a policy priority that will be reflected as well in program,	for populations such as older adults 2.Reinvestment of cross system savings from recognized cost offsets as form of incentive and fiscal supports (see data form FSP studies by UCLA) 3.Attention to is needed to the special populations mentioned in policy area, to ensure development of needed blended funding, team models and workforce expertise	programs "do right". Work to develop and re gear requirements in this way can and should be done collaboratively with counties and key stakeholders 2.The focus in reporting and evaluation should be less on process and more on an agreed upon framework of outcomes at both a state and local level, using the same data systems for both to maximize efficiency and reduce duplication in administrative work. 3.Metrics related to MH and SUD needs and use should address the following types of areas: -Penetration rates for certain populations -Access measures -Incarceration and related measures (e.g. diversion, recidivism) -Housing status; homelessness -School performance -Child custody status; involvement with child welfare system -Institutional care rates, use of alternatives to locked care -Health status -Participation in peer supports (including as provider) -Establishment and use of collaborative networks of	

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
	financing and evaluation work		services (with cost/benefit data – see item #4 below) -Involvement in prevention services 4.We need to work together to address needs for broader accountability through population based evaluation , that examines real costs/benefits related to overall public expenditures 5. Successful engagement of consumers, families and stakeholders in service delivery system design, financing and policies at the state and local level can be done by looking at measures such as: numbers of participants/ their ongoing involvement (e.g. task forces, boards, hearings); surveys of participants to assess their experiences. It is important also to be sure such measures are sensitive to potential sources of local variance especially in small counties.	
1) Realignment/Financing a) How can counties forecast and plan for financial risk particularly with regard to DMC in counties that have had a history of low	1) DMC a) Counties need to establish a mechanism for reimbursement of out-of-county services in DMC. This is a very complex issue with little time to address	1) Service Delivery a) Priorities mentioned included: i) The development of a chronic care service delivery model. ii) A system of care	1) At the client level – a) We need to look at quality of life indicators; broader measures of client outcomes that connect us to the outcomes of other systems. We	1) Regular attendance by stakeholders at key meetings is essential. DHCS and counties may need to take assertive measures to ensure this. 2) Obtain participant feedback, often by survey,

DHCS Business Plan
October 2012
All MH Interview Responses

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
utilization and then experience rapid caseload growth. b) With all the MH & SUD funding in one Behavioral Health (BH) account, how do counties create Board policy, accounting practices or other measures to identify which funds are which. At a minimum, counties need to know when spending patterns in DMC, for example, begin to encroach on other SUD services or the MH budget. Counties need to know their status vis-a-vis the Block Grant MOE on at least a quarterly basis. County SUD programs have to maintain expenditures within a narrow band. c) Constitutional protections under Realignment 2011 are essential, especially if the Governor's initiative does not pass in November. d) Future of the Block Grant – California needs to join advocacy efforts at the national	adequately in the 1915(b) waiver. b) Turn on the SBIRT billing codes. Permit billing for medication assisted treatment. a) Development of a waiver that would support SUD managed care. Create the technical mechanisms to manage DMC services for counties similar to the way the Mental Health Plan is managed. c) Add county-option services to the DMC covered services. If a county can provide the CPEs for match, they should be able to bill for services not currently in DMC – case management or medication assisted treatment for example. b) Narcotic Treatment Program services should be billed and costs reported like all other DMC services. 2) Caseload a) The system at all levels must be competent in dealing with diversity in all its	for youth and their families. iii) Services for older adults including the necessary links with primary care. iv) Treatment of co-occurring SU and both SMI and non-SMI MH disorders. v) Broader use of evidence-based clinical decision-making. vi) Emphasis on high quality, well-coordinated, efficient care not volume of services. i) Broader use of medication assisted treatment as an alternative to Methadone-especially as a treatment option for youth addicted to Rx pain meds. ii) Integration of SUD with MH services and then the integration of Behavioral Health with Primary	need to look beyond SUD specific measures. How do our outcome measures connect to the Triple Aim? This should be the organizing framework for evaluation. We should be looking in general for alignment with the ACA and ACA BH goals. Where would HEDIS measures fit? b) Program efficiencies – These would include engagement, retention, and other NIATx measures. Client level of care transitions with warm handoffs should be tracked. c) Providers should be monitored using (among other things) evidence-based practice fidelity scales. d) Measure client satisfaction using tools along the lines of the MHSIP instrument. 2) At the system level – a) There is effective communication among all partners – DHCS, DSS, and DPH which includes face to face interaction at CMHDA,	at the end of meetings asking what went well and what could be improved. This should indicate that participants believed that their input was heard/considered. Participants would report that understand the issues discussed. 3) Integration of feedback into practice as appropriate with subsequent feedback to stakeholders. 4) "A focus on AOD stakeholders beyond law enforcement!!" 5) Plan activities to include consumers and family members at the county levels. Regional representation may also be appropriate. 6) Providers should be recruited to deliver surveys or sponsor focus groups of their clients. 7) Equal participation between MH consumers and SUD clients.

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
level against any cuts to SAMHSA and Block Grant funding. We need a strategy for block grant utilization post-2014. There is a huge amount of work for counties to get ready for this and not enough staff to do it. e) Realignment presents an opportunity to blend funding for treatment of clients with co-occurring MH & SUD. f) Public Safety Realignment is still a work in progress and MH/SU participation is variable across counties. Maybe this won't be as big an issue to the extent that the offender population becomes eligible for Medi-Cal coverage in 2014. 2) DMC Reform a) DMC should be redesigned to support integrated care. SUD treatment needs to be aligned with primary care and mental health. That said, the constraints of realignment	forms. b) With regard to criminal Justice realignment & offender treatment, we will see a return of Prop 36 as many/most offenders gain coverage under the Medi-Cal expansion. 3) Services a) Working with/around potential gaps/weaknesses in Medicaid relative to providing effective chronic care. We need a new service delivery model that is consistent with the SUD science base and is better aligned with the health care system. b) We need to maintain the role of primary prevention in the health care reform environment and maintain prevention within the new DHCS structure. c) Counties must have the authority to license and/or certify local programs. d) Attach outcome and evaluation	Care. iii) Maintain the ongoing implementation of prevention activities on the SUD side. iv) Keep DUI programs together with other ADP functions as that department is restructured. 2) Workforce Development a) Demands for the implementation of evidence based practices should be contrasted with counselor salaries. What can we expect for $15 per hour? b) The field will need more licensed staff and staff with different skill sets who can function effectively in primary care settings. Where does this additional workforce come from? c) The workforce must be culturally diverse in the broad sense. We do not have a good measure for this. d) SUD counselors that	CADPAAC, CIMH and ADPI venues. b) DHCS should develop an outcome and evaluation plan. Utilize UCLA and work with the RAND Corp (CalMHSA) to develop ideas for evaluation plan. c) The key system measures should be access, cost and outcomes. d) The state and counties should use results-based accountability. We should minimize the investment of taxpayer dollars in services with poor outcomes. e) Track the turnaround time for the different stages in the revenue cycle. f) Outcomes of SUD and MH care need to connect to measures of population health.	

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
complicate wholesale improvements to DMC. b) Counties have no control over provider enrollment, opening the door for incompetent or unscrupulous providers which leave the county financially responsible for audit findings and disallowances. c) Will DMC become managed care, stay carved out or what? Providing DMC benefits at parity increases the demand on the realignment BH account. Specific concerns about the future of Drug Medi-Cal include: i) The 1915(b) Waiver and how that positions DMC for a Managed Care Waiver and other improvements. ii) A better array of benefits for Youth and their families, including a robust EPSDT benefit. iii) Allowing for Rehab Option	requirements as conditions for funding. Connect incentive payments to client outcomes. Tithe state and counties need to develop the capacity to demonstrate cost savings or cost avoidance for SUD prevention and treatment initiatives. e) The field needs to focus urgently on preparing for health care reform at every level. There is a lengthy list of issues here, e.g., 42 CFR Part 2, service integration, workforce, provider readiness, etc. a) Assuming the Block Grant persists, how will this funding complement Medi-Cal in providing services for which benchmark expansion coverage is not provided.	are credentialed under the current system should be allowable (billable) providers of SUD services in all health care settings. 3) Service System Management a) Title 22 outlines DMC program medical necessity but there are no utilization review requirements. UR must be done by licensed staffs who know what they are looking at in a case file. UR in practice is a compliance review but it should also be a clinical review. This is another way in which the DMC model needs to be aligned with standard practice in PC and MH. b) Realignment - Everyone is using different tools, different approaches to the client –Criminal Justice, Child Protective Services, Primary Care, etc. This makes it difficult to standardize costs when practices differ so much.		

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
services. iv) Reimbursement for case management and other services not presently covered. v) Expansion of the definitions for individual sessions in DMC beyond Intake, Crisis, Collateral, etc. d) Beyond the future of DMC, there were concerns about managing the SUD treatment system in a Medi-Cal world after 2014. These include: i) Provider attrition as we move to Medi-Cal reimbursement from Block Grant. Many providers, particularly smaller ones, will have great difficulty ramping up to meet new business and clinical requirements. ii) Purchasing services in a managed care environment. For		c) Develop DMC rates that better reflect actual costs which, in many cases, are higher than the DMC SMA. Include case management and other services as benefits. Impose limits on service – i.e., 2 hrs. of case management per month. Or 200/month for entire 100 client caseload. Need to request authorization if they go over the cap. d) Implement a standardized methodology for provider reimbursement. e) Focus on health information technology as it relates to client safety and outcomes. f) Permit billing for two Medi-Cal services in the same day.		

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
the most part, neither counties nor providers have experience here. iii) Enrolling people for coverage. iv) Questions about the future of the Block Grant as previously noted.				
Overall funding levels and adequacy DHCS needs to play a strong role in ensuring adequacy of funding base for MH and SUD services in face of major changes and fiscal pressures. -This will include being sure systems/providers can meet new requirements for expanded access and parity. For many this focus also means protecting MH and SUD funds under Realignment so they are not used for other priorities. Such protection was also seen as needed in face of pressures to shift possible savings (e.g. in primary care or public safety) to other areas prior to assuring baselines are restored for MH and SUD and needs for mandated expansion addressed. "no erosion of funds" Develop more effective	**Engagement and outreach goals, processes and principles** Develop/strengthen policies supporting/requiring more inclusive decision making, broad participation, and greater transparency in policy development as well as service system operations Engagement of stakeholders should be ongoing and sustained; State agencies such as DHCS should develop and model such more effective and sustained stakeholder processes. This will require rebuilding trust Take advantage of opportunity for "smart" coalition development and collaborative decision making so that there is a more effective common voice among agencies, advocates and stakeholders at state and local levels.	**Workforce priorities** Address major training needs, especially in context of major new workforce requirements for health care reform expansions. Examples: -Include training in areas where new program/financing models are needed e.g. for special needs populations such as autism, traumatic brain injury and dementia -Address staffing/training needs in area of co-occurring disorders -Training to enhance availability of bilingual/bicultural workforce -Cross disciplinary training is also needed, especially to help support integration with primary care Review and revise as needed the scopes of practice in key professional areas in order to support work force flexibility and expansion	**Processes and principles** Consider use of three levels of evaluation: quality of life surveys at consumer level; systems indicators to track system effectiveness and access; program level evaluation of effectiveness and outcomes Need to include consumers, families and advocates Also include representatives from underserved groups May need methods that don't include county /provider staff Overall need to lower the cost /administrative burden of evaluation and measurement processes. Short term need to reduce fragmentation, waste and duplication in these processes; seek to standardize and streamline Use technology more effectively	**Measuring engagement of consumers, families and stakeholders** Exit interviews for consumers leaving programs Quality of life surveys Local name leadership participate in evaluations of MH directors and chief psychiatrists in their areas Use statewide standards for demonstrating meaningful stakeholder engagement in WIC sections re MHSA Track records of recommendations presented by stakeholders and either reports adopting them or can provide explanation/rationale for declining to adopt Increased involvement of families from underserved

DHCS Business Plan
October 2012
All MH Interview Responses

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
advocacy and public education voice for funding Ensure some potential back up plans if tax initiative not passed Prepare to have clear evidence of value of these investments when more state funding will be needed for match under expanded Medi Cal in later stages of health care reform **Fiscal policy priorities** Articulate good and affordable "benefit packages" not only for Medi Cal but for private insurance and other funding streams, so we avoid two-tiered systems . * Fiscal policies in key areas need to help promote integration and reduce the current fragmentation by funding source; continue to develop policies re integration of Medicare and Medi Cal Deal with special issues re IMDS i.e. ancillary medical costs and IMD exclusion Deal with SUD related issues like DMC billing limits Ensure thru policy the appropriate use of Federal funds	**Compliance policies and processes** Develop workable state and local issue resolution processes re compliance with requirements particularly ACA In MHSA work DHCS needs to help ensure sustained and strengthened focus on transformation and cultural change Enforce parity, how to ensure compliance Enforce Olmstead Ensure compliance requirements align with key MH and SUD service values DHCS needs to take lead role in coordinating licensing and certification across multiple agencies for MH and SUD; ensure licensing/certification supports recovery values ; this work should also better coordinate requirements for MH and SUD DHCS needs to be active in supporting cultural competence requirements , working closely with DPH to coordinate **Needed areas of policy development (note-some of**	Ensure appropriate and enhanced use of peers/family members, using certification standards, training, career ladders, and reimbursement options as supports for this expansion **Program types and policy needs/priorities** Sustain and expand prevention/PEI programs in context of changing MHSA requirements Ensure greater availability and effectiveness of culturally responsive services and supports for underserved and/or diverse population. Use quality improvement approaches and emerging /evidence based practices for these needs Develop effective program models for special needs groups such as autism, traumatic brain injury, and dementia Enhance and disseminate models for effective primary care collaboration and integration Add services for SUD to rehab option or similar more flexible Medi Cal coverage	– e.g. shared IT systems, EMR's , "smarter" methods Current systems of local outcomes data collection and other means of reporting are broken/not working effectively. Ensure overall improvement in timeliness, clarity, comprehensiveness and accuracy of data. Needs to be more credible Show data for all clients regardless of funding source Make data available to the public; simplify and make easier to use – and don't overload users Work toward ability to do broader population based evaluations that allow true cost /benefit analyses and consideration of best investments of public dollars across systems Use current info like EQRO more effectively Use TAC report Ensure use of evidence based metrics, needs to have real outcomes not just numbers State needs to model listening/input sessions and	groups Attendance at meetings Representation on policy and program planning groups Satisfaction surveys , data compiled and shared publically Include pg's, protection and advocacy reps Ongoing substantive partnership not just input or participation Multicultural participation Recognize challenges in small rural areas – find more creative ways to engage stakeholders in such situations Avoid stakeholder fatigue State leaders need to model the value of such participation Use planning council definitions of meaningful engagement to measure MHSIP not that helpful

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
wherever feasible Target funds to key service priorities; avoid shifts of funds to inpatient and emergency services Consider policies to provide for incentives for desired outcomes /quality indicators as well as ways MH systems can benefit when MH services help cut costs in other areas Ensure policies make clear need for sustaining progress in area of EPSDT to prevent possible problems/setbacks related to realignment and other recent changes in children's services funding Use policies to communicate clearly new models of financing for current /anticipated environment under realignment and health care reform Develop stronger policies re fiscal accountability, with adequate enforcement Provide policies to ensure greater fiscal transparency and involvement of stakeholders in key fiscal decisions Maintain MHSA principles; don't use MHSA funds as	**these are also mentioned as part of fiscal, program and evaluation areas)** Major need to develop policies that modify fiscal, evaluation and program models/policies to adapt to major environmental changes including health care reform, and realignment. More specifically this will mean new policy development and/or updates in key areas such as : Primary care integration- clarify our goals; how maintain recovery focus and system of care values; relationship with primary care business models/work flows; gatekeeping & coordination requirements; consistency versus many different audit/business requirements; seek to reduce administrative burdens to keep $ maximized for treatment Public safety linkages ensure balance and effective partnerships Co-occurring MH and SUD disorders-reduce barriers and increase skills People who will remain uninsured after 2014 – how finance and serve while maintaining fiscal viability	Ensure effective program models and supports for co-occurring disorders Enhance use of peer supports in program models Use the leanings from Innovative Projects under MHSA to share what works Support strong CSS services continuum including supported employment, housing, case management, peer support. Ensure continued support for the system of care and recovery models/ values that underlie these services as connections to medical models in primary care develop. Ensure network adequacy and core services availability e.g. 24/7 crisis services across the state Support continuing research to support long term development of effective evidence based practices and better understandings of mental illness A range of perspectives were shared re evidence based practices – many encouraged further dissemination, others cautioned against limiting focus	processes DHCS needs to truly evaluate , monitor and enforce not just pass capitation thru to counties and providers; more plan accountability for major initiatives like Healthy families transfers or mandatory managed care enrollment – need bandwidth to do this Do quality improvement and evaluation work across areas/agencies ; link with health, social services, criminal justice etc. to look at outcomes; data matching across systems Provide fiscal incentives for outcomes reporting Use data repositories Focus more on outcomes and less on process; also use qualitative analyses **Possible metrics and measures** Systems savings Access, cost and outcomes are key MORS DLA 20 MHSA measures	

DHCS Business Plan
October 2012
All MH Interview Responses

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
backfill/replacement as funds reduced in other areas; ensure continued focus on PEI and innovative projects as funding is shifted Turn down noise, resolve concerns related to Prop 63 misuse, Use of UCLA study to help resolve concerns? Develop policy guidance re the ways to finance across systems the services needed for special needs such as autism, dementia, traumatic brain injury Need for policies to assure better fiscal support for peer services –.e.g. peer certification, training, Medi Cal billing Administrative procedures Major needs for streamlining , greater consistency and uniformity to reduce burden and excessive overhead costs Provide key supports such as needed IT system development. Provide clear and timely information about any upcoming changes; need to avoid the kinds of problems that developed with Short Doyle II Major need for more timeliness in payments	Poor health outcomes for people with diagnoses of serious mental illness People with special needs not well addressed by single systems e.g. autism, traumatic head injuries, dementia Develop stronger policy re reducing disparities in access and outcomes. Take some short term action as well as longer term development work Assure effective "co-governance" models and policies across the numerous departments now involved in MH and SUD services – need to see joint policies, MOU's etc. Support improvements in SUD services through expectations re use of EBP's , resources for expansion, needed changes in DMC, better linkages for work with co-occurring disorders, joint licensing processes Engage in children's cross system MH policy development work with other key agencies; ensure policies support MH system of care models for children Convey support/ expectations for true systems of care	too narrowly to current EBP's and suggested use of emerging/ new practices for new needs Training will be needed re changing services and benefits to avoid confusion and keep consumers/families informed When program models involve multiple agencies assure there is a clear lead agency to coordinate Consider needs/unique challenges of State Hospital patients as system evolves and changes to have more capacity/treatments/long term care options	Readmissions and recidivism within MH system services(e.g. LA MIS) rates of hospitalization, arrests/re-arrests, crisis events Increases in county penetration levels Housing status/homelessness School performance Child custody status Use of alternatives to locked care Health status Participation in peer supports Involvement in prevention services Consumer, youth, TAY and family member surveys and focus groups Recidivism for key programs such as medical detox Family member questionnaires Improvements in QOL (don't use MHSA measures) MHSA measures especially the five core measures Reductions in disparities	

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
Simplify aid codes for enrollment Ensure better tracking of how funds used by source, tied to key information on recipients, types of services, providers etc. Address special needs such as requests for direct funding of tribes	approaches for adult recovery services, with enhanced coordination and accountability Address needs for support for broader use of peer services through means such as certification, Medi Cal state plan amendment or other means as needed to enhance billing potential Develop policies to support more effective use of technology to coordinate and enhance services (including use of telemedicine in rural areas) Develop policies to support enhanced access and early identification of both MH and SUD needs, to avoid people showing up first in criminal justice or ER's etc. Strengthen policies to combat stigma and develop better public understanding of serious mental illness and recovery Consider needs for special issue policies in emerging areas such as use of assault weapons Consider how to insure appropriate access/services with EPSDT changes including the challenge of school wanting to bill SDMC. Need dialogue across		Enforce current cultural competence plan requirements Matching needs/preferences of consumers with services delivered Numbers of culturally and linguistically competent providers Consumer safety State hospital use; ; use of acute inpatient beds; use of ER's Numbers of individuals served out of host county Benefits of peer supports Functional gains Measures of cross providers coordination and communications Consumer recovery instruments and satisfaction data	

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
	state, county, and school dialogue			
*Use Health Reform as vehicle to revisit what works best for SMI individuals and fund it via Medi-Cal(like housing assistance with rehab and case management supports), create flexible Med-iCal plan that can change as knowledge in the field changes *Fund early identification and early treatment to avoid tragic high costs on healthcare and human lives, presence in schools could make a difference *Tract the school taking over of 3632 insure quality client/family care continues *Inclusion of NAMI in formulation of funding priorities and policy in partnership with Government & private agencies doing treatment and ancillary supports *State leadership around problems solving and standards must continue and be easy to engage *Recognition of the chronic care model as it applies to these conditions with the	*Adequate safe, affordable housing with supports for all SMI clients who need it *Support and fund involvement of peer and family members/supporters in care teams * Safe detox for consumers with SUD and mental health issues including use of acupuncture in detox/ treatment related to cravings * Consider detox a medical issue separate from the psychiatric issues during both outpatient and inpatient treatment. * Transfer consumer to psych unit following detox, if hospitalized. * Stricter regulations on residential detox facilities – perhaps requiring CPR training and first aid * County agencies have safe systems in place and may be models for non-profit hospitals. * Once consumer is no longer at risk for dying from the effects of	Medi-Cal funding for drug detox including acupuncture *Choice of mental health providers and support groups *Integrated treatment programs with one set of standards for dual diagnosis clients including residential treatment and outpatient *Review scopes of practice to expand and create paraprofessional certification for peers/ family support staff * Lack of understanding related to the seriousness of the detox period for the consumer. * Lack of understanding that the detox period is solely a medical issue. No therapy is needed at this time. * Need to consider expansion of Laura's law so those who deny their mental illness and put themselves and others at risk can get treatment and stabilization *Evidence based treatment interventions including support	* Track the number of participants who attempt to complete a programs (both MH and SUD) * Track rates of hospitalization by county, client; arrests and re-arrests; crisis events for MH clients * Track the number who do not successfully complete a program and get feedback from consumer before allowing him/her into another program. * Keep track of recidivism so we have proof that medical care for detox is frequently needed * Outcomes that support de-criminalization of mental health and substance abuse disorders * Increased patient/consumer functionality as measured by living independently, employments, minimal hospitalizations and crisis events, friends and family, not homeless. * Count and compare the number of mandated vs. self-	* Exit interviews upon completion of programs (for consumers) *Client and separate family quality of life surveys statewide *Participation in goal setting and funding decisions for local systems of care *Have local NAMI leadership participate in periodic evaluation of local mental health directors & chief psychiatrists * Questionnaires for family members who are trying to be supportive (what are they doing to replace the expectations they once had with the realities they are now facing?). *Family members frequently understand the effort needed to put programs in place. Consumers do not seem to appreciate this fact. Once again, I stress that this fact needs to be included in psycho-education programs. *Stress that programs can be difficult to keep in place and that they should be appreciated.

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
understanding that consumer training by peers is a very potent intervention *Closer integration between MH and SUD, current system does not work well *Financial incentives for public and private sector coordination of care, make it easy not hard, require coordination for MH, SUD, and Physical Health *Funding for patient activation/education activities, peer support groups focused on different treatment issues and social supports *Insist on MH and SUD within primary care settings so there is less stigma, easier access *Stable adequate funding base to build true system of care(adequate funding for psychiatrists, psychologists and case management teams, integrated care of dual diagnosis patients, additional peer and family member lead support groups, recovery based programs) * Insurance companies need to separate the detox days (medical expense) from the	drugs/etoh then the dual diagnosis should be appropriately treated (e.g. individual therapy, group therapies, 12-step programs, psych education, etc. This seems to already be the direction that we are headed, yeah. *Policy should strongly include families for support care for the person with serious mental illness (the whole family is impacted) *More substance abuse prevention like public health prevention, ads on TV, programs in schools, easy access to treatment when needed, parent education so they recognize signs *Make education of client/family a top priority after first break, very difficult time	for research and new learning in this decade of the brain * We need stricter control over residential detox facilities – or are patients afraid / unable to afford any other care? *Closer relationship between MH and SUD, special program models, evidence based treatment that impacts wellness with both focuses of treatment *Fund client peer activation and supports as key intervention * Stigma reduction is always a concern. Make this a public health issue * Our kids, friends, parents, etc. need to be safe. However, keeping them safe can be difficult and risky for providers of services. Do not coddle the consumer. But, give them clear direction and talk about their losses related to their MH diagnosis and/or SUD. Grief counseling may be appropriate. * The normal out there need to believe in recovery for the consumer. The consumer movement is growing and they already believe that it is possible. If they do not think	enrolling clients. * Get practical outcomes that really help the system * How many of the clean and sober mentally ill can find and keep jobs?	Don't shame the consumer, however. I think that caregivers / parents show enough dissatisfaction already *Track on the MH data system/medical records these measures: Independent living, jobs, no re-hospitalizations, evictions, arrests, homelessness, friends/quality of life, crisis episodes.

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
psychiatric treatment days (mental health and substance abuse expense) to provide safer inpatient care. * Keep Obama in office – we need the 'Affordable Care Act' in place * When the mandated 'cultural diversity training' is offered to healthcare workers (e.g. RNs, CNAs, Physical therapists, Respiratory therapists, MDs, etc.), include mental illnesses and the difference between detoxing and treating the MH issues. Stress that dual diagnosis is increasing. * Insurance companies seem to be focusing on providing care to autistic children (with unlicensed healthcare workers) while the mentally ill with substance abuse disorders are being ignored; I believe this is wrong. Perhaps if the consumer parents are treated (through safe and caring detox programs and then therapy), their parenting skills will improve with their children who are also ill. (Is there a possibility that we are over diagnosing our youth?) * Acceptance by all that there is never enough money or		they have the support they need, they may do additional foolish things to get their needs met (like detoxing in an unsafe residential program). *AA programs need to be educated about the possibility of severe consequences if consumers are encouraged to go off psychiatric medications without physician support.		

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
caregivers to make everyone well. Include in consumer education programs their need to take responsibility for their illnesses (when they are ready, of course). *Stress that federal / state / county programs are great opportunities and should be appreciated. *Educate parents that micromanaging healthcare providers (since they are in limited supply and overworked) sometimes is not a good idea. *Everyone needs to realize that healthcare systems are difficult to navigate regardless of the disease being treated. *MH and SUD treatment can be inadequate due to lack of funding. And, losing programs due to budget cuts can have adverse effects on the consumer. *Oversight of residential treatment, residential detox and board & care homes should be the rule instead of the exception.				
Role of Realignment. This is a huge factor, and we need to acknowledge the dynamics have	Essential Health Benefits (EHB). EHB is one of the policy issues, and how to	We're not ready for integration. Primary care is not ready to take on MH/ADO	Need to identify 1) core performance, 2) missing this one? 3) Outcomes standards,	Stakeholders need to be at the table and part of the decision making process. Measure it by

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
changed. Realignment must be considered along with other stakeholder needs/desires as determined through the interview process. Maintenance of Effort (MOE). This is a federal requirement, and how federal funds are used can impact the MOE and impact the size of the state's block grant. What type of accountability and reporting will be done to meet our reporting requirement? With Realignment, funds for MH and AOD are now in a joint account, and counties can decide how to spend the funds and on what. The choices they make come with consequences to the block grant. What is the financial oversight by DHCS of MHSA dollars? How will we know how the funds are spent? What is the fiscal oversight? What are the data and results? What are the expectations, and are they meeting the intent of these funds? Workforce (WET funds) perspective and financial oversight. In 2017-18 there is a	operationalize parity. What is the role of the federal Block Grant in 2014 in terms of services based on HCR? How do we fund the service system? This may not be covered, and some populations may not be covered. Workforce. Who is going to be able to provide services? What credentials will be needed, and what training? Specialty AOD versus primary care. Who is doing what? Who will have the capability of proving medical substance treatment? And who is doing the peer work? In the short-term, how do we expand the MH and AOD knowledge to primary care physicians, nurses, etc.? There needs to be a measure for success around parity. Is there cultural and ethnic parity? Workforce. Need to be more inclusion in bilingual persons in the workforce. It is important in meeting with stakeholders to ask for comments and suggestions. How will issues around Title 6	disorders. What about intervention and when to use specialty services? We have a shortage of AOD and MH professionals, and we need members to team with primary care to serve MH/AOD patients. We need to address integration and the lack of MH/AOD professionals (psychiatrists, psychologists, etc.). Psychiatrists treat both SUD and MH, yet county MH Directors cannot provide AOD services under the state program. This is an urgent matter, and we may want to go to groups like the medical board for help. What will be the scope of practices for the various medical providers, especially with integration and what is needed/necessary in primary care and specialty care. What do we need to do around prevention? And how to build a system as opposed to sitting on the side? As we move into the early intervention phase, how do we address universal screening and not have it feel like a burden? How do we do it if we	and 4) prevention and education. Need stakeholders to measure this, and what are the consequences? Client outcome should be assessment of program (immediate outcomes and sustaining it). Are improvements to performance measure tied to success in achieving outcomes? Need to tie performance and measures to identify areas such as in-home care versus hospital care. What are the differences? Measurements need to be around outcomes on services delivered. Did we improve the lives of Californians? How do we measure this? What happens to people after they leave treatment?	the number of people in the decision-making process. Should stakeholder process have requirement to report the meeting results to the state? We need to go to the community, go to community meetings or be on calls with directors that cover the unserved or under-served populations. Need accountability and transparency. Involve the community as much as possible. Client-consumer engagement is low, so how to develop skills in consumers to take the message back to the community. Stakeholder groups are concerned about accountability. How will counties be accountable? Where will people go if there is a problem? Stakeholders want to be part of the decision making process, but also are fatigued at the number of meetings and amount of input they give. Concerns over how do/will funds get used properly, and will money drain away from AOD

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
cliff for WET funds. Counties can invest 20% of their own funds for workforce development, but will be impacted if 20% doesn't materialize because the base line is $6 million. Managing the work. What model incentives include prevention services, so in 5 years, which one will be best? What accountable health home do they want? What are County Supervisors thinking? Will it be run by contractors or county employees? For the long-term, having difficulty separating the policy from the financial aspects because financial is dependent on policy.	will be handled as well as many new eligible not being proficient in English? We do not have enough providers yet and have an entry-level workforce in AOD services. We have multiple places for eligible to get services so we need to look at who is responsible for what, and to know how these services connect. What is the delivery system we want in California? What does integration look like and does it differ from county to county or community? How do we develop the delivery system that ensures equal access to care and technology? What is the state role in accountability and oversight around the integration of managed care? What does the OAC expect from DHCS? How will the OAC define the financial and fiscal issues? What are the options; is it an HMO model, a community-based model? What are the changes over time and impact to people using the services? Need	have 2 separate staff to do each? So how to set up a way to be inclusive, but let staffs know what to look for and when to hand off to someone else. How do we look at medication-assisted treatment and build in peer oriented serves, and pay for it? Maintenance of Certification (MOC). We need to put into place things to compel schools to teach MH/AOD. The state could take an upfront role to work with boards and SAMHSA in order to talk with the legislature. We need directed workforce development. New focus is on HCR, but need to remember criminal justice. What is the role of state around licensing and certifications for the AOD workforce? Need to strengthen the referral system around delivery systems for MH/AOD. There is a gap: serious mental illness goes to county and mild goes to primary care, but what about those who fall somewhere in the middle? We need to strengthen		funds? Aligning expectations with realities will be hard to reconcile. Will what we see as our responsibilities coincide with stakeholders' expectations?

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
	to have information on who received services, where they received them, and what is the outcome. What acknowledgement and communication will there be between primary care and MH/AOD. What about CFP (confidentiality) and sharing electronic health records?	referrals, but to what? How can we use the data to assess counties' results and success? How to use the data we receive to inform education and monitor?		
Most focus on funding MHSA values including peer support and positions Increase education and requirements related to informed consent related to medication choices physicians present to consumers, avoid medication conflicts with primary care and make sure consumer has full and complete knowledge of all side effects Funding need for peer crisis models that avoid hospitalization and prevent relapse like the SAMHSA programs like Second Story Insure transparency and genuine input into budget processes and priorities	Require training and work on trauma related impacts and models of successful interventions Careful consideration of any attempts to expand involuntary treatment which can be very traumatic to individuals Insure MHSA funds are not redirected to other programs impacted by state and local budget cuts Increase percentage of MHSA funds for peer oriented services and supports, housing, and drug treatment for dual diagnosis clients coping with both issues	Consider requiring training in trauma related impacts and treatments and other best practices Insure that medications are full researched before release on to the market and clients have full information on the side effects, interactions, and possible alternatives Expand peer self help and support programs Insure peer programs are linked to crisis and inpatient programs as possible alternatives and there is a high level of cooperation and coordination Keep focus on outcomes and quality of life, not just units of service	Meaningful activity as in school, work, family, housing, Avoiding homelessness, hospitalizations, poverty, isolation Look at quality of life in meaningful way	Consistent involvement and presence and learning supports for involvement with program and budget decisions Approval of budget cut strategies and enhancement priorities More consumer staff in public and non-profit mental health programs Strengthen consumer roles in advocacy and treatment planning with peers Allow paid consumer and family members to be on the Local Mental Health Boards Consult CA Network on legislation and how to expand

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
		Work to insure special needs groups have unique programs Certification for staff with life experience is needed for workforce and treatment		meaningful services including in health reform.
*Limited transparency in decisions made for TAY 16-25 year old services, often blended or obscured by general adult programs, need unique funding and service models *Young adults 75% aging out of foster care or juvenile justice do not have family, case management, or advocacy to assist them linking to critical services for successful transition – medications, housing, school, vocational supports *Need unique funding source with specific treatment services not blended with chronic adults, need individuals in the same age group they can identify with who have been successful and understand the SUD and MH services available, also TAY and all ages need programs where MH and SUD are truly integrated and treatment is effective *Unique funding source needed	*Studies show many of these youth in foster care and juvenile justice fall through the cracks and end up with long term institutional or emotional problems, track unique funding investment and strategies for this group; *State can play key role fostering coordination and integration across the various departments serving these youth and funding various services; *High risk of more fragmentation with coordinating council or effort to work together; *Need to have systematic review of continuum of care in MH and SUD and develop gap filling strategy and financing *Standardize paperwork and provider systems to be less burdensome so more funding	*Must develop effective programs for TAY only services, with TAY friendly supports *Insure care is age appropriate, and focused on unique challenges of this age group *Providers need more training in TAY services to assist youth to adapt to changing living, economic pressures, and social/emotional demands of adulthood; staying up to date on what works, how to form therapeutic relationships and foster peer support, friendships, etc. *TAY services also need to be viewed through cultural lens to be effective, communities of color and with different cultural experiences need this integrated into care models *Trauma informed care and PTSD knowledge is critical for clinicians and this stress can	*Consult with consumers/TAY on services and how to get true engagement and successful involvement from youth in crisis *Quality of life impacts, are services working? *MHSA values are important including true transparency and involvement in decisions *What is the method for doing this under realignment and with Counties and State *Require youth representative on LMHB and other key advisory bodies	

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
which recognizes unique stressors for TAY in home settings, schools, foster care, and juvenile justice. This is an important time to invest in services which could benefit the individual and society for many years to come. They traditionally feel unempowered because of their age and often also because of culture and socio-economic status. They will not get better if they do not have voice in their own care, and it rarely happens in current system.	goes to care and less to administration *Need to have no wrong door approach with TAY so no opportunity for positive intervention and support is lost, *MHSA values put high priority on youth involvement in services design and programs but vision is not fulfilled in current system	trigger diagnosis and non-adaptive coping mechanisms and behaviors; extremely important area for training *Bullying and cyber bullying is very real and causes real harm to self-esteem and self-image; providers need training on these realities and how to help youth cope with these harmless environmental factors; communities need to set standard of no tolerance this this type of activity *TAY often reject medications because they do not understand them or their choices, need providers to provide all critical information and help with decisions *Clinically need better partnerships between therapists/psychologists and the physicians who prescribe; better coordination and collaboration should be required not optional *Clinical – TAY LGQB youth particularly need unique services and more of a sense of peer group so not as isolated, and		

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
		feeling stigmatized and rejected by society. Very high risk group for suicide and specialized treatment and supports are needed *Clinical – Many of the service models and programs can work well but need to be TAY friendly and specific		
Need to find way to stop gaming around supplantation. Need rules to do it correctly. Need clear financial oversight system, i.e., how are funds being spent, easier access to financial systems. Concern that Steinberg is leaving legislature next year. If MHSA is not cleaned up – more transparent – MHSA funds will be an easy target. Need rules around parity to access services. Insurers are gaming parity. Need to insure adequate funding for data systems and data infrastructure.	DHCS needs to put a priority on MHSA regulations – clear up confusion Need to continue to clarify roles and responsibility – hopefully through regulations Administrative share dropped from 5% to 3.5%. Need to go back up to 5% if there is seriousness around data and evaluation. • DMH underspent but they weren't doing the job • Oversight is needed Still need more culture change to support a recovery oriented system. Counties and CBOs are	Need to figure out how to integrate the statewide PEI and reducing disparities projects into counties to sustain the work Need to understand DHCS role in oversight of the cultural competence plans Need to prioritize service integration – MH & SUD and MH, SUD, Primary Care People coming out of hospitals do very well in Full Service Partnerships. We need a focus on this instead of people going to IMDs which are more restrictive and more expensive. How to ensure recovery in the new, more medical system under the ACA.	The OAC has invested in a contract to determine the MH baseline prior to enactment of MHSA. Now examining where we are now in contrast to the baseline. However, no measures of client outcomes with the exception of FSP measures; Need a statewide standard measure such as the MORS, LOCUS Need a way to know which sites are going a good job; Need to get serious about statewide measures; Need quality of life measures Need an outcome oriented model based on the MHSA outcomes	Need to look at whether client outcomes improve with client/family/stakeholder involvement How do we know if person centered care is happening, i.e., how do we know if clients are driving their care? Indications of broad, diverse, and representative stakeholder representation What was produced helped achieve desired client outcomes Quality measures of stakeholder process: accessibility, indication that decision makers understand stakeholder concerns, diverse methods utilized to secure input, diverse views expressed and considered, participatory

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
Need priority on training and technical assistance resources to assist sites to provide best practices, evidence based practices.	variable in their success. Need statewide effort to encourage recovery which is both a policy and practice issue DHCS must address the stigma against SMI in health care.	Focus on MH/PC integrated care – very difficult – need to address attitudes, stigma, and resistance from PC to deal with people with serious mental illness	Counties need to report outcomes, LA may have a potential model	decision-making, efficiency Success of stakeholders (community planning participants) to identify and prioritize mental health outcomes for key community needs and priority populations (as is currently required for PEI and could be extended to all MHSA components) Satisfaction and perceived legitimacy among stakeholders and responsible parties regarding engagement opportunities and process Improved relationships Increased ongoing collaboration in planning, designing, delivering, and evaluating mental health services
There should be more media educational awareness for TAY specifically. It's important to have program consistency for TAY. TAY are referred to Alcoholic Anonymous and Narcotics Anonymous groups with older people that may be outside of	Identify TAY as a specific population with unique needs and services. Provide funding for recovered TAY alumni lead programs. For example more providers should hire youth peer mentors and youth advocates as well as family partners with lived experience.	The providers can improve care and services for TAY by building friendships with them not by trying to always come with a professional approach. Providers need to understand that getting information from TAY doesn't happen overnight but over time.	Online surveys for TAY ensure individual voices are being heard. Involving TAY families in the process also helps aid in getting the best services for consumers. There should be more communication between TAY family members and providers.	

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
their agency, most of the time there isn't a mental health focus within the group. It is hard for a TAY to benefit from a group setting like this. Funding to should be put aside just for TAY specific groups that are facilitated by former TAY consumers. Provide better transitions for TAY coming from the child system of care into the adult system of care to ensure they don't fall through the cracks. It is crucial to include TAY in the program development because these programs are being made for TAY population. It is important to reach out to agencies state wide that provide services to the TAY population and implement a survey within each agency in order to identify the most common issues and areas of improvements. It is vital that TAY are aware of the services that are available for them as a youth and as an adult. Extend services and eligibility for at risk TAY. There should be a mass	With such big budget cuts being made, the services that TAY are able to receive has reduced severely. Extend Prop 63 definitively, while raising taxes slightly more on the rich in addition to what is already being collected.	Service providers need to understand that everyone moves at they own pace in life some youth might catch onto things faster than others. Have an authentic approach by truly being passionate about their jobs because a lot of staff within the field make TAY feel as if they are there for the pay check and not really to help them with their needs. Need to have understanding and empathy. It is important for providers to be aware of the ever changing TAY culture and community. A lot of providers are judge mental when it comes down to TAY population and they need to learn how to put there self in other people shoes. Be aware that some TAY have never had anyone teach them basic things like how to iron their clothes every day or how to cook a basic breakfast, lunch, or dinner. Make the TAY feel welcomed and comfortable and at ease in the environment that there are	Simply reach out and ask TAY about the services being provided to them.	

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
directory of TAY specific services and resources state wide. Without education, there is more risk that young adults will confront dangerous methods of coping with stress. Gain more funding for TAY specific services and programs. Provide more anti-bullying, crime prevention, and substance education specifically for TAY.		providing for them. Providers need to meet TAY were they are. For example, have a session at a coffee shop versus an office with a couch and a clipboard with paper. Some of the services that work well for TAY are therapy, housing, and the employment benefits. It's important for TAY to have a good relationship with their providers because the TAY providers are supposed to be there support team. Providers should help TAY with mapping out their future. Trauma informed care. Providers need to take time to explain case plans, diagnosis, and medications to TAY. TAY need more time spent with their providers. Connecting TAY consumers and families to the therapeutic community provides more value and awareness. Provide TAY consumers with a youth advocate and the family		

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
		members with a parent partner.		
*Critical MH Policy issue - What level of MH severity is required to access MH care in the current system? In the current County system only Medi-Cal clients with serious mental illness and profound levels of disability are able to access services. This leaves many individuals with real mental health needs untreated and without access. With the pending decisions on parity, it is important that all individuals with mental health needs get access to care from outpatient, assessments, meds if needed, etc. The threshold of current system is too high and leaves many individuals without access who could benefit from treatment. With ACA and parity this needs to change. *There are gaps in access for substance abuse as well. Many services are done by contract agencies and thus there is some flexibility on access at local level. Medi-Cal covered SUD treatment only covers 10% of the needed clinical services.	* BH area needs serious development in looking at Prop 63 funds, ACA funds, and local realignment funds - how do they support each other in creating a true system of care? Are the restrictions, limits helpful or an obstacle to creating solid systems of care? *How can we know that these sources of funding and programs are making a difference at the client level, community level, and helping align the system with primary care/medical care systems for patients? Integration and new models are needed. Leadership at all levels is critical to support creative efforts to truly bring these systems together. *MH & SUD need to do better job documenting outcomes and value of services and $ spent. Do current services models have solid science behind them or is just the same as we have always done? *Use ACA to look at new models	*There are not enough MH and SUD providers of all types to meet the needs of current clients. There will be serious access issues without a major effort to expand providers at all levels and this should be a major focus of efforts. *Telemedicine is helpful but is not the answer. Creative use of technology is positive, but ultimately you need providers who can speak a variety of languages and with special cultural sensitivity to be effective in care delivery. *Updating the science in the field of addictions is recommended. Current services seem outdated and not based on latest developments in the field. Again Medicaid plan needs review for SUD to include more services and linkage to primary care and MH.	*Data needs to flow from goals and objectives of the system. Obviously the goals must consider what benefits are covered and for what populations. *Paid claims data can be very useful to look at all services being utilized and look at system changes. CMSP did pilot which co-located MH and Primary care. Most were not successful, but those that were saw reduced hospitalizations and institutional care, and increased primary care and medication use. It was a true pattern shift in the delivery system. Data can inform leaders in the field to see if services and systems are improving for patients, costs, and outcomes. *Surveys, assessments, and clinical data can supplement core claims data analysis of patterns. *Again it is important to go back to the core goals taking into account covered services and	

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
The Medicaid plan for SUD needs serious review and is particularly important for parolees coming back to the county and new Med-iCal and insurance enrollees in 2014. Besides the SUD Medicaid plan, there are major gaps in services availability is some parts of the state. More uniform access is needed.	and also Accountable Care Organizations?		target populations for care.	
-Need regional MH Board training funds and structure as CIMH used to do, especially with expanding responsibilities of County Boards? -Need holistic funding approach to MH and SUD, combined programs and funding flexibility -More integrated technical assistance as well as training $ -Protect MH & SUD $ from erosion -Pool resources for research and treatment including with VA and academic sources, share results of research and best practices -Need finances to insure a baseline level of quality of treatment and access across the state? -MHSA has not really had $ for	-ACA preparation and promotion with MH and SUD -CHA wants to make changes in involuntary treatment, possible conflict of interest related to $, changes should not be made unless it really benefits care -Promote MH First Aid similar to Australia, train many community members to have better options for intervention, avoiding client deaths, promoting wellness/self help -Training for all law enforcement should be a must with regular updates, POST training on crisis interventions with clients with mental illness, -Mandated state level local mental health board and commission organization	-85% of state prisoners have substance abuse addiction/use disorders, need funds for treatment before, during, and after incarceration; MH issues for 15% also need treatment but also structure or new crimes/hospitalization likely -insure timely access to initial assessments, treatment for taking advantage of when clients are motivated and in crisis -Add dental care for adult and older adult clients -Insure best practices are well documented and dispersed in the field/community -Clinical data use is important, LMHB need training on how to use and understand, some basic training and supports are	-Access to care timely and of high quality, jobs, community housing -school success for children, -Hospitalizations, arrest, homelessness are negative indicators, out of home placement for children -Numbers of clients need involuntary treatment -Uniform level of core treatment across the state -Different metrics needed for different problems	-Active participation at all stages of planning processes -Informed consultation on the budget process at county/state level -More active community education and involvement

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
true prevention, dollars were restricted to those with diagnosis, not changed, but still need to promote more opportunities for effective interventions	needed, like planning council, CMHDA etc. Organization does not have enough support, propose legislation, more consumer voice/flexibility	needed		

Finance Issues	
	• **California should use this reorganization opportunity to truly integrate our Medi-Cal, non-Medi-Cal, and MHSA services to prioritize assistance to all Californians based on their severity of need rather than source of funding.** • **Evaluation and Quality Improvement.** Our system is broken in terms of collection of data of outcomes at the local level. Coordination of systems partners on this effort is essential, along with standardization of data collection and examination of valid and relevant data: e.g. Consumer recovery instruments and satisfaction data (recognition that these need to be updated and standardized with the involvement of stakeholders). • **Ensure a full array of services and supports are available, accessible, and culturally and linguistically appropriate throughout the state.** In addition to traditional psychiatric services, an array of services should, at a minimum, include: o Housing with supportive services o Employment and education supports o Transportation services o Reduction of individuals engaged with the criminal justice system o Wrap Around Services o Integrated mental health and substance use treatment o Prevention and outreach services o Case management and care coordination o Community skill building/capacity building/technical assistance • Continuation of **prevention and early intervention** through statewide and local policies and programs, which **are key to cost savings in our state**. This means prevention not only through early intervention, but inclusion of individuals

	already identified with serious mental health conditions across the lifespan as prevention is a life-long need. ○ Prevention programs which enhance ability of consumers, families, providers, and community organizations to support recovery and resilience ○ Stigma and Discrimination Reduction ○ Student Mental Health ○ Suicide Prevention • **Crisis Intervention Services in Communities – and State-Level Support to facilitate decreased demand for emergency rooms, state hospital beds, incarceration, and re-hospitalization.** Recognizing it takes time for prevention and early intervention programs to make systemic impacts, there is a dire need for crisis intervention in our state: ○ Recognition and support for Local Community Infrastructure to limit and eventually prevent hospitalization, law enforcement involvement, homelessness and other adverse outcomes identified by our state: ▪ Crisis Support Services (warm lines, hot lines and in person walk-in support to prevent crisis escalation) ▪ Crisis Intervention Teams (including first responders, mental/behavioral health professionals, peers/consumers and family members) ▪ Choices in Crisis Intervention – alternatives that provide a continuum of caring support and healing without trauma and punitive treatment (all with supports for both peers/consumers and families) • Peer Run Respite Centers • Crisis Residential Centers • Detox and Drug and Alcohol Treatment Centers which include mental health supports and transition • Step down programs including housing and other rehabilitative supports ▪ Mental Health Courts and Restorative Adjudication Systems
Policy Issues	• *(Some responses to this question are **partially addressed under Question #1 above** because many of the policy issues that concern us are closely linked to funding and financial priorities.)* • **Any reorganization of California's mental health system within an integrated framework including primary care and substance use services**

	can only be successful if it facilitates the coordination, integration, and linkage of Medi-Cal, non-Medi-Cal, and MHSA services. This integration must be accomplished in order to achieve positive outcomes for all persons living with serious mental illness. • Need for clear and centralized venues for client and family stakeholder engagement in statewide mental health as functions are dispersed to 6 different state departments and in county mental health as outlined in WIC Section 5848. • Need for clear and effective Issue Resolution Process connected to both local and statewide engagement in all areas of mental health and substance use services. • Dept. of State Hospitals – this population should not be further stigmatized and isolated, but stay connected to community mental health to facilitate transition back to their communities.
Program Issues	• *(Some responses to this question are **partially addressed under Question #1 above** because many of the policy issues that concern us are closely linked to funding and financial priorities.)* • **Any reorganization of California's mental health system within an integrated framework including primary care and substance use services can only be successful if it facilitates the coordination, integration, and linkage of Medi-Cal, non-Medi-Cal, and MHSA services. This integration must be accomplished in order to achieve positive outcomes for all persons living with serious mental illness.** • Need for clear and centralized venues for client and family stakeholder engagement in statewide mental health as functions are dispersed to 6 different state departments and in county mental health as outlined in WIC Section 5848. • Need for clear and effective Issue Resolution Process connected to both local and statewide engagement in all areas of mental health and substance use services.

	• Dept. of State Hospitals – this population should not be further stigmatized and isolated, but stay connected to community mental health to facilitate transition back to their communities.
Outcomes Measures	• **Our combined statewide and local systems of evaluation must be prioritized and revamped.** o In the past, our state's Data Collection and Reporting (DCR) system has not been effective in interacting with county databases. Counties have claimed that after they submit data, it is not provided back to them in a way that can positively impact interpretation and quality improvement. o In addition, in terms of MHSA funded programs, more data needs to be mandated to be collected, standardized, and disaggregated – both in terms of recipients of services and in terms of county and provider levels in order to better evaluate characteristics and outcomes of programs. As it now stands, in terms of MHSA, it has been reported that only Full Service Partnership Programs have been linked to the DCR system. o There is pressing need for integration, across the board - in keeping with Health Care Reform – of evaluation of outcomes of mental health, substance use, and primary care. Evaluation should be integrated and not kept separate only for the purposes of satisfying the requirements of separate funding streams such as Medi-Cal. o Evaluation efforts occurring at the Mental Health Oversight and Accountability Commission (MHSOAC) and External Quality Review Organizations (EQRO) need to be integrated with efforts occurring at DHCS, Health and Human Services (HSS), Department of Public Health (DPH), Office of Statewide Health Planning and Development (OSHPD), Social Services (CDSS), Department of State Hospitals (DSH), the Department of Education, the Department of Corrections, and any other evaluations regarding mental health and substance use throughout our state. o Instruments of data collection need to be standardized throughout the state. ▪ Instruments of data collection need to be updated, changed or augmented in this process, as necessary, to reflect peer/consumer and family involvement in evaluation efforts. o Evaluation must include key participatory components that prioritize peer/consumer and family involvement in evaluation design and determination and evaluation of outcomes.

Stakeholder Involvement Measures	• Even prior to the measurement of successful engagement of consumers and families, statewide standards must be in place and desired outcomes of effective engagement identified. o Funding to counties must be attached to a mechanism for accountability at the state level ▪ Plan approval – with MHSA plan approval proposed to occur solely at the local level with final approval by Boards of Supervisors, protections for the interests of client and family stakeholders must be in place ▪ Ensuring stakeholder process occurs and plan meets stakeholder approval ▪ – see WIC 5848: 5848. (a) Each three-year program and expenditure plan and update shall be developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests. **Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations.** A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans. • Statewide standards for demonstrating meaningful stakeholder engagement as outlined in WIC Section 5848 above must be affirmed by stakeholders and incorporated into accountability mechanisms such as the county Annual Performance Contracts and regulations. • Successful engagement would involve: o An inclusive, proactive, respectful and transparent process to gather stakeholders' ideas, feedback, recommendations and concerns.

	○ A collaboration where clients' and family members' priorities lead the agendas, with bi-directional and ongoing information sharing, and creative problem-solving efforts if disagreements or other barriers occur. ○ A commitment to clarity about what the plan or agreement actually entails. • Accountability to Stakeholders is: ○ A commitment by government partners to use the stakeholder process to help design new services and improve and transform current services, including current, MHSA-designed programs, and a commitment to use the results of evaluation of the stakeholder process to improve it if needed. ○ An ongoing process in which an independent, state-level entity or structure is instituted and adequately funded to oversee MHSA planning and implementation in order to ensure meaningful stakeholder engagement through adherence to and promotion of MHSA values; compliance with local, state, tribal and federal law; and transparency as to how MHSA funds are used and how and why decisions are made vis-à-vis stakeholders' recommendations and concerns. ○ The use of performance contract monitoring, qualitative and quantitative measures and enforcement mechanisms, remedial training and technical assistance to ensure meaningful stakeholder engagement. Inclusive of a state-level issue resolution process to enable any stakeholder the opportunity to resolve issues safely and effectively. • Evaluating the Efforts means**:** Regular evaluation of engagement and levels of participation to determine: ○ The extent and quality of their participation. ○ The costs and benefits of participation from the respective communities. ○ The impact of their participation on individual, program and system outcomes, performance, and sustainability. ○ Regular evaluation of stakeholder engagement and levels of participation to determine intensity, cost and impact. • Consequence of not addressing this concern: ○ Stakeholders will remain largely silenced, excluded from the opportunity to impact their own lives and prevented from inciting

	positive change for themselves and their communities. ○ Mental health disparities will expand. ○ The quality, effectiveness and good outcomes of services will be less than they could be. ○ The MHSA's promised transformation of the system to one based on wellness, recovery and resilience, integrated service experience and collaboration that is client- and family-driven, culturally and linguistically competent will not occur.

Other:

Coordination of care: The entire science (and art) of "coordination" in coordination of care within the integrated healthcare paradigm is a high priority. Included within this is the identification and selection of effective models, implementation of value-adding quality improvement processes, and adequate and ongoing support (technical and otherwise) to allow for optimal implementation, maintenance and growth. Measures should look at coordination and communication between physicians, specialists, entry-level professionals and sites of care and integration having responsibility for an overall care plan. These measures may be less specific to a type and site of care, but must look across multiple sites and types of care.

Funding: The funding, the administration of funding, and enforcement of regulations need to be compatible with principles of recovery, client- centered treatment and desired client and system outcomes. Funding should incentivize demonstration of successful interventions that are cost- effective and result in a high level of customer satisfaction, rather than being based on volume of services or on continued re-establishment of medical necessity. The measures for behavioral health should indicate that the qualities of life that mental health/substance abuse issues were hindering have improved, that measurable functional gains have occurred demonstrating this improvement, and that the intervention(s) was/were directly related to the improvement(s). The cost of the interventions that led to improvement need to be tracked in order to demonstrate cost-effectiveness. Moreover, measures should reflect the extent that services are compatible with the needs, circumstances and preferences of the population they are intended to reach, indicating patient/client/consumer satisfaction.

Access challenges: Accessibility of effective mental health and substance use disorder services must meet the needs of the various populations in the communities where selected managed care entities operate. This can be ensured through the establishment of performance indicators that demonstrate real life functional gains as defined by client's treatment goals, tracking the efficiency of interventions that support these gains, the residual system savings, e.g. reduction in emergency room visits, hospitalizations, incarceration, etc. that happen as a result, and the compatibility of the offered services with the communities and populations that need them. . Due to low payment rates many healthcare providers, including those in mental health, do not accept Medi-Cal. Although Medi-Cal rates are scheduled to increase to Medicare levels there are many providers who do not accept Medicare or consumers who cannot afford Medicare co-pay costs for appointments.

Data challenges: Similar to the rest of healthcare**,** there is a lack of data documenting the effectiveness of mental health services. There are long-standing challenges with data gathering and collection that must be resolved. In addition, electronic health record systems are incompatible within/among counties and/or with other health and social service providers, e.g. primary health care. The instruments selected for collecting outcomes data must be simple to use, and must collect data that is immediately relevant for the provider and meaningful to clients. Suggested measurement tools include:

Milestones of Recovery Scale (MORS): We highly recommend the use of the MORS as an evaluation tool for tracking the process of recovery for individuals with mental illness. The MORS takes about a minute to complete, and results at the individual level are immediately available to the provider of service.

The Daily Living Activities functional assessment tool (DLA-20): is designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool quickly identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. Use of this tool ensures valid scores and consistent utilization for healthcare report cards. We recommend considering the use of this tool.

Shortage of mental health care providers: It is estimated that an additional 5,000 "mental health professionals" will be needed in California to accommodate the mental health and substance use disorder needs of people who will have access to services beginning in 2014. This combined with the aging of existing staff will create severe workforce shortages especially for licensed mental health professionals, staff in rural areas, psychiatrists, bilingual/bicultural staff, etc. This workforce shortage creates an opportunity to employ a broader range of mental health staff that includes peer providers, health navigators, Certified Psychiatric Rehabilitation Practitioners (CPRP), etc., and to possibly reevaluate current scope of practice and documentation limitations.

Maintaining Mental Health Service Act values*:* With the passage of the Mental Health Services Act came an increased focus by the mental health system on wellness/recovery and resiliency in individuals with severe mental illness. There is widespread concern that integration with physical health care will shift the focus from a person-centered, people-can-recover paradigm to a medical model of chronic illness and hopelessness. In addition, there is concern that recent legislation, most notably Assembly Bill 100, will decrease stakeholder involvement and oversight of local mental health services, which has been a cornerstone value of the MHSA.

Acknowledging stigma: Stigma and discrimination against people with mental illness within primary care impacts their willingness to seek and allow physical health care as well as the treatment they receive. Active efforts to combat stigma and increase social inclusion must be a part of the overall business plan.

Poor physical health outcomes: A priority must be to improve the physical health outcomes of adults with severe mental illness while retaining a focus on recovery. This must include the reduction of harm from unnecessary services such as medication, hospitalizations, etc. Measures should examine overuse, underuse and misuse of recommended treatments, and medication reconciliation in order to reduce the risk for harm from care from adverse drug reactions, and other unintended consequences.

Increased competition: Projections indicate there will be an increase of approximately $500M or more in increased revenue for the treatment of mental health and substance use disorder treatment. With the potential of this increased revenue there will be new larger providers bidding for contracts who may be better at acquiring contracts than providing services. Long-standing community-based organizations with smaller budgets that provide effective treatment services may be in jeopardy when competing with larger far better funded systems. Care must be taken so that historic turf battles over limited resources and among factions in behavioral health and social services are not exacerbated and exploited.

Evidenced-based and promising practices: With increased focus on outcomes there is increased attention on providing evidenced-based practices. Because of the high cost often associated with these services, larger better funded systems that may do a better job demonstrating outcomes rather than producing them will have a distinct advantage over smaller programs with significantly tighter budgets.

Parity: In spite of state and national mental health and substance use disorder parity laws insurance companies very often do not cover medically necessary mental health and substance use disorder services. The public mental health system has and will continue to have a large stake in the outcome of what will be several years of continued legal wrangling over the implementation of parity. As the provider of last resort, the public mental health system has and will be the system that bears the cost burden for those individuals who fail to have their behavioral health needs met through their private insurance.

Challenges reaching un/under-served communities: In spite of specific targeted strategies, there persists large numbers of un/under-served populations that are not seeking mental health and substance use disorder treatment services. Strategic alliances with physical health providers will be essential in making significant improvements in this area.

Increased confusion over benefits and accessing services: Consumers, as well as providers, will have numerous questions regarding coverage and available services. Clearly communicating options and providing easily accessible answers for both consumers and providers during this time of enormous change will be critical in ensuring consumers receive the appropriate mental health and substance use disorder treatment.

Housing: There are many individuals with psychiatric disabilities who are homeless and there is a severe shortage of housing for individuals with psychiatric disabilities. Changing priorities at the Department of Housing and Urban Development are further decreasing available housing options.

Olmstead Decision: There must oversight ensuring that Medi-Cal eligible persons with psychiatric disabilities do not experience discrimination by being institutionalized when they could be served in a more integrated (community) setting.

CA Mental Health and Substance Use System Needs Assessment: The California Department of Health Care Services contracted with the Technical Assistance Collaborative and Human Services Research Institute to conduct a Mental Health and Substance Use System Needs Assessment and to develop a Mental Health and Substance Use Service System Plan. The Needs Assessment was completed in February 2012 and carried out to satisfy the Special Terms and Conditions required by the Centers for Medicare and Medicaid

Services as part of California's Section 1115 Bridge to reform waiver approval. The primary purpose of the Needs Assessment was to review the needs and service utilization of current Medicaid recipients and identify opportunities to ready the Medi-Cal expansion of enrollees and the increased demand for services resulting from health reform. We suggest that this extensive assessment be reviewed in organizing the business plan.

Certification/Licensing of Programs: The licensing and certification of substance use disorders and mental health 24-hour treatment facilities needs to be under the same authority and should not be split between separate state departments. A distinct unit should be established to perform these licensing and certification functions. This unit should be comprised of staff who previously conducted these functions at the Departments of Alcohol and Drug Programs and Mental Health and/or who have experience working in community substance abuse and mental health treatment. Staff should adhere to wellness and recovery principles and be allowed to modify or waive rules when appropriate to support the people being served. The unit should have an advisory committee comprised of clients, family members, providers and county officials.

Options for individuals in acute psychiatric crisis: Historically there has been a primary focus on psychiatric hospitalization as THE treatment option for individuals in acute psychiatric crisis. It is clinically and fiscally prudent to include crisis and transitional residential treatment as options for individuals experiencing acute psychiatric crisis.

Employment: Employment outcomes for persons with psychiatric disabilities remain dire and must be addressed. The Department of Rehabilitation (DOR) Mental Health Cooperative programs were designed to build partnerships between local county mental health agencies and the DOR to assist consumers in finding, obtaining, and keeping meaningful community employment. Increased monitoring of the administration of this program to ensure the effective coordination between DOR and county mental health agencies and contracted providers could prove effective in improving employment rates for mental health consumers.

Let's face reality, it is all about funding. The current needs for this population continue to be undefended at both the federal and state level with pressure placed on local government to make up the shortfall. The lack of adequate funding is one of the main reasons the voters approved the Mental Health Services Act (MHSA). Unfortunately, funding collected under MHSA has been raided to meet other state financial needs. Further, the act (as initially implemented) failed to recognize the success of current programs and also failed to allow supplementation of these programs from the MHSA even in light of identified funding shortfalls. Coordinating the care needs for this population under a managed care model makes sense and may provide a better approach for more efficient use of current limited funding streams. The recent push to expand managed care under Medi-Cal may provide a greater impetus for this change. However, the managed care approach will only be successful if all of the necessary support systems are in place to integrate and coordinate all of the care needs of this population including, mental health, substance abuse disorder, physical health, and the psycho social.

Our members' individual responses to this survey are also important to us. They were summarized by Rama Khalsa in a separate document and are attached to our email transmission of this document. Thank you for the opportunity to respond to this survey and to continue to be actively engaged in this process.

DHCS Business Plan
All AOD Interview Reponses
October 2012

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
Realignment: Risk to counties particularly with DMC in counties that have low utilization now and then expand; Impact of Medicaid parity Regulations - does DMC become Managed care, stay carved out or what? DMC benefits at parity increases demand on realignment BH account. Possible issues with offender TX. Getting people signed up for benefits. System readiness to operate in a Medicaid world – SAAS Report. Future of Block Grant – We need a strategy for block grant utilization post-2014, Lot of work for counties to get ready for this and not enough staff to do it. Provider attrition as we move to M-C reimbursement from Block Grant.	See Fiscal. HCR preparation at every level: 42 CFR, service integration, etc. A MH issue too. CJS realignment & offender TX: Return of Prop 36 as many/most offenders gains coverage under MC expansion. Working with/around potential gaps/weaknesses in Medicaid relative to providing effective chronic care. – Need a new service delivery model. Dealing with diversity in all its forms.	Develop chronic care service delivery model. Demands for implementation of EBP contrasted with counselor salaries. What can we expect for $15 per hour? Workforce development. Where does additional workforce come from? Inadequate focus on youth. What about older adults and necessary links with PC?	Quality of life indicators – broader measures of client outcomes that connect us to other systems. Not just SUD system specific measures. Role of HEDIS measures? How do our outcome measures connect to the Triple Aim? This should be the organizing framework for evaluation. We should be looking in general for alignment with the ACA and ACA BH goals.	

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
DMC Reform – To support integrated care. Needs to be aligned with primary care and MH. 40% of claims are NTP and 30% Minor Consent. Numerous programs in the remainder are of questionable fiscal and clinical integrity. Counties have no control over who becomes a provider, opening the door for unscrupulous or incompetent providers. Putting together a plan that will support integration and expand benefits using Kaiser Small Group HMO as model. Also, issue of billing for out-of-county clients. (See Policy) Realignment – Money is all in one BH Account. How do counties create ordinances or	Reimbursement of out of county Services in DMC. A very complex issue with little time to address adequately in 1915(b) waiver. Turn on SBIRT Codes, also billing for MAT.	Title 22 outlines DMC program medical necessity but there are no utilization review requirements. UR must be done by licensed staffs who know what they're looking at. UR in practice is a compliance review, not a clinical review. Again need to align the DMC model with standard practice in PC and MH. Realignment - Everyone is using different tools, different approaches to the client –CJS, CPS, PC, etc. Makes it difficult to standardize costs when practices differ so much. Develop DMC rates that reflect actual costs which, in LA at least, are higher than the DMC SMA. Include case management, other services as benefits. Impose limits on	Effectiveness – Turnaround time for the different stages in the revenue cycle. Client level of care transitions with warm handoffs Efficiencies – Engagement, Retention, NIATx measures. Health Outcomes – How to connect SUD services with individual and/or population health measures. How does the implementation of systemic strategies impact population health?	

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
other protections or accounting practices to identify which funds are which? AB109 – "Restores" prop 36 funding. That is, AB 109 provides funding for offender treatment that was lost when SACPA went away. The general financial condition of the state, the country and even the world economy could change things dramatically for all government services.		service – i.e., 2 hrs. Of case management per month. Or 200/month for entire 100 client caseload. Need to request authorization if they go over the cap. Need more licensed staff. Implement Rate study providing a standardized methodology for provider reimbursement and client services.		
Constitutional protections under Realignment 2011, especially if governor's initiative does not pass Advocacy at the national level against cuts to SAMHSA and SAPT funding Local control/establishment of financial priorities Emphasis on fiscal sustainability strategies Blended funding for COD	Outcomes and evaluation requirements for funding Ability to demonstrate cost savings/cost avoidance for prevention and treatment initiatives "Carve out" vs. "Carve in" – a way to look at mitigating selection incentives Application of the IOM six aims NIATx Consideration of a waiver that would support managed care Add County-option services to	Evidence-based decision-making Co-occurring treatment Emphasis on high quality, well-coordinated, efficient care not volume of services Prevention efforts Health Information Technology as it relates to safety Care integration	NIATx Results-Based Accountability EBP Fidelity Scales Customer satisfaction along the lines of the MHSIP	Regular attendance recognizing that DHCS and counties may need to take assertive measures to ensure this. Participant feedback, often by survey, at the end of meetings asking what went well and what could be improved Reports from all participants that they believe that their input was heard/considered Participants would report that understand the proposals

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
	the five Drug Medi-Cal covered services Parity			
Guidance on all fiscal issues, specifically written guidance on items such as the MOE. Regularly occurring DMC policy meeting similar to the Mental Health Medi-Cal policy meeting. 1915b waiver	Integration of Health in accordance with ACA/HCR to ensure appropriate essential benefits for AOD as well as co-occurring 1915 b waiver AB109	Integrated Health as well as the issues of Medication Assisted Treatment in addition to Methadone- especially as a treatment modality for youth AB109 Workforce development for AOD	Communication with all partners- DHCS, DSS, DPH which includes face to face interaction at CMHDA, CADPAAC, CIMH and ADPI	Integration of feedback into practice as is appropriate- and a focus on AOD stakeholders beyond law enforcement!!
Drug Medi Cal-1915 b waiver Specialty mental health services including EPSDT 1115 waiver and health care reform parity Public Safety Realignment	Technical mechanisms to manage the Drug Medi-Cal services for counties similar to the way we manage the Mental Health Plan.	Integration of both Substance Use Disorder Services with Mental Health Services and then the integration of Behavioral health with Primary Health Care. Implementation of prevention activities on the SUD side.	Develop an outcome and evaluation plan. Utilize UCLA and work with the RAND Corp (CalMHSA) to develop ideas for evaluation plan.	Develop activities to include consumers and family members locally at the county levels. Regional representation may also be appropriate.
How to purchase services in a managed care environment. A reasonable reporting (cost report) process for year end Expansion of the definitions for individual sessions in DMC Reimbursement for case management Adoption of the rehab option	Will SUD be carved in or out of the state Medi-Cal Plan The scope of block grant allowable expenditures Local licensing and certification of programs Eliminate FFS for NTP and move toward actual cost reimbursement	Lack of culturally diverse workforce Certified counselors as allowable providers of SUD services in all settings (including specialty and primary care) Keeping DUI programs with ADP Allowing two services in the same day	Access Cost Outcomes	Providers should be recruited to deliver surveys or sponsor focus groups of their clients. Equal participation between consumers of MH and SUD clients.

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
for DMC Inclusion of Minor Consent in the state Medicaid plan	The role of primary prevention in health care reform environment and keeping prevention within the new DHCS structure.			
Governance & oversight *How was it developed?* *Who was consulted?* *Impact on beneficiaries?* – Transparent budgeting, what are benefits to clients? – Any changes from historical trends? Are these good or bad? – Do DMC rates reimburse the full cost of service delivery? – What is quality of payment? Making policy through reimbursement methods? – Relationship between Payments and impact on the provider pool. – Calibration of payments to services – do counties put in additional money? What is true amount of SUD funding locally? How much and why? Is there an increase or decrease? How do counties use the latitude they have under	– BP should address how SUD functions not in DHCS (DPH, DSS) are coordinated with DHCS. Should be an 'accountability office' to address cross-departmental coordination. – Quality and access of service for consumers and a healthy provider pool – Pool requires – System evaluation and problem surveillance. – How does state respond to these issues and, if not, how do counties do this, or not. – There is a continuing role for state government in realignment. How does state maintain a leadership role or assist counties in doing this.		– TBL specifies assessment of client outcomes – what % of clients needing services get them – penetration rates. – Are statewide needs being met – youth, meth, women? – Counties need to have the conversation about monitoring, measuring and QI. Uniform methods.	– Leg. held off on ADP xfer due to concerns expressed by stakeholders that apparently was not considered by the Administration. – DMC xfer plan. Where are quarterly updates? – Need good communication between stakeholder and administration and stakeholders need acknowledgement from Administration that concerns have been heard. A genuine dialog directly with consumers is needed. – Needs to be an open and public conversation and

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
realignment. – #1 – what does realignment mean for the role of the state, relationship with counties, and services to clients? How does local control help the provider pool and clients? How does the state fulfill its				
a) Medicaid (Drug-Medi-Cal) funding for MH and SUD services will require a redesign of the benefit and a revised structure through which the benefit is administered. i) Re-do Drug Medi-Cal benefit Kaiser, plus methadone ii) Eliminate the carve-out iii) Ensure ability to provide multiple services on a single day iv) Ensure provision of funds for recovery support services through the block grant/other funding sources. b) Develop models and financing algorithms for financing SUD and MH services in an integrated manner within a managed care environment.	a) Ensure that MH and SUD services are equally represented within the new Division of MH and SUD Services within DHCS, and are a high priority in the future delivery of health care services in CA. SUD knowledge and expertise is still extremely poorly understood by MH and vice versa. As the leadership of the new SUD/MH entity develop the new division, it will be very important to have the right people at the table to make sure essential SUD EBPS are part of the priorities. b) How do we make sure that as we modify the SUD/MH systems in California to better integrate MH/SUD care and MH/SUD care with primary care, that we don't lose capabilities to meet the needs of special groups (e.g., cultural	a) The culture of MH and SUD services – active process plan to ensure a common understanding across disciplines (PC, MH, and SUD) to ensure adequate and effective functioning of each type of service. b) Use of EBPs and continued development of a care system that promotes long term care and recovery services. c) Continued recognition of the need to expand MAT for SUD disorder treatment in both SUD specialty programs and in MH and primary care integration efforts.	a) Establish a workgroup including representatives from the MH and SUD field (and University researchers) to create new metrics to ensure adequate outcome and performance measurement of services. In the abstract, at present it is impossible to answer this question as it is unclear what data systems will be available. b) Use of surveys of consumers is one, very limited source of information. Although it is an essential domain to know how services met the needs of consumers, it is also essential to have "hard" data on participant outcomes, performance of service delivery units. c) It will be very important to build data systems that can capture the cost offset benefits in primary care, CJ	See # 4

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
	groups, geographic groups, etc.) as the system moves towards larger more business capable organizations. c) There needs to be an aggressive, proactive planning process to develop a workforce commensurate with the new structure of service provision.		systems, social services system that accrue from having MH/SUD services. This will take considerable planning and discussion to be able to get these data, in as efficient and low cost way possible.	
– Expanded services under 1115 Waiver. – State needs to allow MAT meds in DMC. More cost effective than methadone.	– DHCS needs to address legislative directive in AB 106 (DMC xfer) to improve efficiency and outcomes in DMC. – Need to bring DMC up to date and begin the process of improvement. And stream ling and benefit structure. Report to legislature? – Where is the 1115 Plan? – What is DCHS going to do with Needs Assessment results? – No Stakeholder meetings.	– DHCS needs to examine DMC rates in order to attract providers and purchase quality services. – Competition good but can lead to a low bid mindset that conflicts with quality of care.	– SUD TX outcomes measured as with other chronic conditions. In treatment gains, and long-term benefit. – System focuses on health and wellness, quality of life. –	– DHCS has not done a good job in eliciting stakeholder consultation. Need to set a regular system for this. – Counties are not the only players. – Need to follow through with this. – Merge CADPAAC and DAC together. No need to have duplicate meetings. This maintains divisions, not partnerships. – Counties would benefit from a closer partnership with providers. – Division of ADP functions across 3 departments is another force for fragmentation. –
– Create a mechanism for the state to collect fees, via the certification of counselors, to create a stronger	– Development of unified standards for counselors. There needs to be a single test, uniform qualifications,	A uniform set of standards for quality care needs to be developed. This set of standards should be as specific as	There are many outcome devices available for tracking success or failure. Unfortunately, at this time,	Ensure that the number of consumers equals the number of representatives of providers as is required by law for most

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
program for ensuring the competency of AODA counselors. (For instance, assess each certifying organization $5 per certified counselor to fund a single test and create a single data base whereby certifying organizations provide periodic updates for the data base which could be used by employers and consumers) This fee could also be used to enhance enforcement for ethics violations. – Funding for workforce development to expand the workforce in preparation for the implementation of the Affordable Care Act.	and credentialing that improves outcomes and consumer safety. – Regulations for counselor certification need to be modernized. Many of the provisions are functionally unenforceable, vague, or contain loopholes that make them meaningless. – Responsibility for qualifying applicants for certification needs to rest with the state and revocation of credentials necessary to work in license facilities also needs to be within the department's authority.	nationally recognized standards such as Joint Commission or CARF.	none of them measure what quality factors impact outcomes. Most tracking devices assume the inputs to the process are similar. For instance, most states require either a state license or state certification in order to provide AODA counseling. Thus, the competency of the counseling should be similar for most patients. In California there is no single competency measure so that assumption cannot be made. It would be valuable to measure the level of certification/licensure of staff and the outcomes for programs.	boards in California. There also needs to be better representation from those who actually perform the service (counseling). The provider bias in the stakeholder list for this activity is indicative of the imbalance in public input as opposed to input from those who have financial interests in the outcomes of the process. This needs to be corrected.
– Ensuring that reimbursement mechanisms for SUD and MH prevention and treatment services do not pose barriers to access for under-served populations, including the aging/elderly. – Need to ensure that the type of services that are appropriate for an aging population, such as case management and home-based service delivery, are	– Ensuring <u>access</u> to *appropriate* SUD and MH prevention and treatment services for under-served populations, including the aging/elderly. – Ensuring a well-trained workforce who is able to provide *age-appropriate* care and services for underserved populations, including the aging/elderly.	– Ensuring a well-trained workforce who is able to provide age-appropriate care and services for underserved populations, including the aging/elderly. – Ensuring availability of programs to reduce stigma, as this is a significant barrier for aging/older adults to access SUD and MH treatment.	– Hospital data to measure decline in utilization of more expensive SUD or MH care, such as Emergency Room services. – SUD and MH system-wide service utilization rates, by County and by population (i.e. age, ethnicity, etc.). – Stakeholders should create standard definitions of successful discharge and longer-term outcomes. – Providers must have	Set goal for anticipated level of participation among the various stakeholder groups already involved and measure percent of participation in the various events/activities. For example, set goal of 50% of ADP Constituent Committees to participate in the Stakeholder survey administered by CiMH and the AOD Policy Institute; ___% actually participated, thereby meeting or not meeting the goal.

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
reimbursable. – Ensure financial resources are equitably allocated for SUD and MH services, in line with the Parity Act.			outcomes measurement/reporting and quality improvement systems in place to be able to measure, report and make improvements in services as needed.	
– Improve reimbursement policies for providers serving high need Medi-Cal and Medicare clients/patients. – Research and development of Single Payer options for behavioral health services.	– Develop professional and facility accreditation, licensing and certification policies and standards in alcohol and drug programs in alignment with national Cultural and Linguistically Appropriate Services Standards of the Office of Minority Health. – Institute pay parity in behavioral health practices and services with medical health services. – Invest in a workforce in all types of health and human services settings that are skilled in cross-cultural communications, using evidence-based practices for cultural proficiency, effective health screening & health risk assessments. – Support community-based and system wide health and wellness campaigns to	– Expand the role of alcohol and other drug and mental health service providers using screening, brief intervention, brief treatment into health care services using evidence-based modalities like Motivational Interviewing and Appreciative Inquiry. Screening and early intervention/brief treatment saves money and resources by diverting high cost visits to emergency rooms and intensive acute care treatment options. Effective behavior change strategies help to prevent chronic health diseases. – Reduce preventable health care costs associated with behavior choice; utilize wellness coaches trained in Cognitive Behavioral	– Immediate access to services (no wait lists) – Longer periods between relapse – Fewer individuals who relapse – More individuals receiving services at their medical home (not the ER)	– Plan and track the diversity representation of Board appointments; provide culturally and socially relevant incentives and training that empowers participation at meaningful level. – Design effective processes with tangible, achievable measurable and results-oriented goals. – Ensure multiple appropriate places and spaces that provide opportunities for different levels of participation, and invest in a process to review/analyze outcomes of various strategies. – Track advisory committee recommendations that are enacted by policy-making boards.

Finance Issues	Policy Issues	Program Issues	Outcome Measures	Stakeholder Involvement Measures
	reduce stigma associated with behavioral health risks so that people show up for help earlier in their illnesses.	Therapy and other best practices that can intervene early on at a much reduced cost than treating disease.		

Comments

Need to be thinking strategically about this. Where do we want to be several years out? The focus should be on long term improvements and not just getting through the next budget cycle.

Need a proactive plan to develop a workforce commensurate with the new structure of service provision.

I might not be much help on this. I am a bit biased; I would answer every question the same, full parity in service benefits for both fields. I think everything else pales in comparison to achieving there for those who suffer from SUD and/or Mental health disorders. Things like DMC , elimination of the department, how to work with new departments, workforce etc. for me all link back to being able to serve the populations based on their assessed needs, at the right levels of care, for the needed durations of time etc.

CiMH/DHCS Decision Makers Meeting
October 25, 2012, 2 PM to 5 PM
DHCS Business Plan

On October 25, 2012, a meeting was held with DHCS state personnel, CADPAAC, ADPI, CiMH, CMHDA, and county representatives. The purpose of the meeting was to review issues gleaned from stakeholder interviews and decide which issues to assign to workgroups.

The representatives used the following criteria for selecting workgroup issues:

- Do realistic solutions exist? Is there a potential for early wins, for success?
- Does it offer an opportunity to clarify roles and responsibilities at state and local level?
- Is it within DHCS and/or the counties' ability to control and address?
- Is it important to consumers and family members?

After extensive discussion, the following workgroup topics we recommended:

1. Develop a comprehensive evaluation and accountability system that builds on current work.
2. Clarify roles and responsibilities of state and counties re: fiscal and program oversight.
3. Improve integration of services (SUD, MH, and PC).
4. Simplify/reduce administrative burden on providers (free up resources for services).
5. Develop methods, roles and responsibilities for quality assurance and improvement.
6. Address SUD financing issues.
7. Develop strategies for workforce capacity (includes training, peer and family certification, standardized SUD counselor certification).
8. Improve organizational capacity for SUD providers.

The next steps were:

- Get feedback on preliminary workgroup topics from this group (keeping criteria in mind).
- Further articulate scope of work for workgroups.
- Select workgroup members (based on expertise, domain knowledge; no time to teach).
- Develop inventory of other planning efforts (avoid duplication).

CiMH/DHCS Decision Makers Meeting
January 3, 2013
Meeting Synopsis
DHCS Business Plan

On January 3, 2013, a meeting was held with DHCS state personnel, OSHPD, MHSOAC, CADPAAC, ADPI, CiMH, CMHDA, and county representatives. The DHCS Business Plan team presented the two workgroup topics and related issues, and the other issue papers. These topics were chosen during the October 25, 2012 meeting. This is the list:

1. Mental Health and Substance Use Financing
2. Reduction in Administrative Burden
3. Coordination and Integration of Mental Health, Substance Use Treatment, and Primary Care
4. State and County Roles and Responsibilities
5. Evaluation, Outcomes and Accountability
6. Workforce Capacity and Skills
7. Organizational Capacity for Substance Use Treatment Providers

The representatives provided feedback on the work and what are the next steps.

- The counties asked to work in partnership with DHCS in implementing the "plan" as these are the issues to resolve over a period of time.
- The DHCS Business Plan team will take the seven issues paper and developed a "plan" that include goals, strategies and action steps.
    - DHCS will review this "plan".
    - The counties will review this "plan" after receiving confirmation from DHCS that we have something to work in partnership on.

DHCS Business Plan Stakeholder Meeting
November 16, 2012
Questions from Participants

Questions
Q: Has the group looked at the "Strategy for Quality Improvement in Health Care" chaired by Dr. Neal Kohatsu, DHCS Medical Director Q: Is a dedicated Primary Care partner considered for participation on the Evaluation & Accountability workgroup Q: Why is the CAMHPC included in your workgroup (Slide 14) on this issue Q: Question: How will you integrate evaluation efforts and plans currently being developed and presented by the MHSOAC Q: Can someone who is not connected with any particular group or organization participate in the workgroups Q: Can you address concerns about resources and roles of small counties? There are about 21 counties with populations with less than 100K, and about 10 more under 200K Q: Will there be vigilant attention to transformative language and stigma reduction efforts that dignify all people and individuals of diverse cultural backgrounds, moving away from terms or descriptions that "label" or stigmatize - as integration evolves among MH,SUD, PC Q: An overall question, I realize this is a business plan but will there be a way to say that the MHSA core elements will frame all actions? Some of the comments today reflect the loss of this focus as we move into complex issues Q: At the HIE Conference Nov 1, 2; several providers of Electronic Health Records expressed reluctance to include MH and SUD due to confidentiality concerns. Is there some way to include some outreach to EHR developers of care coordination - CiMH LC may help solve it Q: Suggestion under #6: Make sure there is coordination with Working Well Together Peer Certification project regarding their work on statewide peer and family certification Q: How can we ensure that consumers get to participate in the process Q: Comment: Workforce capacity should be looked at in the context of service capacity. Do providers know what their current service capacity is overall; for consumers who need services in a different language? Are processes in place which assures scarce resources such as language capacity are utilized where they are most needed? Can service processes be simplified to maximize both capacities Q: Follow-up on Workforce Development: Has there been outreach to professional nursing organizations/educators regarding input from RNs who work directly with MH and SUD clients in BH clinics or treatment centers? Also with RN/nurse practitioners with psychiatric or counseling specializations? I mention these groups because of the traditional nursing focus on "the whole patient", physical health + mental health and spiritual wellbeing. Q: Small nonprofits that provide harm reduction-based services including peer-delivered street outreach, health education, syringe exchange, secondary distribution, vein care and overdose prevention training with IV drug users also need much greater support in building their capacity and sustaining their work in the hew healthcare reform environment. Will the MH/SUD Division take steps to sustain these organizations in particular

DHCS Business Plan Stakeholder Meeting
December 21, 2012
Questions from Participants

Questions
Q: Shouldn't the same day billing rule be inapplicable for people enrolled in Medi-Cal managed care and doesn't realignment eliminate state costs for the perceived extra mental health and sud services Q: To bring mental health and SA up to primary care parity in financing requires congress to adopt FQBHC (federally qualified behavioral health center) designation and funding to match what FQBHCs now have. Business plan should ask state to support efforts of national council for community behavioral healthcare Q: Not a question but a comment that does not need to be read but as you mention the entities with statutory evaluation roles we should also have on the table the need to eliminate or consolidate any of these roles that add to unnecessary duplication or whose value is no longer that great in light of changes in lAss or practices or whose work is now super ceded by others Q: Can you give us a timeline similar to the one that evaluations task force provided? Q: At the local level, MH Boards/Commissions must be well-informed and consistently active to assure stakeholders in involvement and to have providers be responsive to diversity and building health equity. Boards of Supervisors need to be engaged around this goal and to seek the best possible public servants who have oversight responsibilities to the citizens. Q: Inclusion of community stakeholders, especially bringing the voices of under-served and underrepresented cultural & linguistic communities across all age groups, such as REMHDCO, CMMC, CAYEN, community individuals w/lived experiences, etc.—as participatory evaluation partners -- is essential to enhance Evaluation. Accountability, Outcomes Q: Cultural and linguistic competence must be embedded system wide. The approach of cultural humility is essential in gaining awareness and responsiveness to the needs of California's diverse populous. Q: Focus on stigma reduction must continue Q: The participants should be differentiated between the community and the government respondents. Is this being done?

DHCS Business Plan - Using Measurement to Improve Quality, Outcomes, and Ensure Accountability for CA MH and SUD Service Delivery Systems

1. What is your first name?

	ResponseCount
	14

AnsweredQuestion	14
SkippedQuestion	0

2. What is your last name?

	ResponseCount
	14

AnsweredQuestion	14
SkippedQuestion	0

3. What is your affiliation?

	ResponseCount
	14

AnsweredQuestion	14
SkippedQuestion	0

4. What is your e-mail address?

	ResponseCount
	13

AnsweredQuestion	13
SkippedQuestion	1

5. Do you agree that this document accurately describes the issue (s)?

		ResponsePercent	ResponseCount
Yes		**50.0%**	**7**
No		14.3%	2
Not sure		35.7%	5
		If no, please specify.	2
		AnsweredQuestion	**14**
		SkippedQuestion	**0**

6. Briefly describe any missing issues.

ResponseCount
8
AnsweredQuestion **8**
SkippedQuestion **6**

7. Please comment on the recommendations.

ResponseCount
8
AnsweredQuestion **8**
SkippedQuestion **6**

8. Briefly describe any missing recommendations.

	ResponseCount
	8

AnsweredQuestion	8
SkippedQuestion	6

Q6. Briefly describe any missing issues.		
1	Please review the Native American CRDP report pages 31-32 for evaluation recommendations. http://issuu.com/nativeamericanhealthcenter/docs/native_vision_report	Dec 21, 2012 1:51 PM
2	The document does not address children's issues at all. In addition, SB 1009 required the development of a statewide performance outcome system related to EPSDT. This was not included in the workplan but should be an essential element of it. The document also misses the opportunity to mandate an outcome system that is consistent statewide.	Dec 21, 2012 1:14 PM
3	The groups identified in the Task Force are execllent. The group choice feels like it will be doing 'for' the disabled population and not 'with' the clients and family member population. If the 'quality of life' is a C/F priority, (Under Perspective #1), where are the C/F members voices on the TF?	Dec 20, 2012 5:32 PM
4	Inconsistent use of ADP's CalOMS data from county to county - i.e, some counties have additional questions and others are not able to accept electronic data and require duplicate input (with possible errors). Also, definitions are not clear on completion codes. I call it GIGO, garbage in - garbage out.	Dec 20, 2012 5:03 PM
5	In the “Vision” statement, I think it would be most appropriate to insert the word “support” in front of the second bullet so that it reads “The measurement strategy should support evaluation of performance based on client as well as population outcomes”. The way it is currently written, it sounds like DHCS should do the actual evaluating. They may be doing evaluation in SOME cases (like with MediCal), but they also have to support evaluation of the community mental health system being done by others (like the OAC). Similarly, the word "support" should be inserted before the third bullet (so that it reads something like "The measurement strategy...should support the demonstration of accountability to all appropriate...entities". The primary item in this vision is the measurement strategy. I think this is accurate...DHCS should be able to support and maintain a measurement strategy that supports quality improvement, evaluation, and accountability. This leaves room for other entities (or DHCS themselves) to be carrying out these roles using the measurement strategy that DHCS owns/maintains. A similar change should also be made in Goal 1 (“Develop a comprehensive, statewide, data-driven measurement strategy that supports evaluation, accountability, and quality improvement..”), and in Goal 2 (“Implement the…measurement strategy that supports evaluation…”).	Dec 20, 2012 4:33 PM
6	Bullet two should stress collecting and sharing high quality data so that adequate evaluation and quality improvement can be accomplished. With Realignment 2, county entities must be included since they are going to be responsible for approving annual and three year plans.	Dec 19, 2012 1:14 PM
7	measurement of physical health care for people with severe mental illnesses and measurement of penetration rates and success in identifying mental health and alcohol and drug problems for people in primary care	Dec 19, 2012 7:33 AM
8	Clinic's located in rural areas of larger counties are faced with some of the same financial challenges as clinic's located in small counties. Such is the case in San Bernardino County.	Dec 18, 2012 5:03 PM

Q7. Please comment on the recommendations.		
1	See #6	Dec 21, 2012 1:51 PM
2	These need to be expanded to include issues specific to children, youth and families.	Dec 21, 2012 1:14 PM
3	Please consider developing a committee or advisory group to advise on outcome interpretations and evaluation by the end-user. People with a relationship with local mental health systems. County Board of Supervisors or Local Mental Health Boards/Commissions. CA. Association of Patients' Rights Advocacets. (CAMPHRA), and or CA Planning Council. All with direct end-user participents.	Dec 20, 2012 5:32 PM
4	For Goal 2, I don't see how this highlights the need for DHCS to support and maintain the current data collection and reporting systems, and the need to ensure that these systems will be able to roll up into the new system that they will create. Clearly, the new system won't likely be implemented for many, many years. Entities that need to evaluate the public mental health system currently (like the OAC) won't be able to carry out our statutory roles unless DHCS fixes the current systems and makes an effort to maintain them. Data is currently being lost due to the transition of data from DMH to DSH to DHCS...DHCS needs to be proactive about addressing this issue and trying to fix it (by both supporting the current IT structure and supporting counties in their efforts to collect, enter, and report the data to the state). This is an imperative step that is missing from this plan.	Dec 20, 2012 4:33 PM
5	.	Dec 20, 2012 3:20 PM
6	Agree with recommendations that these organizations need assistance in the transition to managed care.	Dec 20, 2012 3:11 PM
7	The format used in this report is well thought out and will make it possible for DHCS to follow a clar set of goals, objectives and action steps.	Dec 19, 2012 1:14 PM
8	need to broaden the key stakeholders to include all types of providers- both public sector and private sector and mental health and alcohol and drug and primary care and most especially health plans both commercial plans that cover MediCal enrollees as well as the local plans	Dec 19, 2012 7:33 AM

Q8. Briefly describe any missing recommendations.		
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2	Please add recommendations specific to children youth, and families. In addition, on the first page of the goals/objectives grid under criteria, the CANS and ANSA can meet all of these needs and will cover all age ranges. The combined tool should be considered as the cornerstone to this evaluation system.	Dec 21, 2012 1:14 PM
3	Prepare background paper on major issues that incorporates significant current activities and applicable federal and state laws and regulations.	Dec 21, 2012 12:17 PM
4	Quality care has been defined by quality documentation, not quality outcomes. Metal health funding, the administration of funding, and enforcement of regulations need to be compatible with principles of recovery, client- centered treatment and desired client and system outcomes. Funding should incentivize demonstration of successful interventions that are cost- effective and result in a high level of customer satisfaction, not based on volume of services or exclusively on the establishment of medical necessity. The measures for behavioral health should indicate that the qualities of life that mental health/substance abuse issues were hindering have improved, and that measurable functional gains have occurred demonstrating this improvement. It would be an added plus to understand that the interventions provided and received by clients were directly related to improvements thereby indicating effectiveness of services. The cost of the interventions that led to improvement need to be demonstrated to be comparatively reasonable, indicating cost-effectiveness. Measures should reflect the extent that services are compatible with the needs, circumstances and preferences of the population they are intended to reach, indicating customer satisfaction.	Dec 21, 2012 11:32 AM
5	Recommendations should include ongoing support to counties on data quality. There should be parallel processes between State entities and counties and counties and providers. In other words, expectations, feedback and reports should be provided to counties timely, as would be the expectation that counties provide these to providers	Dec 20, 2012 3:20 PM
6	need to also acknowledge the fact that most prevention and early intervention will come from the success or failure of commercial health plans to screen and identify and treat mental health and substance use disorders early in their onset before people become disabled so that there are fewer people who become disabled and MediCal recipients as a result of the failure of these health plans to properly and timely identify and treat mental disorders. This will require DHCS to participate with Health Benefit Exchange and to engage the Exchange and Health Plans and participate in advocacy with mental health community.	Dec 19, 2012 7:33 AM
7	We should be clear that redacted datasets be made widely available to any interested party, including the public. There is an open-data movement across the country and San Diego County would serve the country well to open it's resources for analysis and innovation. Thank you!	Dec 18, 2012 11:27 PM
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DHCS Business Plan - Using Measurement to Improve Quality, Outcomes, and Ensure Accountability for CA MH and SUD Service Delivery Systems

1. What is your first name?

	ResponseCount
	14

AnsweredQuestion	14
SkippedQuestion	0

2. What is your last name?

	ResponseCount
	14

AnsweredQuestion	14
SkippedQuestion	0

3. What is your affiliation?

	ResponseCount
	14

AnsweredQuestion	14
SkippedQuestion	0

4. What is your e-mail address?

	ResponseCount
	13

AnsweredQuestion	13
SkippedQuestion	1

5. Do you agree that this document accurately describes the issue (s)?

		ResponsePercent	ResponseCount
Yes		**50.0%**	**7**
No		14.3%	2
Not sure		35.7%	5
		If no, please specify.	2
		AnsweredQuestion	**14**
		SkippedQuestion	**0**

6. Briefly describe any missing issues.

ResponseCount
8
AnsweredQuestion **8**
SkippedQuestion **6**

7. Please comment on the recommendations.

ResponseCount
8
AnsweredQuestion **8**
SkippedQuestion **6**

8. Briefly describe any missing recommendations.

	ResponseCount
	8

AnsweredQuestion	8
SkippedQuestion	6

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6	Agree with recommendations that these organizations need assistance in the transition to managed care.	Dec 20, 2012 3:11 PM
7	The format used in this report is well thought out and will make it possible for DHCS to follow a clar set of goals, objectives and action steps.	Dec 19, 2012 1:14 PM
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Q8. Briefly describe any missing recommendations.		
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3	Prepare background paper on major issues that incorporates significant current activities and applicable federal and state laws and regulations.	Dec 21, 2012 12:17 PM
4	Quality care has been defined by quality documentation, not quality outcomes. Metal health funding, the administration of funding, and enforcement of regulations need to be compatible with principles of recovery, client- centered treatment and desired client and system outcomes. Funding should incentivize demonstration of successful interventions that are cost- effective and result in a high level of customer satisfaction, not based on volume of services or exclusively on the establishment of medical necessity. The measures for behavioral health should indicate that the qualities of life that mental health/substance abuse issues were hindering have improved, and that measurable functional gains have occurred demonstrating this improvement. It would be an added plus to understand that the interventions provided and received by clients were directly related to improvements thereby indicating effectiveness of services. The cost of the interventions that led to improvement need to be demonstrated to be comparatively reasonable, indicating cost-effectiveness. Measures should reflect the extent that services are compatible with the needs, circumstances and preferences of the population they are intended to reach, indicating customer satisfaction.	Dec 21, 2012 11:32 AM
5	Recommendations should include ongoing support to counties on data quality. There should be parallel processes between State entities and counties and counties and providers. In other words, expectations, feedback and reports should be provided to counties timely, as would be the expectation that counties provide these to providers	Dec 20, 2012 3:20 PM
6	need to also acknowledge the fact that most prevention and early intervention will come from the success or failure of commercial health plans to screen and identify and treat mental health and substance use disorders early in their onset before people become disabled so that there are fewer people who become disabled and MediCal recipients as a result of the failure of these health plans to properly and timely identify and treat mental disorders. This will require DHCS to participate with Health Benefit Exchange and to engage the Exchange and Health Plans and participate in advocacy with mental health community.	Dec 19, 2012 7:33 AM
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DHCS Business Plan - SUD Finance

1. What is your first name?

	ResponseCount
	8

AnsweredQuestion	8
SkippedQuestion	0

2. What is your last name?

	ResponseCount
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AnsweredQuestion	8
SkippedQuestion	0

3. What is your affiliation?

	ResponseCount
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AnsweredQuestion	8
SkippedQuestion	0

4. What is your e-mail address?

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AnsweredQuestion	8
SkippedQuestion	0

5. Do you agree that this document accurately describes the issue (s)?

		ResponsePercent	ResponseCount
Yes		**50.0%**	**4**
No		37.5%	3
Not sure		12.5%	1
		If no, please specify.	2
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		SkippedQuestion	**0**

6. Briefly describe any missing issues.

	ResponseCount
	3
AnsweredQuestion	**3**
SkippedQuestion	**5**

7. Please comment on the recommendations.

	ResponseCount
	4
AnsweredQuestion	**4**
SkippedQuestion	**4**

8. Briefly describe any missing recommendations.

	ResponseCount
	3

AnsweredQuestion	3
SkippedQuestion	5

Q5. Do you agree that this document accurately describes the issue (s)?		
1	Missing key issues related to financing children's behavioral health services and entitlements, specifically EPSDT	Dec 21, 2012 1:16 PM
2	The draft focused solely on substance use disorders.	Dec 21, 2012 11:40 AM

Q6. Briefly describe any missing issues.		
1	Need to address how the EPSDT entiltement will be equally protected across the state.	Dec 21, 2012 1:16 PM
2	There are numerous issues related to mental health financing that must be addressed. Metal health funding, the administration of funding, and enforcement of regulations need to be compatible with principles of recovery, client- centered treatment and desired client and system outcomes. Funding should incentivize demonstration of successful interventions that are cost- effective and result in a high level of customer satisfaction, not based on volume of services or exclusively on the establishment of medical necessity. The measures for behavioral health should indicate that the qualities of life that mental health/substance abuse issues were hindering have improved, and that measurable functional gains have occurred demonstrating this improvement. It would be an added plus to understand that the interventions provided and received by clients were directly related to improvements thereby indicating effectiveness of services. The cost of the interventions that led to improvement need to be demonstrated to be comparatively reasonable, indicating cost-effectiveness. Measures should reflect the extent that services are compatible with the needs, circumstances and preferences of the population they are intended to reach, indicating customer satisfaction.	Dec 21, 2012 11:40 AM
3	The paper demonstrates a lack of partnership with primary care and county health systems. These systems provide primary, specialty, emergency and primary care services to millions of low income uninsured and Medi-Cal beneficiaries. Improving and expanding SUD services in primary care will generate significant savings to county emergency, inpatient and specialty care. The CMSP pilot demonstrated exactly this--savings on inpatient and emergency care and HIGHER primary care (where SUD services were integrated) and pharmacy costs The paper makes strong relevant recommendations for moving to a BH system based on EBPs, demonstrating outcome but recommends that SUD providers be exempted from collecting data and billing. SUD providers will be unprepared to contract in a managed care environment if that is the proposal that goes forward.	Dec 20, 2012 5:41 PM

Q7. Please comment on the recommendations.		
1	Lacking any recommendations specific to children, youth, and families	Dec 21, 2012 1:16 PM
2	This paper is organized in desired outcomes and milestones. The milestone "The carve-out prevents access to Primary Care funding. This needs to be resolved" needs to be clarified--what does the author mean? The carve out restricts the provider network and and provides a very narrow time limited benefit. Not clear what "accessing primary care funding means. Current primary care funding in community clinics and health centers is a volume based per visit reimbursement. Change the milestone of "reinvesting PC savings into MH/SUD. It should read, reinvest hospital inpatient and emergency room savings into expanding integrated SUD services. The paper should acknowledge the current DHCS/duals' county work group that is seeking to create a model data sharing template and build upon and disseminate the end product.	Dec 20, 2012 5:41 PM
3	Agree with all recos.	Dec 20, 2012 3:13 PM
4	Recommendations are solid, but the prime issue has got to be getting DMC up to par with Short-Doyle Medi-Cal. The current siloed arrangement will not work after Jan1, 2014.	Dec 19, 2012 1:22 PM

Q8. Briefly describe any missing recommendations.		
1	see above	Dec 21, 2012 1:16 PM
2	Prepare background paper on major issues that incorporates significant current activities and applicable federal and state laws and regulations.	Dec 21, 2012 12:20 PM
3	1. The State certify BH counselors and amend the State Medicaid plan to include a broader range of SUD services and eligible providers. 2. Resolve the carve in/carve out dilemma soon so that all Medi-Cal beneficiaries in 2014 receive access to a uniform bundle of services. 3. The State issue policy to create a single administrative billing structure for MH, SUD and primary care.	Dec 20, 2012 5:41 PM

DHCS Business Plan -Service Integration for MH, SUD, and Primary Care

1. What is your first name?

	ResponseCount
	14
AnsweredQuestion	14
SkippedQuestion	0

2. What is your last name?

	ResponseCount
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AnsweredQuestion	14
SkippedQuestion	0

3. What is your affiliation?

	ResponseCount
	14
AnsweredQuestion	14
SkippedQuestion	0

4. What is your e-mail address?

	ResponseCount
	14
AnsweredQuestion	14
SkippedQuestion	0

5. Do you agree that this document accurately describes the issue (s)?

		ResponsePercent	ResponseCount
Yes		**42.9%**	**6**
No		28.6%	4
Not sure		28.6%	4
		If no, please specify.	3
		AnsweredQuestion	**14**
		SkippedQuestion	**0**

6. Briefly describe any missing issues.

	ResponseCount
	9
AnsweredQuestion	**9**
SkippedQuestion	**5**

7. Please comment on the recommendations.

	ResponseCount
	8
AnsweredQuestion	**8**
SkippedQuestion	**6**

8. Briefly describe any missing recommendations.

	ResponseCount
	10

AnsweredQuestion	10
SkippedQuestion	4

Q5. Do you agree that this document accurately describes the issue (s)?		
1	service integration for children should also include child welfare and school systems	Dec 21, 2012 1:31 PM
2	Native American representation is needed	Dec 21, 2012 11:22 AM
3	The framework of the Business Plan should set forth the desired outcomes of the subsumption of formerly discrete behavioral health departments into the Department of Health Care Services. This merger should not be purely an administrative matter, but also a philosophical and practical framework for creating and promoting a unified system of care for treating the entire spectrum of behavioral health disorders. The Service Integration component of the draft Business Plan fails to identify a concrete approach to implementing such a system of care and should incorporate a statement of vision and strategy, desired outcomes, and milestones reflecting this approach.	Dec 21, 2012 10:47 AM

Q6. Briefly describe any missing issues.		
1	There is no recognition of the need to integrate service systems rleated children, youth, and families (such as education, child welfare, juvenile justice, etc)	Dec 21, 2012 1:31 PM
2	The OHE needs to be included to support cultural and linguistic competence and assure responsiveness to the diverse communities.	Dec 21, 2012 12:48 PM
3	Pg.1, 2nd paragraph: 2nd sentence should include "underserved communities" Pg.3, Section1.: Allow for changing landscape of evidence based/promosing practices. Also, be sure CRDP populations are included. Pg.3, Section2.: Be sure "incubator" models are not a "one-size fits all" as this doesnt work for Native American populations. Pg.4,Section3.:Is a good idea but make sure "cultures" are with respect to individual population values/norms. Pg.4, Needed Supports: How will funding sources reach Native American communities? Pg.6, J) & Sec.6: Ensure funding atonomy for NA tribes/urban non-profits etc. Pg.6 Sec.6: What is "not" working for Native Americans Pg.6,Sec.7: "barriers in the area of information technology and data systems" -- tribes may/will have different reporting sysytems -- how to meet this need? Pg.7 Sec.8: CRDP representatives need to be included here.	Dec 21, 2012 11:22 AM
4	Four key issues are missing: First, as mentioned above, the Service Integration component lacks an overarching theme of bringing together the various elements and participants required to develop a cost-effective, highly functional system of care. Second, the document fails to recognize and build upon the tremendous amount of work that has already been done to this effect, including the 1115 waiver needs assessment and the partnerships and innovations that have created successful models of integrated care. Examples include the LIHP, MHSA-funded collaborative efforts between counties and community based organizations and clinics, the Integrated Behavioral Health Project, the Integration Policy Initiative (IPI) report, projects developed for the dual eligibles demonstrations, and the SAMHSA-HRSA Primary Care and Behavioral Health Integration sites, among others. Third, the document does not include any discussion about the role of primary care providers in service integration, the continuum of need in the community (mild, moderate and serious), and patients' desire to obtain services in their own neighborhood in a culturally competent manner by trusted providers. Finally, the document misses an important opportunity to set forth the crucial role of the state—including working collaboratively to address financing challenges and regulatory barriers—in supporting counties, community clinics and other local partners as they operationalize or further enhance integration.	Dec 21, 2012 10:47 AM
5	The paper demonstrates a lack of knowledge and partnership with the health and primary care systems that currently provide primary, specialty and inpatient care for millions low income uninsured and Medi-Cal people. Significant work is already underway in counties where DHS and DMH are partnering with each other and the Substance Abuse agency, the community health centers and clinics and the Medi-Cal health plans for the expansion of MH services funded by the LIHP, the SPD managed care conversion and preparation for the Duals Demonstration. The business plan should build upon the local integration efforts, innovations and relationships. As DHCS develops the business plan it should acknowledge and include the California Primary Care Association and the County Health Executives Association of California (CHEAC) as key partners. Both these organizations are peers to CiMH and CAADPAC. Throughout the paper, county and community clinic and health center systems are omitted from	Dec 20, 2012 4:50 PM

Q6. Briefly describe any missing issues.		
	inclusion as leaders and participants in proposed task forces. The author demonstrates a lack of knowledge about how primary, specialty and inpatient care is paid for and the State's Medicaid Plan that covers health care.	
6	Include the same measures for the education system.	Dec 19, 2012 2:43 PM
7	adoption of health home option under section 2703 to coordinate care for people with severe mental illness and get additional federal funds for two years. also consider section 1915 (i) as way to improve federal funding.	Dec 19, 2012 7:49 AM
8	integration in commercial plans. Prevention and early intervention for MH and SA must start wherever people are not just those already in MediCal. Must develop strategies to get all health plans to support integration and to keep people from having their mental illnesses progress to being severe and disabling before they get help. Since this pays for itself with savings in physical health care there is no cost to those health plans but it is beyond the authority of DHCS to require it. A first step is for DHCS to make this happen for all MediCal health plans. That is also missing.	Dec 19, 2012 7:40 AM
9	Committees composed of State bureaucrats and other vested interest groups (e.g., CMHDA, CiMH) appear more invested in preserving existing delivery structures than in creating improvement through innovative change. See below comment.	Dec 18, 2012 11:44 AM

Q7. Please comment on the recommendations.		
1	Recommendations focus on building a workforce, but there are no recommendations related to the services this workforce will deliver	Dec 21, 2012 1:31 PM
2	The CMMC also can be utilized to identify recommended practices for under-served and under- represented cultural communities across the age lifespan.	Dec 21, 2012 12:48 PM
3	See #6	Dec 21, 2012 11:22 AM
4	This component lacks substantive recommendations other than to form an integration task force and technical subgroups to address (1) financial, regulatory, and technological barriers to integration and (2) workforce initiatives. Notably, despite the stated goal of reducing silos, no primary care representatives were identified as key participants of the task force or subgroups. Failing to include all partners involved in the service delivery system when discussing integration is a critical omission.	Dec 21, 2012 10:47 AM
5	1. Partner with CPCA and CHEAC to re-write this paper and begin the process of relationship building and integration. 2. Build upon the work that CPCA has already done in analyzing the policy barriers that primary care faces to integrate cre. 3. Utilize CPCA's expertise to correct the misstatements about FQHCs 4. Include OAC as a named partner and engage them in this process. Recommending to seek MHSA funding without their involvement could be a misstep. 5. Change the financing recommendations to include seeking a full range of COD services and team care throughout a beneficiary's lifespan. 6. Recommend that DHCS adopt CPT codes that support integrated care. 7. In addition to telemedicine consults and funding, include bi-direction econsults to increase access and efficiency	Dec 20, 2012 4:50 PM
6	The task force needs to include other provider association representation and not just CMHDA and CADPAC.	Dec 20, 2012 3:20 PM
7	this is a supplemental comment to what i already submitted	Dec 19, 2012 7:49 AM
8	For example, resource-starved County Mental Health Plans could "carve out" four walls within an existing building and staff a new clinic with nurse practitioners and social workers from a local FQHC to deliver both primary and behavioral healthcare on site. In so doing, billing for such services rendered would be at the FQHC's PPS rate; thus saving the MHP considerable staff time and money while providing "integrated" care. This recommendation did not appear in the document and reflects the "in the box" thinking referred to above.	Dec 18, 2012 11:44 AM

Q8. Briefly describe any missing recommendations.		
1	All recommended workgroups limit membership to county and state administrators. Consumers, family members, and providers need to be represented as well	Dec 21, 2012 1:31 PM
2	Prepare background paper on major issues that incorporates significant current activities and applicable federal and state laws and regulations.	Dec 21, 2012 12:35 PM
3	The entire science (and art) of integration is a high priority. Included within this is the identification and selection of effective models, implementation of valueadding quality improvement processes, and adequate and ongoing support (technical and otherwise) to allow for optimal implementation, maintenance and growth. Measures should look at coordination and communication between physicians, specialists, entrylevel professionals and sites of care and integration having responsibility for an overall care plan. These measures may be less specific to a type and site of care, but must look across multiple sites and types of care.	Dec 21, 2012 12:03 PM
4	In addition, "health" people from DHC, not just mental health people from DHCS, should be included. The outcomes achieved by Federally Qualified Health Centers must be thoroughly assessed for outcomes not solely the “number of behavioral healthcare visits generated” before expansion of these services are decided on. Convene a sub group including CMHDA, CADPAAC, ADPI, CIMH, and DHCS representatives (as well as other possible resource people) to review and develop further the workforce recommendations relevant to integrated care from interviews. The California Association of Social Rehabilitation Agencies (CASRA) should be included in the aforementioned subgroup for the following reasons: Since 1999, CASRA has worked closely with the California Mental Health Planning Council’s Human Resource Committee to address critical workforce needs. We have been intimately involved in the implementation of the 5 Essential Strategies that serve as a foundation of the Workforce Education and Training initiatives funded through the Mental Health Services Act (MHSA). CASRA was one of the founding organizations of the Bay Area Workforce Collaborative which provided the inspiration for regional workforce collaborative. In addition, CASRA has played a leadership role the effort to incorporate Psycho-Social Rehabilitation (PSR) principles and practices within academic settings. Betty Dahlquist, CASRA Executive Director, taught the first PSR course in a graduate MSW program in the California State University system, and her syllabus has been adopted by other schools of social work throughout California. Her 5 course competency-based curriculum in PSR was cited by the Annapolis Coalition in a survey of notable education and training programs.	Dec 21, 2012 11:46 AM
5	See #6	Dec 21, 2012 11:22 AM
6	It may be useful as this process continues to review the CDSS and DHCS Core Practice Model document, currently in draft, that will serve as a guide for how we do what we do when working with children and families across systems. Further consideration might be given to following the CPM document that has a unifying vision and mission statement and a clear statement of Foundational Concepts that can be edited and included in the Service Integration for MH, SUD and Primary Care document or perhaps use it as a model guide to be developed in the future.	Dec 21, 2012 11:02 AM
7	1. Concrete recommendations should be made with regard to the state’s role in	Dec 21, 2012 10:47 AM

Q8. Briefly describe any missing recommendations.		
	supporting county-level efforts, including both public and private organizations, to develop partnerships in integration. 2. Primary care providers should be included in all discussions around integration, including participation in task forces and work groups. 3. This integration process should not be dictated from the top down (e.g., from the State to the providers), but rather should take its direction from public and private front-line providers and local administrators, who in many cases already have a track record of developing and implementing integrated services. 4. The discussion of financing barriers (item 5, p. 4-6) should focus not on creating a large bureaucratic structure, but rather on removing barriers and properly aligning multiple levels of incentives to reward for integration and collaboration as well as positive outcomes.	
8	1. Include specific recommendations on amending the State Medicaid Plan to enable a broader range of services, eligible providers and teamcare 2. Include recommendation for covering treatment for mild to moderate SUD conditions 3. Redraft recommendations to insure patient centeredness is demonstrated as a core value	Dec 20, 2012 4:50 PM
9	Combined with #6 there is a need to broaden the key stakeholders and planning to include all types of health plans and providers that will be affected.	Dec 19, 2012 7:40 AM
10	Missing from the recommendations is mention of the CPCA and its affiliated FQHCs as important stakeholders and providers of integrated care.	Dec 18, 2012 11:44 AM

DHCS Business Plan - Reduce/Simplify Administrative Burden on Programs/Providers

1. What is your first name?

	ResponseCount
	8
AnsweredQuestion	8
SkippedQuestion	0

2. What is your last name?

	ResponseCount
	8
AnsweredQuestion	8
SkippedQuestion	0

3. What is your affiliation?

	ResponseCount
	8
AnsweredQuestion	8
SkippedQuestion	0

4. What is your e-mail address?

	ResponseCount
	8
AnsweredQuestion	8
SkippedQuestion	0

5. Do you agree that this document accurately describes the issue (s)?

		ResponsePercent	ResponseCount
Yes		**50.0%**	**4**
No		12.5%	1
Not sure		37.5%	3
		If no, please specify.	1
		AnsweredQuestion	**8**
		SkippedQuestion	**0**

6. Briefly describe any missing issues.

ResponseCount
3
AnsweredQuestion **3**
SkippedQuestion **5**

7. Please comment on the recommendations.

ResponseCount
3
AnsweredQuestion **3**
SkippedQuestion **5**

8. Briefly describe any missing recommendations.

	ResponseCount
	5

AnsweredQuestion	5
SkippedQuestion	3

Q5. Do you agree that this document accurately describes the issue (s)?		
1	fails to address issues related to children, youth, and families	Dec 21, 2012 1:27 PM

Q6. Briefly describe any missing issues.		
1	missing any reference to children, youth, and families. Fails to address overlaps in documentation and increased limits on federal entitlements (EPSDT) which county MHPs often include.	Dec 21, 2012 1:27 PM
2	Include integration with the education systems as a component as well.	Dec 19, 2012 2:41 PM
3	contracts between counties and providers	Dec 19, 2012 7:35 AM

Q7. Please comment on the recommendations.		
1	Workgroups should include consumers, family members, and providers. Right now they are limited to state and county adminstrators.	Dec 21, 2012 1:27 PM
2	If we are ever going to have any significant degree of "statewideness" (to use the federal term) we need a unified system for billing, date entry, outcomes, etc, etc.	Dec 19, 2012 1:58 PM
3	need to address requirements counties impose on providers and work to develop standardized and simplified requirements. this will likely not only require working with associations of providers but also a working group of county counsels and county IT vendors and staff.	Dec 19, 2012 7:35 AM

Q8. Briefly describe any missing recommendations.		
1	Add recommendations to improve entitled services to children. In the health technology recomendation (#4 on page 3), add in the requirement that these recards are updated in a timely manner and ensure that all required elements can actually prove useful.	Dec 21, 2012 1:27 PM
2	Prepare background paper on major issues that incorporates significant current activities and applicable federal and state laws and regulations.	Dec 21, 2012 12:32 PM
3	In order to address the difficulties with Medi/Medi billing, the state should advocate for a pre-emptive determination that for certain services that are never covered by Medicare, initial billing to Medicare to obtain the denial before billing MediCal would not be necessary. Due to recent legislation there is greater discretion and oversight at the county level. There is a range of interpretation among counties of what services can be provided by whom when billing MediCal for specialty mental health services. The state should provide clear direction to counties as to exactly what services can be provided by whom and how frequently medical necessity must be established.	Dec 21, 2012 11:44 AM
4	If a unified cost reporting system is to be created, then it needs to break costs down to the program level, at a minimum, and preferably down even further to specific components within various programs. This unified system would need to allow counites to report on MHSA-funded programs (e.g., FSP, all of CSS, Prevention, Early Intervention), and would need to provide easy to understand definitions for how to classify the programs (so there is consistency in reporting). The discussion of provision of quality improvement and assurance systems should be had in collaboration with evaluators and those responsible for development of the DHCS measurement strategy. Overall, whatever counties submit should be systematic and allow for meaningful aggregation and assessment. Ideally, cost reports would also include a description of clients served with those funds (when the focus is on programs); and the clients should be broken down by relevant demographic categories (e.g., race, ethnicity, gender, etc.).	Dec 20, 2012 4:48 PM
5	see #7	Dec 19, 2012 7:35 AM

DHCS Business Plan - Workforce Capacity & Skills

1. What is your first name?

	ResponseCount
	9
AnsweredQuestion	9
SkippedQuestion	0

2. What is your last name?

	ResponseCount
	9
AnsweredQuestion	9
SkippedQuestion	0

3. What is your affiliation?

	ResponseCount
	9
AnsweredQuestion	9
SkippedQuestion	0

4. What is your e-mail address?

	ResponseCount
	9
AnsweredQuestion	9
SkippedQuestion	0

5. Do you agree that this document accurately describes the issue (s)?

		ResponsePercent	ResponseCount
Yes		**66.7%**	**6**
No		11.1%	1
Not sure		22.2%	2
		If no, please specify.	1
		AnsweredQuestion	**9**
		SkippedQuestion	**0**

6. Briefly describe any missing issues.

	ResponseCount
	4
AnsweredQuestion	**4**
SkippedQuestion	**5**

7. Please comment on the recommendations.

	ResponseCount
	5
AnsweredQuestion	**5**
SkippedQuestion	**4**

8. Briefly describe any missing recommendations.

	ResponseCount
	7

AnsweredQuestion	7
SkippedQuestion	2

Q6. Briefly describe any missing issues.		
1	Misses large issues related to workforce, including delays in licensing (BBS timelline issues)	Dec 21, 2012 1:44 PM
2	At this time it covers what is need. I am sure as the process unfolds, additional criteria and or needs will become more apparent if it is applicable.	Dec 19, 2012 2:39 PM
3	Further discussion of the challenge of utilizing Peer Providers E.G, role-clarification, stigma, need for Certifying Body or Bodies.	Dec 19, 2012 12:36 PM
4	parts on collaboration requires partnerships with provider associations as well as health plans. also needs to acknowledge that under ACA there will also be expansion of MH/SA services in commercial sector and to work with health plans and the providers they work with.	Dec 19, 2012 7:45 AM

Q7. Please comment on the recommendations.		
1	Need to address training at the university level specific to the delivery of community based services - California universities and colleges continue to train to the private practice model	Dec 21, 2012 1:44 PM
2	I would like to see a detailing of the recommnedations for Peer and Family Advocate certification as well as guidelines on Medi-Cal billing. California is years behind other states in thise and CMS indicated how to do this many moons ago as well.	Dec 19, 2012 3:20 PM
3	I recommend orienting delivery of care systms who are not familiar to the "family movement" or community based delivery of service unique principles. For example, "Family Voice and Choice." As well as a feed back loop available to stakeholders that will allow for input on all levels of care, survey monkey for example.	Dec 19, 2012 2:39 PM
4	Key in this is the need to broaden the base of para-professionals that are welcomed in the system. We have found in community mental health that true recoveery based services use a lot of people with lived experience. Some of these have graduate degrees and some don't even have a GED. But they are among the most successful in helping people toward real recoveery. Our systems have minimal history in valuing their contributions.	Dec 19, 2012 2:31 PM
5	Pretty useful, mostly actionable.	Dec 19, 2012 12:36 PM

Q8. Briefly describe any missing recommendations.		
1	Prepare background paper on major issues that incorporates significant current activities and applicable federal and state laws and regulations.	Dec 21, 2012 12:39 PM
2	It is estimated that an additional 5,000 “mental health professionals” will be needed in California to accommodate the mental health and substance use disorder needs of people who will have access to services beginning in 2014. This estimate should be examined based on the knowledge/skills needed to complete identified tasks not solely by increasing current positions to meet the projected need of newly insured individuals seeking mental health and/or substance use disorder services. CASRA completed an assessment of competencies for mental health providers working in public mental health that revealed that less than ten percent of the identified tasks required a licensed mental health provider. (Please contact us for this report.) Therefore, we contend that there are tasks performed by licensed graduate level clinicians that could be performed by a broader range of mental health staff including peer providers, health navigators, mental health rehabilitation specialists, Certified Psychiatric Rehabilitation Practitioners (CPRP), etc. Your workforce capacity and skills draft report includes peer providers but is noticeably absent of numerous positions between peer providers and graduate level clinicians. Because these tasks can be performed by staff other than licensed graduate level clinicians and that is it is unlikely there will be sufficient graduate level/licensed clinicians to meet current projections or that the system can afford to employ this level of expertise we highly encourage the inclusion of a broader range of mental health staff. Ideally we’d focus solely on client outcomes thereby making who provides what service obsolete.	Dec 21, 2012 11:37 AM
3	Use as a guide a March 2009 publication entitled, " The Mental Health Workforce in California: Trends in Employment, Education, and Diversity." Work with graduate programs and training institutes on training on evidence-based practices. Create career pathways where they do not currently exist. continue to advocate aggressively for state-level and federal financial supports to attract and retain individuals into critical occupations. Create training and support for supervisors of integrated services.	Dec 20, 2012 3:13 PM
4	See above	Dec 19, 2012 3:20 PM
5	This may come later, but making sure that the idea of integration is the goal across all systems. For example, we all have varying language and criteria. The goal should be to deliver a plain language treatment plan with the driving principles of recovery and resiliency as it applies to the person, regardless of the care being delivered, whether it is behavioral health or physical health. Additionally, how does this all tie together for the individuals over all holistic health.	Dec 19, 2012 2:39 PM
6	Peer Providers and Medi-Cal Billing. Recommend that Cerfication for MH Peer Providers will create a qualification to bill Medi-Cal for Peer Services.	Dec 19, 2012 12:36 PM
7	need to ensure providers and health plans are represented in all work groups and discussions	Dec 19, 2012 7:45 AM

DHCS Business Plan - Organizational Capacity for Current SUD Providers

1. What is your first name?

ResponseCount
6

AnsweredQuestion	6
SkippedQuestion	0

2. What is your last name?

ResponseCount
6

AnsweredQuestion	6
SkippedQuestion	0

3. What is your affiliation?

ResponseCount
6

AnsweredQuestion	6
SkippedQuestion	0

4. What is your e-mail address?

ResponseCount
6

AnsweredQuestion	6
SkippedQuestion	0

5. Do you agree that this document accurately describes the issue (s)?

		ResponsePercent	ResponseCount
Yes		**66.7%**	**4**
No		16.7%	1
Not sure		16.7%	1
		If no, please specify.	2
		AnsweredQuestion	**6**
		SkippedQuestion	**0**

6. Briefly describe any missing issues.

	ResponseCount
	1
AnsweredQuestion	**1**
SkippedQuestion	**5**

7. Please comment on the recommendations.

	ResponseCount
	2
AnsweredQuestion	**2**
SkippedQuestion	**4**

8. Briefly describe any missing recommendations.

	ResponseCount
	2

AnsweredQuestion	2
SkippedQuestion	4

Q5. Do you agree that this document accurately describes the issue (s)?		
1	fails to address any issues related to behavioral health services to children, youth, and families	Dec 21, 2012 1:20 PM
2	Does not include the organizational capacity for mental health providers	Dec 21, 2012 11:34 AM

Q6. Briefly describe any missing issues.		
1	see above	Dec 21, 2012 1:20 PM

Q7. Please comment on the recommendations.		
1	This document provides recommendations for transformation of the private provider system of care, but fails to address system of care issues which are under the control of DHCS.	Dec 21, 2012 1:20 PM
2	Developing a coalition of providers is critical. A potential solution is for SUD provideers to join in with CCCMHA for unified strength of advocacy around policy issues. They also need to form an ASO so that the virtues of smallness and personalization can be joined to the efficiency of a larger umbrella organization.	Dec 19, 2012 1:29 PM

Q8. Briefly describe any missing recommendations.		
1	If DHCS values the private providers, as they state in the document, they should recommend TA and sustainable funding which would both ensure sustainability of this essential provider network.	Dec 21, 2012 1:20 PM
2	Prepare background paper on major issues that incorporates significant current activities and applicable federal and state laws and regulations.	Dec 21, 2012 12:23 PM

DHCS Business Plan - State and County Roles & Responsibilities

1. What is your first name?

	ResponseCount
	11
AnsweredQuestion	11
SkippedQuestion	0

2. What is your last name?

	ResponseCount
	11
AnsweredQuestion	11
SkippedQuestion	0

3. What is your affiliation?

	ResponseCount
	11
AnsweredQuestion	11
SkippedQuestion	0

4. What is your e-mail address?

	ResponseCount
	11
AnsweredQuestion	11
SkippedQuestion	0

5. Do you agree that this document accurately describes the issue (s)?

	ResponsePercent	ResponseCount
Yes	**45.5%**	**5**
No	27.3%	3
Not sure	27.3%	3
	If no, please specify.	3
	AnsweredQuestion	**11**
	SkippedQuestion	**0**

6. Briefly describe any missing issues.

	ResponseCount
	8
AnsweredQuestion	**8**
SkippedQuestion	**3**

7. Please comment on the recommendations.

	ResponseCount
	6
AnsweredQuestion	**6**
SkippedQuestion	**5**

8. Briefly describe any missing recommendations.

	ResponseCount
	8

AnsweredQuestion	8
SkippedQuestion	3

Q5. Do you agree that this document accurately describes the issue (s)?		
1	no recommendations related to child and family services	Dec 21, 2012 1:39 PM
2	See WIC Sections 5848, 5604, 5604.2, 5604.3; CCR Title 9 Section 3320	Dec 21, 2012 12:13 PM
3	The document fails to identify the crucial role the state plays in encouraging and fostering strong partnerships between the state, counties, and community providers, including primary care providers and others. The business plan should incorporate a statement of vision and strategy, desired outcomes, and milestones reflecting a responsible and inclusive approach to defining roles and responsibilities. Statewide and local-level partnerships are vital to achieving integrated care and innovative solutions.	Dec 21, 2012 10:49 AM

Q6. Briefly describe any missing issues.		
1	Page1,1st Paragraph: Native American communities must be addressed successfully by state and counties. Page1, 2nd bullet point: in the final sentence Native American communities need to be treated uniquely for accountability/performance due to cultural/historic norms. Page 1, 3rd bullet point: what flexibility for underserved communities (i.e. Native Americans) Page 2, 3rd bullet point: when reducing potential fragmentation be sure Native American communities are not "swept under the carpet" Page 2, in paragrpah beginning "To support these...": what about underserved populations? Page 5, County Roles/Responsibilities: what will be roles/responsibilities working with tribes? -- keep in mind federally recognized tribes are soverign entities.	Dec 21, 2012 1:41 PM
2	There is no mention of the MHP (local or state) responsibility related to the EPSDT entitlement, or other MH services. This document should also plan for the implementation of Katie A and other litigation related to Children's mental health. In addition, since virtually all children's mental health services exist due to litigation, a plan needs to be put in place to provide services to these beneficiaries because it is the right thing to do, not just to avoid or respond to litigation.	Dec 21, 2012 1:39 PM
3	t is imperative that each person on county MH Boards/Commissions be well-informed and consistently active in ensuring stakeholder involvement. With Boards having 15, 20, or more members, EACH ONE must take serious responsibility to fulfill his or her role as a public servant to ensure diverse stakeholder involvement . Stringent guidelines for these individuals must be re-assessed in order to have the best appointments possible and raise standards to meet oversight duties that ensure health equity and effective cultural responsiveness.	Dec 21, 2012 12:41 PM
4	A question missed in the section entitled “Coordination of Roles with Other Involved State Departments/Organizations” (p. 4-5) is “How can DHCS help create a climate for collaboration among primary care providers and county mental health services departments?” A similar question should be posed in the “County Roles and Responsibilities” section (p. 5-6): “How can a climate of real partnership best be developed between counties and primary care providers?” Counties should be contractually required to include community clinics in their delivery network, otherwise many will not be motivated to do so, as was seen previously under the Coverage Initiative.	Dec 21, 2012 10:49 AM
5	Caution against more silos with MH and AOD for the clients, family members and care givers. I agree with the statement, “needs a system wide leadership . . . (pg 1 State & Co Roles...) to achieve this collaboration.	Dec 21, 2012 10:18 AM
6	While the problem is accurately described, the issue of properly funding treatment will continue to be an issue. Re- alignment continues to be out of balance in favor of the State and counties and other local funding sources will continue to struggle while the clients and others in need of services struggle to receive the care they need. Until this issue is solved policy makers will continue to pay lip service to resolving the problem of behavioral health and substance abuse within the population as a whole.	Dec 20, 2012 3:26 PM
7	Inclusion of the education system is and has always been the missing piece in the case of family and youth. It is not sufficient enough to have one or two mental health counselors, psycho-education is also needed for teacher and front	Dec 19, 2012 2:48 PM

Q6. Briefly describe any missing issues.		
	line staff who interact with potential behavioral health issues. A component for accountability is needed as well.	
8	best practices. dhcs should have role in using performance reports to identify best practices among health plans, providers and counties and to document recommendations so that others change their practices as needed	Dec 19, 2012 7:43 AM

Q7. Please comment on the recommendations.		
1	see #6 also refer to http://issuu.com/nativeamericanhealthcenter/docs/native_vision_report	Dec 21, 2012 1:41 PM
2	The "recommended actions" listed on page 1 and 2 are good. However, there is no plan included that insures all of these actions will be accomplished	Dec 21, 2012 1:39 PM
3	Cultural and linguistic competence must be embedded systemwide. The approach of cultural humility is essential in gaining awareness and responsiveness to the needs of California's diverse populous.	Dec 21, 2012 12:41 PM
4	My suggested "3 C's" are comprehensive (PH, MH, SUD), coordinated (stakeholders, federal, state, local governments, private-profit, private non-profit), and continuous (changing environment, continuous improvement).	Dec 21, 2012 12:13 PM
5	As noted above, the recommendations fall short in that they fail to emphasize the roles of the state and counties to encourage local partnerships and consider the role of primary care in the service delivery system.	Dec 21, 2012 10:49 AM
6	Integrating data systems (pg 1, bullet 5 - pg 3, bullet 3) has been an ongoing task with MH and physical health. Including Alcohol and drug will take more testing and work with IT developers. Additional funds for small counties need exploring or a pilot that is applicable to other counties should be developed by the state in collaboration with the counties.	Dec 21, 2012 10:18 AM

Q8. Briefly describe any missing recommendations.		
1	see #6	Dec 21, 2012 1:41 PM
2	The state is responsible for ensuring federal mandates. Therefore, the state needs to develop plans to accomplish that mandate and ensure consistent access to timely, appropriate services in all counties.	Dec 21, 2012 1:39 PM
3	Among the underserved groups needing focus named by stakeholders were special needs populations such as those with dementia, traumatic brain injury and autism, as well as underserved cultural/ethnic groups ACROSS THE AGE LIFESPAN; AGING ADULTS - ESPECIALLY AGING SINGLE ADULTS; SINGLE PARENTS - ESPECIALLY SINGLE CUSTODIAL DADS WITH YOUNG CHILDREN AND TEENS	Dec 21, 2012 12:41 PM
4	Prepare background paper on major issues that incorporates significant current activities (DHCS Strategy for Quality Improvement in Health Care, MHSOAC FY 2013-14 MHSA Annual Update Instructions) and applicable federal and state laws and regulations.	Dec 21, 2012 12:13 PM
5	California has led the way in developing alternatives to hospital-based acute care (e.g., crisis residential programs aka acute diversion units), psychiatric emergency services that are tied to acute diversion units and are not hospital-based, and the mental health analog to physical health care rehab (e.g., transitional residential treatment aka social rehabilitation facilities). The opportunity to improve patient outcomes, the overall health of our population, and reduce costs by promoting these alternatives to psychiatric hospitalization should be promoted by the state in this business plan. Furthermore, by doing so, the state would demonstrate a commitment to the policy of non-institutionalization as it applies in both acute care and longer term services and thereby be compliant with the Olmstead decision. In order to meet their parity obligations, the state should actively advocate for the provision of the full array of rehabilitation services (as in the rehab option of Medicaid) by insurers/payers including Accountable Care Organizations. In order to address the difficulties with Medi/Medi billing, the state should advocate for a pre-emptive determination that for certain services that are never covered by Medicare, initial billing to Medicare to obtain the denial before billing MediCal would not be necessary. Due to recent legislation there is greater discretion and oversight at the county level. There is a range of interpretation among counties of what services can be provided by whom when billing MediCal for specialty mental health services. The state should provide clear direction to counties as to exactly what services can be provided by whom and how frequently medical necessity must be established. In addition, the state should define and ensure community stakeholder participation at both the county and state levels. The state should advocate for the licensing and certification of substance use disorders and mental health 24-hour treatment facilities to be under the same authority and should not be split between separate state departments. A distinct unit or county oversight should be established to perform these licensing and certification functions. This unit or county oversight should be comprised of staff who previously conducted these functions at the Departments of Alcohol and Drug Programs and Mental Health and/or who have experience working in community substance abuse and mental health treatment. Staff should adhere to wellness and recovery principles and be allowed to modify or waive rules when appropriate to support the people being served. The unit or county oversight should have an advisory committee comprised of clients, family	Dec 21, 2012 12:05 PM

Q8. Briefly describe any missing recommendations.		
	members, providers and county officials. The state should continue to require and score county mental health cultural competency plans and offer technical assistance to those counties with the highest mental health disparity rates. In addition, the state should define and monitor community stakeholder participation at both the county and state levels.	
6	1. DHCS should play a strong leadership role in requiring county contracting with primary care providers, such as FQHCs, to encourage integration. 2. DHCS should play a key role in providing a strong advocacy voice for MH and SUD fields, but also for integration and local partnerships. This would also include leveraging federal funds, legislative and administrative advocacy, ensuring visibility, and returning cost savings for reinvestment. 3. The counties should play a lead role in setting local standards for contracting with FQHCs and coordinating with primary care providers.	Dec 21, 2012 10:49 AM
7	need to broaden sense of partnerships to include providers and health plans not just state and county.	Dec 19, 2012 7:43 AM
8	There is a significant body of highly talented software programmers and user-experience experts that are ready to work with the County to help develop technological solutions, typically on a pro-bono basis. The county should be seeking such help to both improve systems and procedures as well as engaging stakeholders in process improvement. My hope is that you will include "engaging local stakeholders to develop technologiical and data-centric tools". I also believe here that creating an atmosphere of open-data philosophies, and striving to release MH and SUD datasets to the public will create untold opportunities for improvement. Thank you!	Dec 18, 2012 11:40 PM

Appendix D

Executive summaries of each of the California Reducing Disparities Project Reports (Native Americans; Latinos; Asian/Pacific Islanders; African Americans; and Lesbian, Gay, Bi-sexual, Transgender, Queer and Questioning)

California Reducing Disparities Project

In a national call to reduce health and mental health disparities and seek solutions for historically underserved communities in California, the Department of Mental Health, in partnership with the Mental Health Services Oversight and Accountability Commission (MHSOAC) and other stakeholders, called for a statewide policy initiative to make recommendations. The goal was to improve access, quality, and positive outcomes for racial, ethnic, and cultural communities. These reports developed by experts in the field and underserved communities were key references and recommendations in the California Department of Health Care Services (DHCS) work plan for Mental Health and Substance Use Treatment services. The reports focused on five populations: African American, Asian/Pacific islanders, Latinos, Lesbian, Gay, Bi-sexual, Transgender, Queer/Questioning (LGBTQ), and Native Americans.

For those not familiar with this important body of work, it was decided to include an overview as well as all available executive summaries from these reports. In addition, there are links to the full reports. There are very important themes and recommendations integrated into the work plan from these policy papers, particularly in the area of workforce, integration/innovative models, evaluation, finance, and roles (particularly local roles). Below is a summary of these key themes from the policy papers, as well as the executive summaries and full report links.

This body of work was referred to over and over again in developing recommendations and, therefore, important core documents were included in the references and materials as a key stakeholder set of recommendations.

CRDP population reports summary – key themes and recommendations:

(1) *Historical trauma*: As demonstrated in the Native American and African American population reports, when attempting to understand the mental and behavioral health needs of various under-served communities, it is useful to remember the historical injustices experienced by various ethnic groups and the LGBTQ communities. The current mental health system often fails to develop programs with the lived experiences of people of color and those of different sexual orientations. In other words, historical persecution and present-day struggles with racism and discrimination are rarely taken into consideration, which diminishes the impact these providers currently have on mental health or substance use of specific communities. Along with careful consideration of culture and language, examining the impact of historical trauma when developing programs and diagnosing mental illness can help lead to a mental health system that is congruent with cultural norms. The stresses of the environment and social context must also be considered when developing effective programs for substance use treatment, as well.

(2) *Community defined evidence*: A major theme throughout the population reports is a need for integration of programs developed using community defined evidence and practice-based evidence as opposed to the current system, which favors evidence-based practice. This approach would encourage unique treatment and case management approaches that are needed for care to be effective. An argument put forth in the population reports is that evidence-based practice, while studied and shown to work with white Americans, are rarely studied on people of color. As a result, evidence-based practices may not work within communities of color, because such practices, in many cases, have not been culturally validated. It is proposed that community defined evidence – a validated practice that is accepted by the community but not necessarily empirically proven – be given a place *alongside* evidence-based practice. Funding structures should allow culture-specific factors to be considered and incorporated into services appropriate for that cultural community.

(3) *County engagement*: Distrust of counties and the need to build a partnership between county systems and local culturally relevant community agencies was also cited as a concern. Cited most consistently among the population reports is a concern that suggested interventions and programs will not be accepted or used for future program development and evaluation. This concern is based on past community collaboration with county and state agencies that ended in communities feeling as if their voices were not heard. An example of additional concerns cited are that counties do not understand the needs of communities, which results in inadequate delivery of programs and services; a need for counties to disseminate funding based on cultural needs that may be unique and not fit traditional MediCal requirements; and that county involvement adds another layer of administrative bureaucracy. Population report authors have proposed that counties and government agencies collaborate with community leaders in all aspects of mental health and substance use services, ranging from program development and evaluation to allowing greater opportunities for community involvement in the policy-making process, standards of success, methods of outreach and engagement, and actual service design. These issues would be relevant for both mental health- and addiction-related treatment.

(4) Consistently named *barriers* include, but are not limited to:
- Stigma
- Lack of culturally and linguistically appropriate services
- Lack of qualified mental health professionals
- Lack of school-based mental health programs
- Socioeconomic challenges (economic resources and living conditions)
- Inadequate transportation
- Perceived discrimination and mistrust
- Programs and services not embedded in local cultural milieu

(5) Consistently *named strategies to improve health and behavior health* include, but are not limited to:
- Strengthening identity and cultural grounding
- Access to traditional healing practices
- Spirituality
- Interdependence vs. individuality
- Bilingual and bicultural staff
- Familial support and focus
- Holistic Interventions in community context, including integrated approaches with health
- Culturally diverse staff, including non-licensed staff embedded in the community
- Community outreach and engagement

In summary, the CRDP strategies and recommendations, which are attached in the executive summaries from each available report, have implications for the recommendations on workforce, financing, integration with healthcare, local roles, and health disparities overall. DHCS, counties, and local stakeholders must all become aware of these strategies and support integration of these in planning efforts and follow-up work.

Attached are the executive summaries from the reports, where available, and the links to full reports. It is important to recognize the broad stakeholder involvement in each report and leadership to provide these tools for planning and health system enhancement.

All report links on California Department of Public Health
http://www.cdph.ca.gov/programs/Pages/CaliforniaReducingDisparitiesProject(CRDP).aspx

African American Brief
http://www.aahi-sbc.org/uploads/African_Am_CRDP_ComBrief2012.pdf

African American Full Report with Executive Summary embedded
http://www.aahi-sbc.org/uploads/African_Am_CRDP_Pop_Rept_FINAL2012.pdf

Latino Full Report with Executive Summary embedded
http://www.ucdmc.ucdavis.edu/newsroom/pdf/latino_disparities.pdf

LGBTQ Full Report with Executive Summary embedded
http://www.eqcai.org/atf/cf/%7B8cca0e2f-faec-46c1-8727-cb02a7d1b3cc%7D/FIRST_DO_NO_HARM-LGBTQ_REPORT.PDF

Native American Full Report that is very interactive, but does not have an executive summary but recommendations was included in the attachments.
http://issuu.com/nativeamericanhealthcenter/docs/native_vision_report

Asian Pacific Islander
http://crdp.pacificclinics.org/news/crdp/01/02/api-population-report-final-draft

Attachments:

CRDP Fact Sheet

African American Executive Summary

Latino Executive Summary

LGBTQ Executive Summary

Native American Recommendations

Asian Pacific Islander Report, still pending approval

California Department of Mental Health

FACT SHEET

OFFICE OF MULTICULTURAL SERVICES

JANUARY 2010

CALIFORNIA REDUCING DISPARITIES PROJECT (CRDP)

Background and Purpose

In response to the call for national action to reduce mental health disparities and seek solutions for historically underserved communities in California, the Department of Mental Health (DMH), in partnership with Mental Health Services Oversight and Accountability Commission (MHSOAC), and in coordination with California Mental Health Directors Association (CMHDA) and the California Mental Health Planning Council, have called for a key statewide policy initiative as a means to improve access, quality of care, and increase positive outcomes for racial, ethnic and cultural communities. In 2009, DMH launched this two-year statewide Prevention and Early Intervention effort utilizing $3 million dollars in Mental Health Services Act (MHSA) state administrative funding.

This initiative, entitled the California Reducing Disparities Project, is focused on five populations:

- African Americans
- Asian/Pacific Islanders
- Latinos
- Lesbian, Gay, Bi-sexual, Transgender, Questioning (LGBTQ)
- Native Americans

Strategic Planning Workgroups (SPW)

In October 2009, after a competitive bid process, DMH awarded contracts to each of the five population groups listed above. These groups are all required to develop population-specific Strategic Planning Workgroups. These Strategic Planning Workgroups will be comprised of community leaders, mental health providers, consumers and family members from each of the five target populations. The goal of these five Strategic Planning Workgroups (SPWs) will be to develop population-specific reports (strategic plans) that will form the basis of a statewide comprehensive strategic plan to identify new approaches toward the reducing of disparities. These population-based strategic plans will move beyond defining disparities and seek new approaches from those communities most impacted by disparities. The strategic plan will include community-defined evidence and culturally appropriate strategies to improve access, services, outcomes and quality of care for the five ethnic and cultural populations identified for this project.

The five SPWs will work to identify new service delivery approaches defined by multicultural communities *for* multicultural communities using community-defined evidence to improve outcomes and reduce disparities. Community-defined evidence is defined as "a set of practices that communities have used and determined to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community."[1]

The five SPW contractors will have two years to complete the population-specific strategic plans. The second phase will include implementing the strategic plans at the local level. The current implementation plan is to fund selected approaches across these five communities for four years with a strong evaluation component. After successful completion of this [more than] six year investment in community-defined evidence, California will be in a position to better serve these communities and to replicate the new strategies, approaches, and knowledge across the state and nation.

[1] National Latina/o Psychological Association, Fall/Winter 2008, National Network to Eliminate Disparities in Behavioral Health, SAMHSA and CMHS, Larke Nahme Huang, Ph.D

The five SPW contracts were awarded to the following entities to address disparities in the identified populations:

- African American: The African American Health Institute of San Bernardino County
- Asian/Pacific Islander: Pacific Clinics
- Latino: The Regents of the University of California, Davis
- LGBTQ: Equality California Institute
- Native American: The Native American Health Center

California Reducing Disparities Project Strategic Plan

DMH is also developing two additional contracts to support the California Reducing Disparities Project (CRDP). One of these contracts will fund a single contractor who will serve as the facilitator/writer of the California Reducing Disparities Strategic Plan to collaborate with the Strategic Planning Workgroups and compile all of the population-specific reports developed by the five SPWs into one comprehensive strategic plan.

This comprehensive CRDP Strategic Plan will be developed in partnership with the five Strategic Planning Workgroup (SPW) contractors in an effort to identify population-specific strategies and, as appropriate, similarities between and among the five identified populations. It will provide the public mental health system with community-identified strategies and interventions that will result in relevant and meaningful culturally and linguistically competent services and programs to meet the unique needs of the five racial, ethnic, and cultural populations identified for the CRDP. It is expected that once the CRDP Strategic Plan is completed, the practices and strategies identified will be funded over four years and evaluated to demonstrate the effectiveness of this community-defined evidence in reducing disparities.

California MHSA Multicultural Coalition

The final contract will fund a California MHSA Multicultural Coalition (CMMC) to address a variety of mental health issues and provide state level recommendations on all of the MHSA components and related activities. The CMMC's primary goal will be to work toward the integration of cultural and linguistic competence into the public mental health system. The CMMC will provide a new platform for racial, ethnic, and cultural communities to come together to address historical system & community barriers, and work collaboratively to seek solutions to eliminate barriers and mental health disparities. By creating and funding this coalition, DMH is developing a new structure to bring forward diverse multicultural perspectives that have not been adequately represented in the mental health system or in previous efforts to obtain consumer and family member input. The CMMC will be pivotal in providing critical insights and assessments of systems, e.g., policies, procedures, and service plans, in moving toward a more culturally and linguistically competent system.

Individuals who have expertise in areas concerning multicultural communities, community members interested in improving the mental health system (including consumers and family members from diverse backgrounds), and service providers who work with racial ethnic and cultural groups will form the membership of the CMMC. DMH recognizes the need to include people with experience across various systems, e.g., social services, criminal justice, and education), and across the life span, to better serve individuals with mental health challenges who have not yet been identified in the mental health system. The coalition will include representatives from each of the five CRDP Strategic Planning Workgroups and will also represent a broader spectrum of unserved and underserved ethnic, cultural communities in California.

For updates and more information about the California Reducing Disparities Project, please visit the CA Department of Mental Health Office of Multicultural Services web site:

http://www.dmh.ca.gov/Multicultural_Services/CRDP.asp

Executive Summary

On behalf of the California Department of Mental Health (CDMH), we are pleased to present the research results of the **California Reducing Disparities Project (CRDP): Latino Strategic Planning Workgroup (SPW)**. This Executive Summary offers a brief background of the CRDP Project, followed by an overview of the research purpose, mental health status of Latinos, and findings.

This project examined mental health disparities for the Latino population. Our aim was to develop and implement the appropriate process for identifying community-defined, strength-based promising practices, models, resources, and approaches that may be used as strategies to reduce disparities in mental health. To accomplish this goal, we adopted a set of topics from the California Department of Mental Health (2009). We also adopted the community-based participatory research (CBPR) framework from Minkler and Wallerstein (2008) to ensure a continuum of community involvement that over time builds and strengthens partnerships to achieve greater community engagement (McCloskey, 2011).

Our overall findings suggest that racial and ethnic minority groups in the U.S. fare far worse than their white counterparts across a range of health indicators (Smedley, Stith, & Nelson, 2003). As the nation's population continues to become increasingly diverse (non-white racial/ethnic groups now constitute more than one third of the population in the United States; Humes, Jones & Ramirez, 2011), the passing of the health care reform law (Andrulis, Siddiquui, Purtle & Duchon, 2010) becomes a critical piece of legislation in advancing health equity for racially, ethnically, and sexually diverse populations.

THE CALIFORNIA REDUCING DISPARITIES PROJECT

In order to reduce mental health disparities and improve access, quality of care, and increase positive outcomes for racial, ethnic, sexual, and cultural communities in California, the California Department of Mental Health launched a statewide Prevention and Early Intervention initiative effort utilizing Proposition 63, known as the Mental Health Services Act (MHSA), dollars that funded the California Reducing Disparities Project. The project focused on the following five populations: (1) African Americans, (2) Asian/Pacific Islanders, (3) Latinos, (4) Lesbian, Gay, Bi-sexual, Transgender, and Questioning (LGBTQ), and (5) Native Americans. As part of the project, five Strategic Planning Workgroups (SPWs), corresponding to each population, were created to provide the California Department of Mental Health with

community-defined evidence and population specific strategies for reducing disparities in behavioral health.

The Prevention and Early Intervention (PEI) initiative is key to reducing disparities and risk factors and building protective factors and skills. The National Research Council and Institute of Medicine (NRC/IOM; 2009) defines prevention as programs and services that focus on "populations that do not currently have a disorder, including three levels of intervention: *universal* (for all), *selective* (for groups or individuals at greater than average risk), and *indicated* (for high-risk individuals with specific phenotypes or early symptoms of a disorder). However, it also calls on the prevention community to embrace mental health promotion as within the spectrum of mental health research" (p. 386).

The first activity of the Latino Strategic Planning Workgroup occurred in May of 2009 when fifteen individuals who are researchers, policy makers, public mental health leaders, consumers and advocates, community health leaders, ethnic services managers, and education professionals attended a one-day meeting. The initial meeting consisted of: (1) a presentation and discussion of the overall goals of the Latino SPW, (2) a presentation of the CBPR model as a framework to guide the work of this stakeholder group, and (3) the creation of the California Latino Mental Health Concilio (see Appendix 1 for a list of the Concilio members). The Concilio is a core stakeholder group representing a range of constituencies and various age groups. The Concilio included mental health consumer advocates, ethnic service managers, mental health providers, promotoras, educators, and representatives of a variety of groups, such as migrant workers, juvenile justice workers, and LGBTQ individuals. The California Department of Mental Health funded the University of California, Davis Center for Reducing Health Disparities (CRHD) to develop the Latino SPW and plan and execute the Latino SPW's objectives and activities. The UC Davis CRHD was selected because of its history in studying and addressing mental health issues among Latinos in California. Moreover, at the meeting, the Latino SPW sought to develop a long-term research and policy agenda to help sustain strength-based strategies for reducing disparities in mental health services for Latinos in California.

MENTAL HEALTH STATUS OF LATINOS

Many foreign-born Latinos began in the U.S. as migrant workers and, after years of hard work, brought their families to settle permanently in this county. However, the immigration process and transition from their country of origin to the U.S. has been difficult for this segment of the Latino population. Most have become susceptible to increased pressures to acculturate and assimilate, as well as deal with stress from hardship and poverty that often accompany these

difficult transitions. As a result of immigrating to the U.S., many Latinos have endured a range of life stressors and experiences (e.g., poor housing, abuse, trauma, stigma, and discrimination) that when left unaddressed and unresolved can lead to mental health problems.

The lack of culturally and linguistically appropriate mental health services (e.g., language skills) compounded by mental health stigma keeps many Latinos with mental illness from seeking services. A lack of sufficient bilingual and bicultural mental health professionals usually translates into language barriers and often results in miscommunication and misinterpretations. Language is an important factor associated with the use of mental health services and the effectiveness of treatment. Unfortunately, the number of Spanish proficient providers continues to be insufficient to meet the needs of Latinos, especially monolingual immigrants. Latinos with limited English proficiency frequently do not have critical information, such as how and where to seek mental health services. Moreover, language barriers contribute to the problems Latinos face when accessing public transportation to visit mental health clinics and the difficulties that they encounter with completing required paperwork at clinics.

ACCESS: INDIVIDUAL, COMMUNITY, AND SOCIETAL BARRIERS TO CARE

The central focus of this study was to identify effective, community-defined practices for increasing awareness and access to mental health services and improve prevention and intervention for Latinos in California. This portion of the report is organized into three major areas: (1) individual level barriers, (2) community level barriers, and (3) societal barriers.

Key Finding 1: Study/forum participants saw negative perceptions about mental health care as a significant factor contributing to limited or no access to care. Among the many concerns--stigma, culture, masculinity, exposure to violence, and lack of information and awareness--were the most common.

Forum participants reported that limited or no access to mental health services was a significant factor affecting the mental health of the Latino community. The participants also cited barriers to accessing mental health services and identified many causes related to these barriers. The content analysis of the *Mesas de Trabajo* summaries and focus groups generated five major themes related to individual level barriers: (1) stigma associated with mental health problems, (2) cultural barriers, (3) masculinity, (4) violence and trauma, and (5) lack of knowledge and awareness about the mental health system. We have outlined below each barrier and included quotations to allow the reader to understand the views of the forum participants in their own words.

Key Finding 2: A substantial proportion of the Latino participants felt that the major causes of limited access and underutilization of mental health services in the Latino community were primarily due to gaps in culturally and linguistically appropriate services, in conjunction with a lack of bilingual and bicultural mental health workers, nonexistent educational programs for Latino youth, and a system of care that is too rigid.

From the content analysis, four persistent community-level themes emerged throughout the *Mesas de Trabajo.* The themes, which are barriers that contributed to inadequate care and overall poorer mental health and outcomes, included: (1) a lack of culturally and linguistically appropriate services, (2) a lack of qualified mental health professionals, (3) a lack of school-based mental health programs, and (4) structural barriers to care. These four key themes were viewed as common areas of concern in addressing the causes of mental illness and were considered barriers to accessing and utilizing mental health services.

Key Finding 3: Participants identified social and economic factors as major causes of mental illness and significant barriers to achieving and sustaining wellness among Latinos.

Social determinants of mental health were an overarching theme across all groups. Social determinants refer to the social conditions in which people grow, live, work, and age that have a powerful influence on people's health (Commission on Social Determinants of Health, 2007). The following three key barriers emerged from the content analysis: (1) social and economic resources and living conditions, (2) inadequate transportation, and (3) social exclusion.

STRATEGIES TO IMPROVE ACCESS TO EXISTING PROGRAMS AND SERVICES

This section of the report identifies and describes strategies that address the issues relating to reaching out and engaging the Latino community in California. Specifically, it focuses on identifying community-defined strategies to improve access, quality of care, and increase positive outcomes for Latinos in California. This portion is organized into two major areas: (1) community and cultural assets, and (2) community-identified strategies for prevention and early intervention programs.

Key Findings 4: Participants identified community assets that promoted the mental health of their communities. Our data indicated that the following five community and cultural assets were cited as critical elements to improving access to care: (1) individual and community

resiliency, (2) family involvement, (3) church and religious leaders, (4) community role models and mentors, and (5) community *Pláticas*.

Community assets and strengths can be understood as the total participation of individuals and community organizations coming together to mobilize and leverage existing community resources to improve access to existing programs. Participants believed that co-locating services is a strategy that can maximize community resources and give families and consumers a voice in their recovery. Co-location is an approach where community-based organizations collaborate and share resources to better serve the Latino community.

Key Finding 5: Programs recommended using the following types of strategies for prevention and early intervention: (1) school-based mental health programs, (2) community-based organizations and co-location of services, (3) community media, (4) culturally and linguistically appropriate treatment, (5) workforce development to sustain a culturally and linguistically competent mental health workforce, and (6) community outreach and engagement.

Our data indicated that the practice of co-locating services may play an important role in building a mental health infrastructure that is culturally relevant and comfortable for the Latino community. The participants outlined a number of potential benefits of co-locating services for Latinos. For example, one Ethnic Service Manager (ESM) participant remarked, "Latino families benefit when agencies collaborate and share resources within the community as opposed to making the consumer come to our agency."

EVALUATION AND OUTCOMES

Key Finding 6: Participants identified four major evaluation areas: (1) reliability and relevance, (2) knowledge and commitment to serving Latinos, (3) consumer and family participation, and (4) accountability panels. Participants perceived these areas to be key components to measure and achieve positive outcomes in so that Latinos can access mental health services based on the community-defined evidence practices, have high retention rates, and experience high quality services.

Across all forums, participants emphasized that mental health agencies need to demonstrate commitment to serving Latino communities. In other words, it was suggested that mental health programs receiving funding to serve Latinos and improve mental health disparities for Latinos should be required to produce outcomes that demonstrate increases in access to

services, improved retention rates, reduced dropout rates, and increased quality care. It was further recommended linking funding with the number of Latinos served and the effectiveness of follow-ups with consumers who terminated treatment early.

PREVENTION AND EARLY INTERVENTION EVIDENCE-BASED COMMUNITY-IDENTIFIED STRATEGIES FOR IMPROVING MENTAL HEALTH TREATMENT

Core Strategy 1. Implement peer-to-peer strategies, such as peer support and mentoring programs, which focus on education and support services.

Core Strategy 2. Employ family psycho-educational curriculum as a means to increase family and extended family involvement and promote health and wellness.

Core Strategy 3. Promote wellness and illness management and favor community-based services that integrate mental health services with other health and social services.

Core Strategy 4. Employ outreach and engagement strategies that promote the connection of community-based strengths and health.

Core Strategy 5. Create a meaningfully educational campaign designed to reduce stigma and exclusion that targets individuals, families, schools, communities, and organizations/agencies at the local, regional, and state level.

Core Strategy 6. Include best practices in integrated services that are culturally and linguistically appropriate to strengthen treatment effectiveness.

STRATEGIC DIRECTIONS AND RECOMMENDATIONS FOR REDUCING MENTAL HEALTH DISPARITIES

Strategic Direction 1: School-Based Mental Health Programs

Focus on adolescents and the impact of failing to adequately detect and diagnose potential mental health issues in a timely manner. Schools represent a safe setting to educate families and their children about mental health. Tie mental health programs to academic achievement and performance.

Strategic Direction 2: Community-Based Organizations and Co-locating Services

Increase collaboration among community-based organizations, schools, and other social services agencies by coordinating and maximizing community resources to achieve an increase in access to treatment among Latinos.

Strategic Direction 3: Community and Social Media

Use mainstream and Latino media to raise mental health awareness with messages that reduce stigma associated with mental health disorders and promote information and resources about early intervention.

Strategic Direction 4: Workforce Development

Develop and sustain a culturally competent mental health workforce consistent with the culture and language of Latino communities.

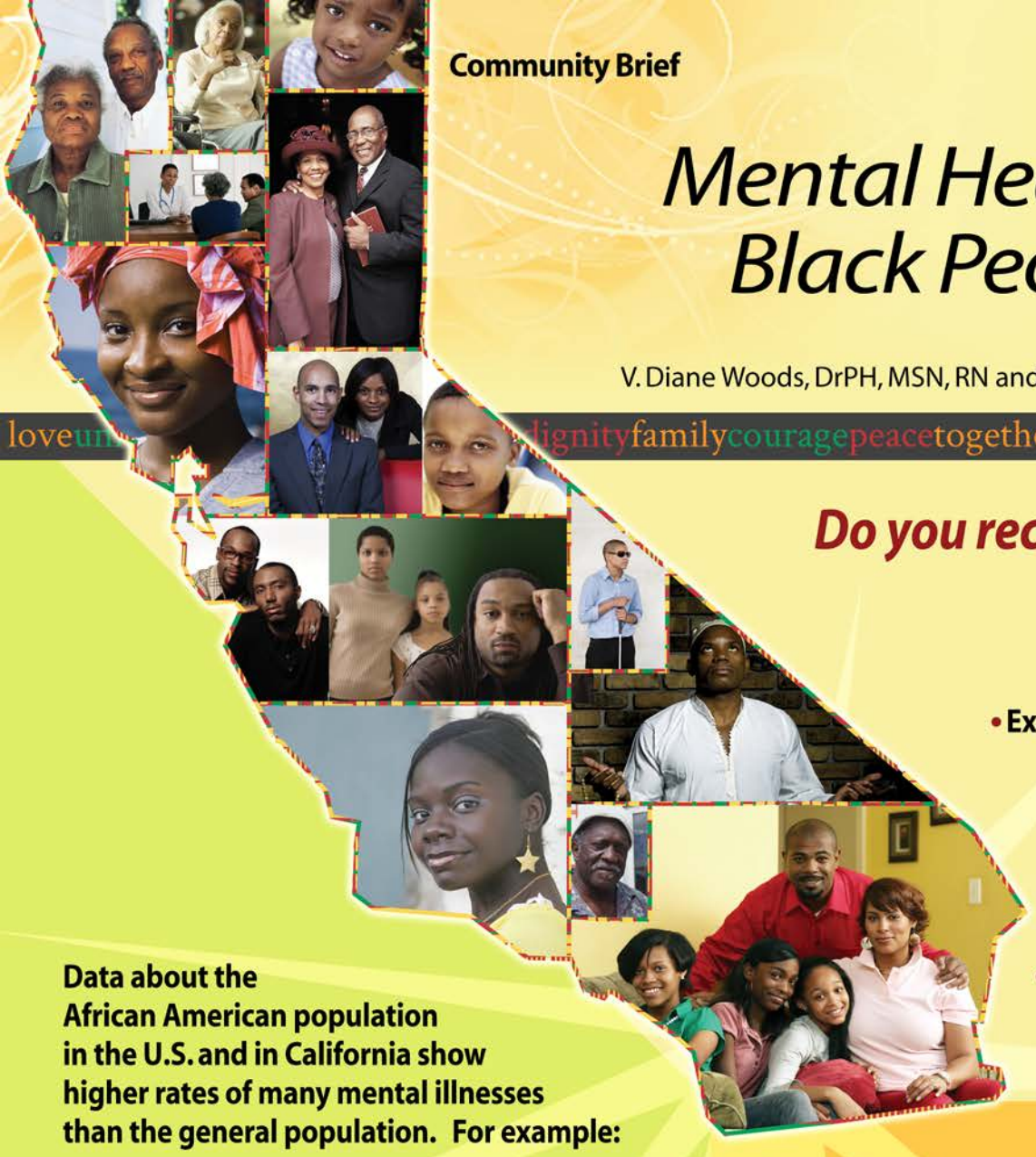
Strategic Direction 5: Culturally and Linguistically Appropriate Treatment

The key to providing treatment and quality care to Latino communities lies in mental health providers and support staff communicating with consumers in a way that acknowledges the consumer's beliefs about mental health.

Strategic Direction 6: Community Outreach and Engagement

Provide resources for grassroots community outreach and engagement efforts to coordinate with Latino leaders and tailor the Latino SPW recommendations from this report for statewide dissemination through a summit, educational campaigns, and other activities to best meet the needs of the Latino community.

Although there are many commonalities across the various Latino groups, there are also cultural, linguistic, educational, and socioeconomic differences that sometimes make it necessary to group Latinos into sub-populations for investigative purposes. It is important for future research to distinguish between Latino groups from different regions and examine their demography, history, culture, and views on mental health. Researchers should not attempt to characterize all Latinos as one homogenous group and ignore within-group heterogeneity. Therefore, strategies and recommendations for providing mental health care for Latinos must not be from a "one size fits all" recipe (Aguilar-Gaxiola & Ziegahn, 2011; Willerton, Dankoski, & Martir, 2008).



Community Brief

Mental Health & Black People

V. Diane Woods, DrPH, MSN, RN and Nacole S. Smith, MPH

lovedignityfamilycouragepeacetogethernessculturefaithloveunity

Do you recognize symptoms of mental issues?

Some are:

- Excessive psychological distress
- Substance abuse
- Depressive episodes
- Suicidal attempts
- Sever mood swings
- Sudden personality changes
- Uncontrollable rage

Data about the African American population in the U.S. and in California show higher rates of many mental illnesses than the general population. For example:

- In 2007, U.S. African Americans were 30% more likely to be diagnosed with serious psychological distress
- In 2007, U.S. African Americans were 50% more likely to report symptoms of depressive episodes
- In 2007, U.S. African American students were more likely than their White counterparts in grades 9-12 to attempt suicide (females were twice as likely; males were 1.6 times as likely)
- During FY 2007-2008, the California Department of Mental Health (DMH) reported the top three mental health diagnoses among African Americans were depressive disorders (12.6%), schizophrenia (8.4%), and bipolar disorder (6.2%)
- During FY 2007-2008, in California 27.6% of African Americans using mental health services were diagnosed with dual diagnoses, probably a mental health disorder and substance abuse disorder
- During FY 2007-2008, the California DMH reported African Americans were the third highest users of mental health services, 16.6%; compared to Whites at 36.0% and Latinos at 30.7%
- Despite these statistics, during FY 2007-2008, less than 1% of California's nearly 2.2million African American population used the DMH services

Data Source:
California Health Interview Survey (CHIS), 2012 from http://www.chis.ucla.edu/main/DQ3/output.asp?_rn=0.1598169
Department of Health and Human Services (DHHS), Office of Minority Health (OMH), African American Mental Health FACT Sheet, 2011
California Department of Mental Health (DMH) Client Service Information (CSI) database, 2011 from http://www.dmh.ca.gov
The Education Trust-West, Opportunity lost: The story of African American achievement in California, research report, 2010

California Department of Mental Health

MHSA California 03 Wellness · Recovery · Resilience

AAHI

"Fubu" - for us, by us

What you can do, now...

loveunityrespecthopecompassiondignityfamilycouragepeacetogethernessculturefaithloveunity

To improve ***your*** mental health, maintain a strong mind, and prevent mental issues:

Individual Personal Actions

Love and respect yourself; look in a mirror each morning and say, ***"I love you."***

Love Black people and Black culture; ***"Be Black and PROUD!"***

Maintain a daily positive social network with healthy family connections and interactions

Eat healthy foods; drink plenty of water every day; be active; get physically fit; stay fit

Develop a daily meditation routine and meditate daily

Participate in cultural education and child rearing practices

Be positive, think positive; **share 5 positive compliments with others every day**

Avoid negatives; escape negative environments, people, and thoughts

Feeling sad sometimes? Talk to a trusted family member, friend, spiritual leader, or counselor

Call 4 HELP – (916) 567-0163/www.NAMI.org; or, 1-800-273-8255/www.SuicidePreventionLifeline.org

Community Actions

Develop **"neighborhood healing circles"**

Establish neighborhood and community ***"health check stations"***

Create neighborhood positive mobilization efforts

Be a part of positive consciousness raising advocacy, leadership, and collaboration

Design culture centers for people of African ancestry, staff with Black community people

Keep houses of worship open every day of the week; create "***safe spaces***" for people to gather

System Responses

Implement a mass multi-media campaign promoting positive images of Blacks

Establish financial partnerships with Black grassroots organizations

Establish a network of Black professionals to provide culturally grounded services

Create school-based wellness and prevention centers for youth

Fund culturally grounded one-stop health centers

Created by the African American Health Institute-SBC (www.AAHI-SBC.org) under contract #09-79055-006 with the Department of Mental Health
California Reducing Disparities Project (CRDP) funded by the Mental Health Services Act (MHSA) Prop 63

"WE AIN'T CRAZY!
Just Coping With a Crazy System"

Pathways into the Black Population for Eliminating Mental Health Disparities

EDITORS

V. Diane Woods, Dr.P.H.
Project Director, Client Family Member

Nicelma J. King, Ph.D.
Public Policy Analyst, Client Family Member

Suzanne Midori Hanna, Ph.D.
Marriage and Family Therapist

Carolyn Murray, Ph.D.
Psychologist

“NOTHING COULD BE MORE TRAGIC THAN FOR MEN TO LIVE IN THESE REVOLUTIONARY TIMES AND FAIL TO ACHIEVE THE NEW ATTITUDES AND THE NEW MENTAL OUTLOOKS THAT THE NEW SITUATION DEMANDS.”

MARTIN LUTHER KING, JR 1967

"We need more African American providers. The system must respond to that. We need someone who understands where I am coming from culturally. I need someone comfortable enough to sit and talk with use from my culture to understand what we need in our family. Right now, we do not get the help we need. This system has failed, and continues to do so."
37 year old Black single mother, daughter with schizoid-affective disorder
Solano County Client Family Member (Bay Area Region)

"It's amazing to me that Black people are not in an insane asylum. Some of the types of things in my 79 years, I have had to put up with just to survive, is amazing to me. As I think back over it. I should have been in counseling a long time ago. I think, if counseling was available to me, I would have been in counseling a long time ago. I wish I had access to talk to somebody about what I feel. If I can talk I can get this up. If I had access, I would have taken advantage of it. We need help from ethnically qualified counselors."
Helen B. Rucker, 79 year old Black community activist
Monterey County (Coastal Area)

"Major mental health problems for Blacks are depression, stress, and anxiety. We need safe communities and free and open health services."
25 year old African American, Latino, Caucasian single male
San Diego County (Southern Region)

"Proper diagnosis... I have two daughters; you know going through stuff...It's very frustrating.... I took them in for mental health services... But I think because one presented well, bright kid, it was like, 'Why are you here? You alright, you come from a good family." And I'm, I'm very upset about that. I feel like she didn't get the help she needed, because there's some things that we're talking about now that, that I think could have been caught when she was 16. She did not have a proper assessment."
57 year old African American female, client family member
Fresno County (Central Valley Region)

"I have a 17 year old son with ADHD. He does not like to take his medication. The medicine makes him mellow. He doesn't like that... I came from a family where my mother didn't take anything stronger than an aspirin, and she did not believe in pills and all of that...."
Glenn, 46 year old same gender loving gay male client family member
Sacramento County (Northern Region)

"I hate my family. They didn't treat me right. I was abused. I did not get the help I needed. Nobody helped me. That's why I am like this today. That's sad... I can't take care of myself. I have to have a care giver with me all the time."
Sharonda Capers, 38 year old Black female diagnosed bipolar
member Black Los Angeles County Client Coalition (BLACCC) (Los Angeles Region)

"I see mental illness as a dysfunction in a relationship, or something traumatic has happened to you..."
22 year old Black female, diagnosed with childhood depression
Riverside County (Inland Empire Region)

The African American CRDP is to be commended on the effort and quality of this first report on the rationale and the approaches to eliminating mental health disparities in the African American population in California. Although the report focuses on mental health of the African American population in California, it is clear from the Surgeon General's Report that the insidious elements of racial disparities are disturbingly nationwide.

The states of Ohio and Virginia have developed similar committees, studies, and reports that parallel the CRDP's findings and set of recommendations. In each of these state reports, there should not be any doubt about the importance of the charge, its complexity, or reality. Racial disparities are real phenomena and have devastating results in communities already suffering from poverty, addiction, and unemployment. There are multiple factors that make the work of the CRDP and their methodology difficult and illusive. One of these factors is the long history of mental disorders in the African American community and the contradictory policies and approaches that have been instituted in California and the rest of the United States.

These policies were initiated as early as 1765 in Virginia with the unscientific belief that Africans were immune from mental illness made its way into public policies. The resulting policies created a system of mental health care that left Africans without a means of accessing clinical services outside of the rubric of the Black church. Their reliance on the church is a second complicating factor since there are few linkages between the church and the more formal mental health system as was noted in New Orleans following hurricane Katrina.

Numerous reports over the decades have identified key factors within the formal mental health system that act as impediments to access by African Americans and their families. In its relationship to the African American population, the formal mental health system has offered inaccurate diagnoses, disproportionate findings of severe illness, greater usage of involuntary commitments, and a woeful inadequacy of service integration. Another impediment has been the tendency of African Americans to delay seeking help, sometimes for decades following the onset of mental illness. The complexity of these factors has created an intense stigma in the African American community that disparages mental illness as crazy – a condition and a status that is viewed as personally caused and difficult to resolve.

The California story, as shown in this report from the African American CRDP parallels these same issues and the need for new approaches to address the remnants of disparities. The African American CRDP Population Report offers a number of new thoughts and ideas about how to address a series of old and interrelated issues that need to be considered in this new decade. The African American Strategic Planning Workgroup has outlined a path that if followed and supported offers a vision for change and improvement.

King Davis, Ph.D., Professor and Robert Lee Sutherland Endowed Chair
Mental Health and Social Policy School of Social Work
The University of Texas at Austin
U.S. Surgeon General's Workgroup on Mental Health, Culture, Race and Ethnicity

The African American Health Institute (AAHI) of San Bernardino County took on the enormous task of implementing the California Reducing Disparities Project (CRDP) for African Americans. The task required gathering information, identifying issues, and taking the time to understand and report community-defined practices from the perspective of the population that support indicators of mental health disparities for Black Californians. The CRDP African American Strategic Planning Workgroup (SPW), in addition, identified disparities in mental health access, availability, quality and outcomes of care regarding mental health issues.

This project, CRDP, services to continue the process of enlightening the general public about the on-going lack of appropriate preventive or early intervention of mental health services as well as services to initiate programs that address the disparities among Black Californians. Without a doubt, issues of depression, anxiety, alcohol, substance abuse, eating disorders, sleep disorders, sexual disorders, schizophrenia, bi-polar, dementias, stress, death and dying, suicide, domestic violence and a host of other physical causes of mental suffering, can be understood and treated. Therefore, a focus on early interventions that includes an educational approach regarding mental illness can lead to greater understanding, and awareness of treatment methods that eliminate incidents of disparities among Black Californians.

Mental health researchers and practitioners have collaborated to create treatment plans for groups, individuals and families as well as extended family members that address the most common mental difficulties and disorders that affect adults, children, and adolescents. The AAHI project identified barriers that especially prevent African American individuals and families from receiving services, and offered recommendations as well as plans that address the mental health needs of African American people.

I believe the CRDP African American Population Report serves as a bridge that will connect the dots for early treatment and appropriate intervention for people of African descent. In addition, I believe the project's goal is to end continued documentations of disparities and, implement programs that actively administer services throughout California that address the mental health needs of the African Americans. This project also addresses the need to establish funds to fight against system wide racial discrimination directed toward the African American population.

Efforts to address the issues of cultural populations that are presently "unserved, underserved, or inappropriately served" in the mental health system is overdue. I support the efforts of AAHI and the recommendation in this African American Population Report. We must change our system here in California to establish early intervention programs for Blacks and other cultural and ethnic groups.

Dee Bridges, M.F.T., B.C.P.C., President
African American Mental Health Providers of Sacramento

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DEFINITIONS OF COMMONLY USED TERMS

African Ancestry/Descent: People having origins coming from Africa
African American: A person of African origin born in America (American citizen)
African: A person born on the continent of Africa
Afro-Caribbean: People of African ancestry born in the Caribbean
Afro-Latino: People of African ancestry born in Latin America

Community: Any group having interest in common; working together for mutual benefit

Community Defined Evidence (CDE): A set of practices that communities have used and found to yield positive results as determined by community consensus over time. These practices may or may not have been measured empirically (by a scientific process) but, have reached a level of acceptance by the community. CDE takes a number of factors into consideration, including a population's worldview and historical and social contexts that are culturally rooted. It is not limited to clinical treatments or interventions. CDE is a complement to Evidence Based Practices and Treatments, which emphasize empirical testing of practices and do not often, consider cultural appropriateness in their development or application. DHHS SAMHSA, 2009 / *Community Defined Evidence Project*

Client: A person with a mental health diagnosis

Client and Services Information (CSI) System: The California central repository for data pertaining to individuals who are the recipients of mental health services provided at the county level. CSI contains both Medi-Cal and non-Medi-Cal recipients of mental health services provided by County/City/Mental Health Plan program providers (CSI, 2011)

Consumer: One who uses mental health services for personal use

Client Family Member: Family member of a person with a mental health diagnosis

Culture: "The vast structure of behaviors, ideas, attitudes, values, habits, beliefs, customs, language, rituals, ceremonies, and practices peculiar to a particular group of people and which provides them with a general design for living and patterns for interpreting reality." Wade Nobles, 1986 *African Psychology: Toward its Reclamation, Reascension and Revitalization*

Cultural Competence: Having knowledge to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (DHHS, 2011).

Culturally Congruent: *"Cultural consistency (congruency) means that the phenomena (prevention programs, training activities, and so on) can be judged as congruent with the particular cultural precepts that provide people with a 'general design for living and patterns for interpreting reality' (i.e., giving meaning to) their reality."* That is the program emerges and is predictable from the cultural substance of the group being served. Cultural congruent refers to the need for services and programming to be in agreement and consistent with the cultural reality of the community being served. Wade Nobles and Lawford Goddard, 1993 / *Toward an African-centered Model of Prevention for African-American Youth at High-risk*

Culturally Proficient: A level of knowledge and skills used to successfully demonstrate interacting effectively in a variety of cultural environments; consistently demonstrate what you know about a given culture; performance *(Parham, 2004)*.

Culturally Relevant: Reacting to others cultural suggestions or appeals

Culturally Sensitive: Highly aware of personal beliefs about other cultures and assumptions, and exploring the reality by asking others to give information that verify personal assumptions.

Health: Total person well-being, be it physical, mental, social, spiritual, or psychological

Health Disparity: United States Public Law (P.L.) 106-525, Minority Health and Health Disparities Research and Education Act of 2000 (page 2498): "A population is a health disparity population if there is a significant disparity [difference] in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in the population as compared to the health status of the general population." Health disparities are the persistent gaps between the health status of minorities and non-minorities in the United States. DHHS, 2010 / *The National Plan for Action to End Health Disparities*

Institutionalized Racism: Refers to a systemic and systematic set of attitudes, beliefs, and behaviors within social systems that reinforces concepts and actions of racial inferiority or superiority

Internalized Racism: Self perpetuated oppression

LGBTQI: An acronym that refers to people who identify themselves as lesbian, gay, bi-sexual, transgender, queer, questioning, or intersex; a group of people who embrace same gender loving (SGL) sexual orientation

Prevention and Early Intervention (PEI): Prevention and early intervention means the component of the Three-Year Program and Expenditure Plan that consists of programs to (1) prevent serious mental illness/emotional disturbance by promoting mental health, reducing mental health risk factors and/or building the resilience of individuals, and/or (2) intervene to address a mental health problem early in its emergence. California Code of Regulations, Title 9, June 2010

Penetration Rate: California DMH penetration rate in the CSI database referred to as "Comparison of Total Clients to Holzer Targets" and "Percent Difference from Target." The penetration rate was calculated by using census data combined with estimates that were calculated by applying prediction weights (CSI, 2011). The rate is determined by dividing the number of unduplicated clients by the number of average monthly eligible individuals, and then multiplying that number by 100. California Department of Mental Health, 2011

Prevalence: California DMH prevalence data in the CSI database shows the number of youth who have serious emotional disturbances (SED) and the number of adults who have serious mental illnesses (SMI). [Prevalence is defined as the total number of cases of a disease in a population at a specific time *(Webster's Dictionary, 2009)]*. California Department of Mental Health, 2011

Race: A socially determined or generated designation to a group based on genetic traits

Racism: Racism refers to more than attitudes and behaviors of individuals, but includes concepts of power, stratification, and oppression. It is the institutionalization of the attitude of race prejudice through the exercise of power against a racial group defined as inferior. Carolyn B. Murray, 1998 / *Racism and Mental Health*, p 345

Social Determinants of Health: The complex, integrated, and overlapping social structures and economic systems that include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world. Scientists generally recognize five determinants of health in a population (CDC, 2011):

- Biology and genetics: such as, gender and age
- Individual behavior: such as, alcohol use, smoking, overeating, injection drug use
- Social environment: such as, discrimination, income
- Physical environment: such as, where a person lives, and crowded conditions
- Health services: such as, having or not having insurance, or access to quality care

Stakeholders: A person or organization with an invested interest

Strategic Planning: A disciplined effort to produce fundamental decisions and actions that shape and guide what organizations and communities will do, and why. The process requires the use of the best available information to make decisions now while considering future impact. Strategic planning requires broad scale information gathering, identification and exploration of alternatives, and an emphasis on future implications of present decisions. Strategic planning emphasizes assessment of the environment outside and inside the organization or community. R. Kaleba, (2006) / *Strategic Planning; Healthcare Financial Management,* 60(11):74-78

White Privilege: *"In critical race theory, 'White privilege' is a way of conceptualizing racial inequalities that focuses as much on the advantages that White people accrue from society as on the disadvantages that people of color experience."* Wikipedia Encyclopedia, 2011

LIST OF ACRONYMS:

CDE	Community Defined Evidence
CDMH	California Department of Mental Health
CRDP	California Reducing Disparities Project
CSI	Client and Services Information
DHHS	Department of Health and Human Services
GIS	Geographic Information System
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex
MHSA	Mental Health Services Act
MHSOAC	Mental Health Services Oversight and Accountability Commission
NAMI	National Alliance on Mental Illness
PEI	Prevention and Early Intervention
PTSD	Post Traumatic Stress Disorder
RFP	Request for Proposal
SAMHSA	Substance Abuse and Mental Health Services Administration
SMI	Severe Mental Illness
SPW	Strategic Planning Workgroup

DISCLAIMER:

Throughout this document the words Blacks and African Americans are used interchangeably. They refer to people of African ancestry irrespective of nationality. The terms are used interchangeably because many people continue to refer to themselves in this manner and reports, statistics, and other resources use the terms in this manner.

EXECUTIVE SUMMARY

The African American Health Institute of San Bernardino County, a non-profit 501c3 grassroots community-based organization, was awarded a $411,052 contract (#09-79055-006) to conduct the California Reducing Disparities Project (CRDP) for the African American population. Funds were made possible by the Mental Health Services Act (MHSA) 2004. Contract period was for two years, from March 1, 2010 to February 29, 2012. The primary deliverable of the contract was the development of a Reducing Disparities Population Report that would include an inventory of community-defined strength based promising practices, models, and/or other resources and approaches to help better address mental health needs. In addition, the Population Report will form the foundation for the final California Reducing Disparities Strategic Plan.

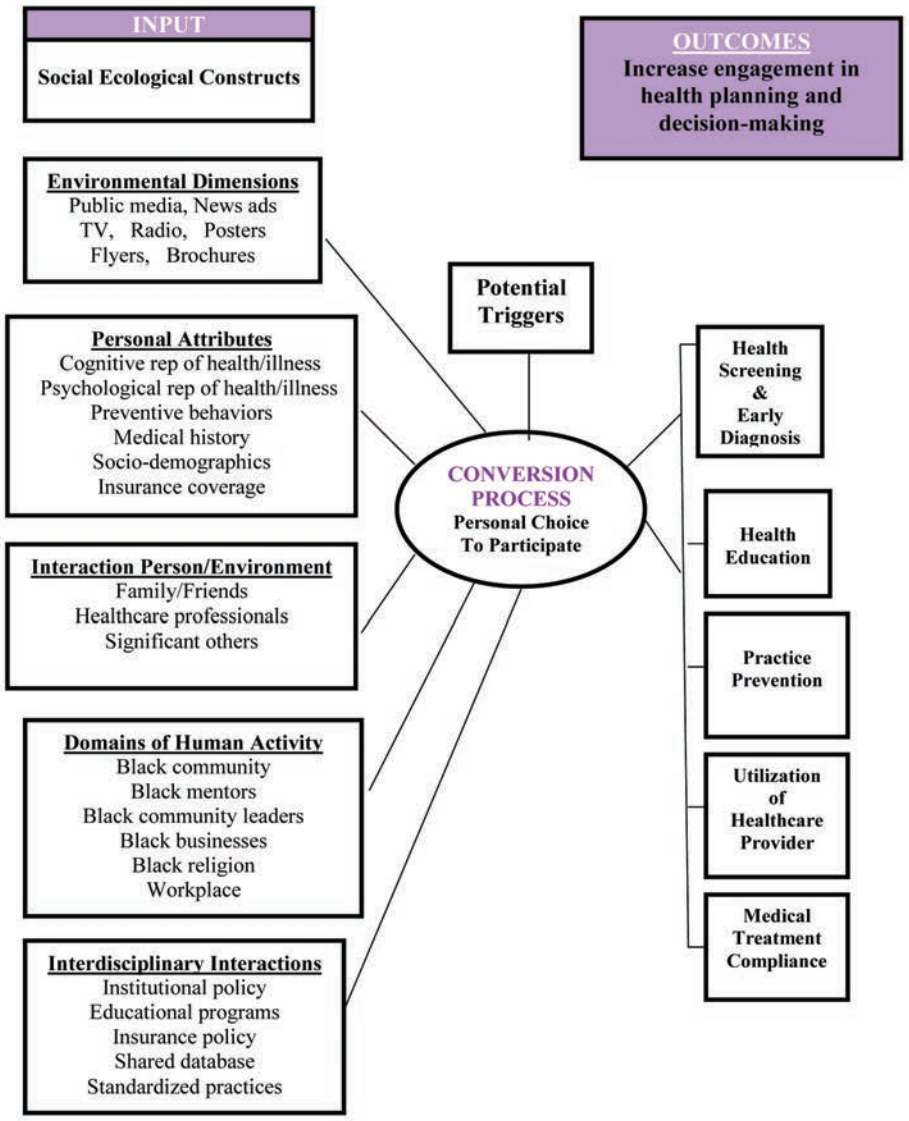
"We Ain't Crazy! Just Coping with a Crazy System" Pathways into the Black Population for Eliminating Mental Health Disparities is the population report created by the African American Strategic Planning Workgroup (SPW) during this contract period. It contains the most current disparity data and related information about mental and behavioral health prevention and early intervention (PEI) affecting the target population. Information in this report is about people of African ancestry living in California, including American citizens, Africans, Afro-Caribbean, Afro-Latino, Afro-Native American, Afro-Asian, Afro-Filipino, and African any other nationality.

"We Ain't Crazy! Just Coping with a Crazy System" is a descriptive investigative discovery of mental health issues and recommended community practices. Recommendations are based on meaningful practices as identified by the population.

DESIGN

The AAHI-SBC project design was framed according to a community grassroots engagement approach successfully implemented in the past by Dr. Woods while working with the Black population; see *Figure 1* our community engagement logic model (Woods et al.,2004a, Woods et al., 2004b; Woods, 2004c; Woods et al., 2006; Woods et al., 2008; Woods, 2009). Community-based participatory research (CBPR) methods were employed to implement a large scale population-based approach to engage Black people for project input from the beginning of the process unto the end.

A community grassroots ecological design was necessary based on the expressed needs of the population. According to their reported lived experiences Black people throughout California repeatedly expressed that their local DMH system has failed them and continue to do so. The population wanted assurance that participating in the CRDP and producing a population report was not going to be "business as usual." Participating in the CRDP was an affirmation that the population believed that the truth was going to be told. The Black population expressed they would **no longer be ignored, used, abused, or threatened, neither would they any longer tolerate inhumane, insensitive interactions from the local DMH system.** The CRDP design was to ensure that Black people had the freedom to comfortably share their perspectives without fear of retaliation or harm to client family members. This CRDP African American Population Report is the reality of Black people living in California and their experiences using the local DMH system for mental issues, as well as what they believe is needed for PEI.



A Social Ecological Logic Model Operationalize for the African American Health Initiative Planning Project in San Bernardino County, California (Woods, 2004c & 2009).

Figure 1: *A Community Engagement Logic Model*

NO EXCUSES. This report is not an excuse document. Our CRDP Population Report has been developed based on a fact finding approach. We have taken time to collect extensive data and present factual information based on the data collected. A strategic broad scale community-based approach was utilized to identify what Blacks in the State of California need for prevention and early intervention (PEI) of mental health issues.

We triangulated our fact finding approach to obtain a better insight into the issues and forthcoming recommendations. Therefore, a diverse Black population was engaged to include those affected by mental health issues, those who provide mental health services, as well as interested others. This approach involved **broad scale information gathering, identification and exploration of alternatives,** with emphasis on immediate actions and future implications. Special efforts were undertaken to identify expressed meaningful community-defined mental health practices and to make recommendations that would significantly change the way Blacks are treated and how they are provided mental health services in the State of California.

During the CRDP SPW efforts to create an African American Population Report to honor the request of the population for the truth to be told and that we must tell the "entire story" was the community driving force behind the process. We present the final CRDP results in a collection of several documents. Document #1 is the complete comprehensive report, *"We Ain't Crazy! Just Coping with a Crazy System" Pathways into the Black Population for Eliminating Mental Health Disparities.* It includes disparity data, a discussion on various barriers, a historical context, an overview of the California MHSA and how care is received and perceived by the population, presentation of various meaningful community practices as identified during statewide data collection with Blacks; policy, system, community and individual recommendations and resources. The *"We Ain't Crazy! Just Coping with a Crazy System" Executive Summary* (document #2) provides a snapshot of the CRDP community process used to develop the report, and highlights major project findings. A *"We Ain't Crazy! Just Coping with a Crazy System" Community Public Policy Brief* (document #3) is two pages and contains facts and major recommendations for the population. Finally, the collection of resources are separate published documents that include, a *Directory of California African American Mental Health Providers,* a compendium of *Black Mental Health Scholars and Scholarly Work,* a report on the *African American Practitioner Education and Training Curriculums in California,* in addition to specific county reports such as the *Los Angeles County African and African American Mapping Project* and the *Alameda County African American Utilization Study.*

STRATEGIC PLANNING PROCESS

The project was implemented in three stages: Phase 1, Phase 2, and Phase 3. A detailed discussion is included in Section D (page 123) of this report. The goal for Phase 1 was to establish the Strategic Planning Workgroup (SPW), and develop the background sections of the report. Utilizing the African American Health Institute of San Bernardino County's extensive statewide and national partnership network, diverse people of African heritage were contacted and invited to participate base on their availability to work on the project. Final SPW members, advisors and consultants totaled 58 individuals. A complete list of SPW members and their affiliation are included in *Appendix L*. Selected SPW members volunteered for a specific team assignment and agreed to work with the team based on a specific predetermined timeline for written project deliverables. The following individuals participated in key informant interviews and project pre-planning:

NAME	AFFILIATION	RESIDENT COUNTY & REGION
Valerie Edwards, LCSW	Clinical Social Worker	Alameda County, Northern & Bay Area
Richard Kotomori, MD	Psychiatric Medicine	Riverside County, Inland Empire
Walter Lam	African Immigrant Health, Consumer	San Diego County, Southern
Rev. James Gilmer, MA	Minister, Consumer	Ventura County, Los Angeles
Phyllis Jackson	Community Leader, Client Family Member, LGBTQI	San Diego County, Southern
Gloria Morrow, PhD	Clinical Psychologist	San Bernardino County, Inland Empire
Terri Davis, PhD	Counseling Psychology	Contra Costa County, Northern & Bay Area
Edward T. Lewis, MSW	California Black Social Workers Association	Sacramento County, Northern
Daramöla Cabral, DrPH	Epidemiology/Health Behavior	Alameda County, Northern & Bay Area
Stephanie Edwards, MPA	Resource Development, Client Family Member, LGBTQI	San Diego County, Southern
Suzanne Hanna, PhD	Marriage & Family Therapist	Riverside County, Inland Empire
Temetry Lindsey, DrPA	Mental Health Providers Assoc	San Bernardino County, Inland Empire
Erylene Piper-Mandy, PhD	Psychological Anthropologist	Los Angeles County, Los Angeles
Wilma Shepard, LCSW	Clinical Social Worker	Riverside County, Inland Empire
Carolyn Murray, PhD	Psychology	Riverside County, Inland Empire

Sequentially, an extensive literature review and archival resources were gathered on mental health in the Black population with emphasis on prevention and early intervention and published African American scholarly work. Over 200 articles were reviewed. This information was used to provide background data to guide the strategic planning process.

Phase 2 involved collecting information and data from the Black population. **Phase 3** was the final stage that included analyzing all data, writing the report, conducing validation meetings, finalizing the report, and collaboration in the development of the State Reducing Disparities Strategic Plan.

METHODS

We used a mixed methods approach framed in an ecological design to engage statewide community participation. Community-based participatory research methods used to engage the diverse Black population were regional focus groups, small group meetings, one-on-one interviews, public forums, and surveys using standardized processes, procedures and protocols. General information obtained from the population centered on good mental health and how to prevent mental issues, and how to intervene early when mental issues happen.

Participant recruitment targeted 19 different categories, such as: African American citizens, African immigrants, Africans (born in Africa), clients & family members, consumers, faith community, grassroots organizations, homeless, forensics, LGBTQI, substance abusers, foster care, older adults, musicians, artist, youth (students), government officials, mental health providers, social workers, Black mental health workers, educators, teachers, and academics. Each regional consultant was responsible for recruiting for project participation and for making sure regional input was maintained in the project. After initial data and information was collected and compiled in a draft population report, public forums were conducted in each region to validate report content and to obtain additional information from the population.

A total of **35** focus groups, **43** one-on-on interviews and **9** public forums were conducted; **635** surveys administered; and 6 small group meetings attended to collect data. See the summary participant demographics below across all target populations and methods of data collection.

A Matrix of the African American CRDP Participants across All Methods of Participation

	SPW, Advisors & Consultants	Phone & Email Surveys	Focus Group Participants	In-depth 1-on-1 Interviews	Small Group Attendees	Consumers, Clients, Client Family Member Surveys	Public Forum Attendees
TOTALS	**58**	**70**	**260**	**43**	**98**	**305**	**188**
Female	72%	70%	53%	46%	59%	68%	68%
Male	28%	30%	47%	54%	41%	32%	32%
LGBTQI[1]	1%	NA	9%	2%	13%	5%	3%
Age Range	28 - 73	NA	17 - 81	29 - 81	NA	18 - 82	18 - 82
Average Age	54	NA	46	56	NA	51	52
Consumer, Client & Client Family Member	57%	NA	69%	42%	65%	47%	35%

[1] LGBTQI = Lesbian, Gay, Bisexual, Transgender, Questioning/Queer, Intersex

MAJOR FINDINGS

A total of **1,195 "unduplicated" individuals** statewide participated in the African American CRDP, including SPW members, consultants, advisors, contractors, volunteers, as well as participants in focus groups, surveys, individual interviews and public forums.

Using the best available data, the African American population revealed alarming statistics related to mental health, such as high rates of serious psychological distress, depression, suicidal attempts, dual diagnoses, and many other mental issues. Co-occurring conditions with physical health problems such as high rates of heart disease, cancer, stroke, infant mortality, violence, substance abuse, and intergenerational unresolved trauma provides a complexity of issues that places the population in a **CRISIS** state. In the report we present the most recent California mental health data available to provide a visual picture of the population's condition.

In relationship to the Black population, the mental health system has offered inaccurate diagnoses, disproportionate findings of severe illness, greater usage of involuntary commitments, and a woeful inadequacy of service integration. The complexity of these factors has created an intense stigma in the Black community that disparages mental illness as "crazy" – a condition and a status that is viewed as personally caused and difficult to resolve. The Black population has rejected the label "crazy" and continues to work within their communities using strategies and interventions they know works to help their people overcome physical, social, emotional and psychological limitations and challenges.

But, data is missing that would clarify how "persons" use the mental health system, and the actual level of care received which is critical in determining how to prevent mental illness in the population. Findings in the CRDP are based on actual lived experiences of the Black population in California and documentation about the population and current mentail health system

RECOMMENDATIONS

As a result of reviewing the most current data available and information collected from the people, we provide several new thoughts and ideas about how to address a series of old, unresolved, interrelated issues that perpetuate disparities.

Participants were clear in articulating 274 PEI practices that are helpful at the individual, community and systems levels. If practices are implemented in counties, they could help to improve and enhance the existing mental health system, as well as assist in re-designing the system to align with culturally congruent practices for PEI in people of African heritage. Our CRDP African American Strategic Planning Workgroup has outlined a pathway into the Black population to eliminate mental health disparities as recommended by the people affected by mental health issues. If followed and supported offers a vision for permanent change.

However, complex, aggressive, and urgent actions are needed. Immediate responses are demanded by Black people based on what the population identifies as their need for help. NOT what the system wants to do that is easy or convenient for the system. The recommendations from the population need to be accepted to bring health and healing to people of African ancestry living in California.

NATIVE VISION:

A Focus on Improving Behavioral Health Wellness for California Native Americans

California Reducing Disparities Project

Native American Strategic Planning Workgroup Report

March 30, 2012

Dear Community:

As the Native Vision program director I am pleased to share with you the ***California Reducing Disparities Project (CRDP) Native American Population Report.*** The importance of this report is that it addresses Native behavioral health Prevention and Early Intervention (PEI) service delivery defined *by* Native American communities *for* Native American communities. Native behavioral health issues in California vary by community and stretch beyond PEI services. We must also consider mental health treatment and socioeconomic factors and how these all intertwine with traditional cultural practices and beliefs. This report includes Native American community member recommendations to address disparities, as well as strategies for creating culturally competent PEI to promote mental wellness of Native people throughout the state. This report highlights 22 community-defined practices identified by our Native American population. However, there are dozens, if not hundreds, of past and present practices that improve our Native behavioral health wellness. This report should be considered an ongoing process and not a definitive "final" report of Native American PEI practices in California.

The CRDP is a landmark undertaking and the first of its kind in the nation. It is a response to the call for action to reduce mental health disparities and seek solutions for historically underserved communities in California. The CRDP is focused on five populations: African Americans; Asian/Pacific Islanders; Latinos; Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ); and of course Native Americans. Our report was created for the Department of Mental Health (DMH) and funded by the Mental Health Services Act (MHSA). This report should not be intended as a "how to" manual but as a resource to connect with the PEI community projects referenced in the catalogue section of this manuscript as well as Native American communities across California.

Through funding from the MHSA, $60 million has been allocated to implement and evaluate community-defined PEI mental health practices for the underserved communities in the CRDP. Perhaps in 2013, an announcement will be made on how MHSA funding will support Native-specific PEI behavioral health projects. The success of the CRDP in our Native communities depends on your continued support and future participation. I look forward to working with you toward the improvement of behavioral health across the Native American population in California. Native Vision has been funded through the end of 2012 to conduct statewide forums, culminating in a behavioral health wellness conference.

I would like to thank the Native Vision 8-member advisory workgroup; the 11 Native communities in which information gatherings took place; staff with the Office of Multicultural Services at the California Department of Mental Health; the fellow CRDP population groups, coalition, and facilitator; and my fellow co-workers who assisted with the Native Vision project at the Native American Health Center. Thank you for helping make this report a reality.

This final report is available in electronic format on our Native American Health Center website www.nativehealth.org. You may also request printed copies by contacting NAHC —Native Vision, 3124 International Blvd., Oakland, CA 94601. Feel free to contact me directly at kurts@nativehealth.org

Sincerely,
Kurt Schweigman, MPH (*Lakota Tribe*)
Program Director, Native American California Reducing Disparities Project

Native Vision Project Statement

*The goal of **Native Vision** is to develop a culturally competent plan to improve behavioral health and well-being for Native Americans across California. **Native Vision** will bring forward community-defined solutions and recommendations from across the diverse Native American populations of tribal, rural, and urban California.*

TABLE OF CONTENTS

Acknowledgements

The Native American Strategic Planning Workgroup met over the course of 2 years to establish the strategic directions and recommended actions contained in this document. With workgroup participation, 11 statewide community-based regional meetings were held during the project to gather input on mental health issues from Native American community members, including youth, families, and behavioral health workers. One-on-one feedback and follow-up, semi-structured interviews, and site visits were also conducted to garner input for this report. We gratefully acknowledge all the communities who partnered with us to participate and provide personal and local input with the intent of creating meaningful local change.

The 8-member Native American Strategic Planning Workgroup Advisory Committee guided the project "in a good way" and represented the project statewide. The workgroup is made up of Native American behavioral health professionals from across the state of California. They have a rich knowledge and diverse background experience within the California Native American mental health arena. All workgroup members have Native American tribal affiliations.

Tony Cervantes, BA
Chichimeca
Native American Center for Excellence

Dan Dickerson, DO, MPH
Inupiaq
University of California Los Angeles

Michael Duran, MA
Apache
Indian Health Center of Santa Clara Valley

Carrie Johnson, PhD
Wahpeton Dakota
United American Indian Involvement

Janet King, MSW
Lumbee
Native American Health Center

Tene Kremling, LCSW
Yurok
Humboldt State University

Art Martinez, PhD
Chumash
Shingle Springs Tribal Health Program

Martin Martinez, CSAC II
Pomo
Redwood Valley Little River Band of Pomo Indians

The Native American Health Center, Inc. through the Native American Strategic Planning Workgroup (also known as the Native Vision Project), has developed a significant and meaningful community-based report to the State of California Department of Mental Health, Office of Multicultural Services. The Native Vision project has accumulated and provided community-defined best and promising strategies for addressing mental health disparities among Native Americans, particularly with regard to prevention and early intervention. This has been completed through the development and input of a workgroup that is broadly representative of the diverse Native communities throughout California, and by facilitating 11 community-based regional focus group gatherings over two years, and is documented in this report.

This report includes recommendations for community-identified tools, such as projects and programs, and grassroots community member recommendations to address disparities, as well as strategies for creating culturally competent prevention and early intervention to promote the mental well-being of Native people throughout the state. The Native American Health Center's Community Wellness Department staff that contributed to the project delivery and/or final report are listed below with accompanying tribal affiliations when appropriate.

Tenagne Habte-Michael, MBA
Cherokee/Creek
Program Evaluator

Janet King, MSW
Lumbee
Program Director

Jessica LePak, MSW
Oneida
Program Coordinator

Esther Lucero, MPP
Navajo
Program Director

Ethan Nebelkopf, PhD
Senior Advisor

Tommy Orange, BS
Southern Cheyenne
Media Coordinator

Kurt Schweigman, MPH
Lakota
Program Director

Nazbah Tom, MFT
Navajo
Program Director

Serena Wright, MPH
Interim Director

Part 3: Strategic Directions and Recommended Actions

Core Principles

The core principles for alleviating the mental health disparities of Native Americans in California must directly correlate to the root causes of the disparities. The disintegration of community empowerment and directed efforts to eliminate cultural responses to community ailments must be rectified through community reempowerment.

1. Respect the sovereign rights of tribes, and urban American Indian health organizations to govern themselves.
2. Support rights to self-determination for tribes and urban American Indian health organizations to determine and implement programs and practices that will best serve their communities.
3. Value Native American cultural practices as stand-alone practices, validated through community defined evidence.
4. Incorporate the use of Native American specific research and evaluation methods unique to each community.

"Donate Fallen Redwood trees so we can reestablish our tribal canoe making. This three-month process of making the canoe as a tribal group can maintain good mental health and wellness for our community."

-Native American Community Member

The right of all Native Americans to believe, express, and freely exercise their traditional spiritual and healing beliefs is a core principal to improve behavioral health wellness in California Native Americans. The American Indian Religious Freedom Act (AIRFA) of 1978 clearly states that it is federal policy "To protect and preserve for American Indians their inherent right to freedom to believe, express, and exercise the traditional religions of the American Indian, Eskimo, Aleut, and Native Hawaiians, including but not limited to access to sites, use and possession of sacred objects, and the freedom to worship through ceremonial and traditional rites." It is imperative to have appreciation for the traditional healing toward harmony and balance of Native American individuals, tribal agencies, and other Native American entities. Non–Native American entities must recognize the importance of supporting and respecting those healing practices. Mental health workers and consultants should be sensitive and respectful of traditional beliefs and practices, especially when attempts are made to meld Western-healing delivery services with traditional practices.

Recommendation 1: Empower Native Communities

1A. Native American communities in California need to be included on all levels of the California Reducing Disparities Project (CRDP). Many Native American agencies and tribes have data sources that represent the most accurate information and have added insight into the mental health needs of Native communities. CRDP's Native Vision program staff and the Native American Strategic Planning Workgroup Advisory Committee are optimally positioned to continue informing and advising the state on the best strategies for implementing programs that will have the greatest success in Native California. California tribes, Native American organizations, and rural and urban Native American health clinics need to be involved in the next steps of the CRDP to maintain the integrity of this initiative beyond the original 11 regional focus group meetings that took place for input toward this report. Native Vision recommends the staff and workgroup advise the state, reengage communities, and educate other communities

not reached by this project to promote the CRDP next phase implementation.

1B. Support cultural revival for tribal, rural, and urban communities. Strengthening cultural identity is a core value in promoting wellness for Native communities. Communities should be encouraged to revive community traditions, cultural practices, languages, and ceremonies, and address loss of cultural connection. These efforts should be supported as valid research to further identify what works for specific populations. Across the 11 focus group gatherings, community members voiced the importance of returning to Native American cultural practices to improve community mental health and well-being. This report contains community defined examples of cultural traditions that are an integral part of wellness. Many of these practices have predated European contact. The state and counties should consistently support such efforts.

Recommendation 2: Structure Funding and Implementation to Ensure Success for Native Americans

2A. Distribute next phase funds through a grant mechanism. Distribute the funding as a grant instead of as a Request For Proposal (RFP/RFA) process to ensure the process is streamlined and less time consuming. Granting the funds takes much less time and once set up it can be done in less than a month, while the RFP/RFA process takes up to six months or more. To maximize access, a simple application from each interested California Native American organization/tribe participating should suffice. If a California Native American organization/tribe is not interested in participating then it does not need to return the application by the due date. This is the same process that was used to distribute funds for the CalWorks Program for Mental Health and Substance Abuse Services for Indian Health Clinics. It reduces Native resistance to government control by empowering community fiscal responsibility for program funds.

2B. Support the communities receiving the funds. Distribution of next phase funding should be equal across the five CRDP population groups. Ensure the Native American specific grant program includes a strong linkage to technical assistance and training for every participating California Native American organization/tribe. The focus should include support regarding invoicing, data collection reporting, and evaluation. There should also be suitable funding for all operational needs, including direct services, outreach, data collection, reporting and evaluation, suitable staffing, overhead, travel, and miscellaneous. Funding should include consideration for traditional Native American cultural services and evaluation processes. It is important Mental Health Services Act (MHSA) resources beyond the next phase CRDP funding support Native American PEI practices. Nearly all the MHSA funding has been distributed to California counties to be administered. Through this additional funding, counties need to make a greater effort to engage and fund Native American communities within their respective counties.

2C. Apply a thoughtful assessment to the population estimates for communities. Do not solely utilize U.S. Census data to determine population numbers for funding of Native American communities. Racial misclassification and historical undercounts of California Native Americans are well documented and have not given a true representation of our population. Datasets that include American Indians and Alaska Natives alone or in combination with one or more races should be included in population counts. An adjustment factor should be applied to census data or an alternative means

of population counts should be used to develop a more accurate count of Native Americans. Many Native American agencies and tribes have data sources that represent a more accurate count.

2D. Ensure accountability of CRDP services to the community. As this funding is specifically targeting Native communities, it is crucial that Native American organizations/ tribes in California have streamlined access and input into resource dissemination and program responsiveness. A significant issue discussed repeatedly in focus groups is that many California counties are poorly allied to Native communities. They do not understand the need in Native American communities, do not know how to deliver services to our population, and have few Native people even access their services. If past performance is an indicator of future performance, it is difficult to trust that counties will allocate funds to ensure the cultural needs of the Native American community are addressed by their service offerings. Further, a keen knowledge of the community – which county government typically lacks – is essential to execute these programs or disseminate funding appropriately for the best outcome. To ensure accountability, Native American organizations and tribes need to have input into how programs will be responsive to the communities they serve and how services are implemented.

2E. Ensure oversight of services is culturally competent for Native Americans. Two specific strategies are recommended to support a more culturally competent and successful inroad into addressing the mental health disparities in Native American communities. First, we strongly recommend that funded projects be managed through the Office of Multicultural Services or other culturally competent entity at the State Level. Second, we recommend a strong Native American advisory council to be convened on a regular basis for the purpose of advising the management of the CRDP so as to best address mental health disparities in this community. The diverse needs of the many different Native American communities in California require broad representation. The current Native Vision advisory committee for this work would be an appropriate group to fill this role, as they reflect the diversity of Native California geographically, and culturally, are experts in the field of Native mental health, and have extensive familiarity with the CRDP. Culturally competent oversight and input will provide measured steps toward ensuring culturally relevant programs are administered more cohesively for Native Americans. It will also help prevent the "business as usual" that has existed in many county projects disseminated to Native American organizations/tribes. The Native Vision advisory committee can provide input on strategies to streamline bureaucracy without weighing down project implementation and evaluation in these communities and also ensure maximum dissemination of information about availability of resources. These steps would help assure those who provide input into this report that the state recognizes its own role in the ongoing disparities and that it is going to take practical steps to legitimately address them for the health of Native communities.

2F. Encourage the use of Native American practices. The grant administrator must be an entity that understands Native American practice–based services as well as best practice approaches. In addition, the grant should have language incorporated into it that encourages and supports American Indian approaches. Culturally relevant technical assistance and training and cross-site meetings should occur in order to encourage the use and uptake of practice-based services as well as to facilitate cross-fertilization of information. Regular meetings throughout the state, with all participating grantees/ contractors, will allow sharing of innovative ideas, service challenges, and successes in streamlining delivery.

"Western evaluation wants us (Natives) to prove our culturally based practices are effective; instead we should be telling them to prove our practices are not effective."

-Native American Community Worker

Recommendation 3: Use Community Driven Participatory Evaluation Strategies for Next Phase of the CRDP

3A. Ensure a community driven evaluation process. Require the use of community-based participatory research methods within each community. It is essential to move beyond "cookie cutter" paper surveys to community members and standardized forms to project staff as methods to evaluate the success of program implementation. Much as a community-based strategy has been used during the current phase of creating this report, it should be continued into the next phase with a strong grassroots evaluation strategy that is driven, literally, from the ground up.

3B. Use mixed methods evaluation to ensure strongest reflection of successes and challenges. Community-based participatory research and evaluation is rapidly becoming the most valid way of reflecting information and priorities from communities; however in order to ensure the most valid information it is often critical to use a combination of qualitative and quantitative evaluation methods. We strongly encourage the content of all evaluation to be driven by the community through a participatory process and that it utilize methods that are of the highest integrity to ensure validation of outcomes both from a community and a scientific perspective.

3C. Gather consent from communities as well as individuals. While it is traditional in mainstream practice to gather consent from individuals who engage in evaluation activities, it is essential to also gather consent from the communities where the work occurs. Much akin to the research world's Ethical Review Board, nearly every California Native American community has a panel of elders, council members, or community members who serve in this role within the community. It is important to respect the nature of Native Communities and engage the community leaders to ensure work is in alignment with community priorities. This is particularly relevant as we move toward evaluating best/promising practices that may be culturally based and provoke ethical sensitivities around documentation and evaluation.

3D. Set strict criteria for evaluation of cultural and traditional practices. It is essential to protect the integrity of Native American ceremonial knowledge, which is passed from individual to individual and usually is never written down. For evaluation purposes, when a ceremony is administered it must only report the input and outcomes. The ceremony itself may be described as to the purpose, but not the details. The leadership must set strict criteria for evaluation and description of cultural and traditional practices for entities reporting findings as part of the CRDP project.

3E. Utilize a consultant who is experienced conducting evaluation in Native American communities. Community-based participatory evaluation — the most appropriate model for research and evaluation in Native communities — focuses on involvement, development, participation, and empowerment, where the community is seen as the expert with the best ability to identify issues and solutions. This approach can be time-consuming and requires a unique set of evaluation skills on the part of the evaluation team. It is important that whoever is hired in this capacity has experience working in the Native American community and is familiar with the strong similarities between community-based participatory methods and cultural norms relating to evaluation methods. This

approach coupled with mixed-methods evaluation, will ensure that practice-based evidence is evaluated at the standard of evidence-based practices without sacrificing the integrity and need for community-driven evaluation questions and analysis. There are Native American specific evaluation methods available defined by tribes and Native American based organizations that can be utilized in the next phase of the CRDP.

"No one cares how much you know until they know how much you care."

-Native American Community Worker

3F. Ensure that each local community is reflected uniquely in its own evaluation process. Local community driven input and direction should be gathered for each community to reflect the range of values and issues seen as important for mental health prevention and early intervention. Information from each of these communities should be integrated to form a quantitative and qualitative evaluation that can be used statewide. If a Native American organization/tribe does not have capacity for evaluation, it is recommended to partner with the Indian Health Services California Tribal Epidemiology Center at the California Rural Indian Health Board or other Native American based research centers in California.

3G. Develop a community advisory board to ensure evaluation integrates traditional and culturally based services and ensure appropriate community involvement. Many counties do not have a clear understanding of what Native American culturally based services are and how they relate to Native American mental health, best practices, or even community-based evaluation processes. We recommend Native American organizations/ tribes do their own evaluation without relying on state or county evaluators who may not know about Native American issues. It is important that Native American grantees/ contractors not be forced into a prepackaged evidence-based service delivery system that is top down and culturally disengaged.

"If our communities are healthy, then people don't have as many mental emotional problems."

-Native American Community Member

Part 4: Next Steps

This report has highlighted 22 community-defined practices that improve behavioral health in California Native Americans. These are only a handful of all the existing community-defined practices, many of which are unique to a particular community, and some of which can be replicated and tailored to specific communities. There are many other Western-based and culturally based prevention and early intervention practices and activities that are effective, but not listed here. Based on the work of the Native Vision Project, it is overwhelmingly clear that the preservation and revitalization of cultural practices in our California Native communities is imperative for Native mental health. It is likely dozens, if not hundreds, of Native community defined PEI practices exist that are not listed in this report but may be worthy of funding in the next phase of the CRDP.

In order to effectively address mental health issues, it is essential that implementation and evaluation of the next phase of the CRDP be centered in the community and not rely upon a top-down approach. In order to provide our Native community with the maximum chances of successful intervention, the ideal is to work transparently and closely with all interested partners at the Mental Health Services Oversight and Accountability Commission (MHSOAC), and the California Mental Health Directors Association (CMHDA) and any other entities associated with the MHSA project. We strongly recommend maintaining the Native American workgroup as the state moves forward to ensure sustainability and effectiveness of program implementation. This is a landmark project for California—one where voters chose to take a momentous step toward rectifying serious and sustained mental health disparities—and the recommendations made herein are essential to transforming mental health in Native California. If the implementation is business as usual—funds channeled through the counties and/or lacking strong oversight from and accountability to Native communities—this project will undoubtedly fail.

Improving mental health in Native California depends greatly on many factors, including 1) the establishment of a least-bureaucratic management and oversight structure; 2) strong technical assistance and training support to tribal communities; 3) the continued inclusion of Native communities in all aspects of implementation and evaluation; 4) reduction or elimination of county-level oversight of programming; and 5) empowerment of Native communities in all aspects of the project.

California Reducing Disparities Projects

Asian Pacific Islander (API) POPULATION REPORT

In Our Own Words

Wellness 康健

Kalusugan

Haengh Wangc

Manuia

Nyob Nyab Xeeb

Mo'ui Lelei

Maika'i

CALIFORNIA REDUCING DISPARITIES PROJECT

ASIAN PACIFIC ISLANDER

STRATEGIC PLANNING WORKGROUP

THE ASIAN PACIFIC ISLANDER POPULATION REPORT:

In Our Own Words

Prepared For:

OFFICE OF HEALTH EQUITY

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

By:

Pacific Clinics on behalf of the API-SPW

JANUARY 2013

TABLE OF CONTENTS

LETTER FROM PROJECT DIRECTOR

This API population report is one of the end products of the Phase One of California Reducing Disparities Project API Strategic Planning Workgroup (CRDP API-SPW). It is with much excitement, appreciation and gratitude that we present this population report to the community on behalf of the API-SPW. Our 55 project members, steering committee members, consultants, and staff have put in tremendous amount of hours and work for the past two and half years. This report is the culmination of this effort that documents the disparities experienced in the community. It also offers recommendations to reduce these disparities.

CRDP is funded from the Prevention and Early Intervention (PEI) portion of the Mental Health Services Act (MHSA). It was administered by the Office of Multicultural Services (OMS) of the California Department of Mental Health since 2010 and will be administered by Office of Health Equality (OHE) of the California Department of Public Health (DPH). MHSA is designed with the unserved, under-served, and inappropriately served in mind. CRDP is one of the best examples illustrating this spirit. CRDP is one of a kind and is the largest investment in the nation to look into diverse community perspectives on mental health disparities. This is a ground-breaking project and we feel fortunate to be part of this project. We have received much interest from different parts of California, and even Washington, DC, during the development of this project. People are interested in learning from our California experience.

In order to maintain the community perspective, we have selected the grassroots approach in organizing the AANHPI (Asian American Native Hawaiian and Pacific Islander) communities from five regions in California. We have used a collaborative and strengthen-based philosophy to gather as much data from as many diverse sectors and representation as possible. This report is an authentic documentation of this journey and has been vetted through its members and a public review process. With the limited resources allotted, we were able to hold 30 regional meetings, 5 statewide meetings, 12 Steering Committee meetings, 23 focus groups, 8 community forums, and a statewide conference to gather information, formulate our recommendations, and share our findings.

At the dawn of the nation moving towards healthcare reform and the Affordable Care Act (ACA), we trust this report will offer helpful insights to improve our current mental health system and services. As gaining better access, providing quality services, and eventually lowering the cost in healthcare are the three pivotal principles in ACA, it will be critical to reference the key points of this report to better serve the AANHPI communities. We know the community holds a lot of experience and wisdom in working with AANHPIs. It is our hope that we will be able to continue the work via collaborating with local, regional, and statewide government entities to address and reduce the mental health disparities in the community. By working together, we have better chance of reducing disparities.

C. Rocco Cheng, Ph.D., Pacific Clinics
CRDP API-SPW Project Director

ACKNOWLEDGEMENTS

Over the last two years, the Asian Pacific Islander Strategic Planning Workgroup (API-SPW) had been given the task to engage various Asian Pacific Islander (API) communities in California to identify unmet mental health service needs and to collect community-defined strategies to address these needs. The goal was to identify the current state of disparities and to develop a strategic plan to reduce mental health service disparities in the API community based on input from community members, cultural experts, API-serving organizations, and other interested parties. During the course of the project, many individuals, agencies, and organizations have made generous contributions to this Project, including the development and completion of this report, with their time, knowledge, and expertise. Without the dedication and commitment from all those involved, this report would not have been made possible. Therefore, we would like to express our sincere appreciation to the following individuals and organizations (listed in alphabetical order by last name):

CRDP API-SPW Members:

Annie Ahn *(UC Irvine Counseling Center),* **Ellen Ahn** *(Korean Community Services),* **Noel Alumit** *(Asian Pacific AIDS Intervention Team Health Center),* **Jay Aromin** *(Kutturan Chamoru Foundation),* **Khatera Aslami** *(Peers Envisioning & Engaging in Recovery Services),* **Kavoos Bassiri** *(Richmond Area Multi-Services),* **Leina Bell** *(Samoan Community Council of San Diego),* **Laurel Benhamida** *(Muslim American Society – Social Services Foundation),* **Ben Cabangun** *(Asian and Pacific Islander Wellness Center),* **Ramon Calubaquib** *(Japanese Community Youth Council),* **Blia Cha** *(Hmong Women's Heritage Association),* **Christine Chang** *(Korean Community Services),* **Fam Chao** *(United Iu-Mien Community, Inc.),* **H. Nhi Chau** *(Oakland Asian Students Educational Services),* **Raymond Chavarria** *(United Cambodian Community),* **Ranjeeta Cheetry** *(South Asian Network),* **Sunjung Cho** *(Asian American Recovery Services),* **Jocelyn Estiandan** *(Asian Pacific Health Care Venture),* **Marita (Merly) Ferrer** *(Council of Philippine American Organizations),* **Koua J. Franz** *(Hmong Women's Heritage Association),* **Dixie Galapon** *(Union of Pan Asian Communities),* **Terry S. Gock** *(Asian Pacific Family Center),* **Mutsumi Hartmann** *(Asian Pacific Community Counseling),* **Calvin Hsi** *(Tzu Chi Foundation),* **Rimmi Hundal** *(South Asian Community Representative/Tri-City Mental Health Services),* **Connie Chung Joe** *(Korean American Family Service Center),* **Sam Joo** *(Koreatown Youth and Community Center),* **Christine Kim** *(Korean American Family Service Center),* **Sean Kirkpatrick** *(Community Health for Asian Americans),* **Ford Kuramoto** *(National Asian Pacific American Families Against Substance Abuse [NAPAFASA]),* **Phuong Lan Le** *(Vietnamese Federation of San Diego),* **Amy Lee** *(Oakland Asian Students Educational Services),* **Beatrice Lee** *(Community Health for Asian Americans),* **Joua Lee** *(Merced Lao Family Community),* **Kirk Lee** *(Hmong Cultural Center of Butte County),* **Vivian Lee** *(Little Tokyo Service Center),* **Laura Leonelli** *(Southeast Asian Assistance Center),* **Nancy Lim-Yee** *(Chinatown Child Development Center),* **Edwin Lin** *(Chinese Service*

Center of San Diego), **Jennifer Lin** *(Transitional Age Youth Representative/San Gabriel Valley Youth Council),* **Catherine Ofa Mann** *(To'utupu'o e Otu Felenite Association [TOFA]),* **Candice Medefind** *(Healthy House Within a MATCH Coalition),* **Marilyn Mochel** *(Healthy House Within a MATCH Coalition),* **Fawada Mojaddidi** *(Afghan Community Representative/Hume Center),* **Jeff Mori** *(Asian American Recovery Services),* **Palee Moua** *(Healthy House Within a MATCH Coalition),* **Hiroko Murakami** *(National Asian Pacific American Families Against Substance Abuse [NAPAFASA]),* **Desiree Nguyen** *(Vietnamese Community of Orange County),* **Tricia Nguyen** *(Vietnamese Community of Orange County),* **Amy Phillips** *(Little Tokyo Service Center),* **Sara Pol-Lim** *(United Cambodian Community),* **Myron Dean Quon** *(National Asian Pacific American Families Against Substance Abuse [NAPAFASA]),* **Yasuko Sakamoto** *(Little Tokyo Service Center),* **Farhana Shahid** *(South Asian Network),* **Leena Shin** *(Korean Community Services),* **Joty Sikand** *(Hume Center),* **Talaya Sin** *(Cambodian Community Development, Inc.),* **Dolly Solomon** *(Punjabi Community Representative/Healthy House Within a MATCH Coalition),* **Sharon Stanley** *(Fresno Interdenominational Refugee Ministries),* **Lily Lue Stearns** *(Asian Community Mental Health Services),* **Dong Suh** *(Asian Health Services),* **Angela Tang** *(Richmond Area Multi-Services),* **Ge Thao** *(Merced Lao Family Community),* **Ger Thao** *(Fresno Center for New Americans),* **Kao C. Thun** *(United Iu-Mien Community, Inc.),* **Lance Toma** *(Asian and Pacific Islander Wellness Center),* **Jonathan Tran** *(Southeast Asia Resource Action Center),* **Diane Ujiiye** *(Asian and Pacific Islanders California Action Network),* **Nilda Valmores** *(My Sister's House),* **Pa Kou Vang** *(Hmong Women's Heritage Association),* **Susan Vang** *(Hmong Health Collaborative),* **Benny Wong** *(SteppingStone – Golden Gate Day Health),* **Jorge Wong** *(Asian Americans for Community Involvement),* **Mandy Wong** *(Chinese Service Center of San Diego),* **Sally Wong-Avery** *(Chinese Service Center of San Diego),* **Franklin Yang** *(Fresno Interdenominational Refugee Ministries),* **Linda Yang** *(Lao Family Community of Stockton),* **Mee Yang** *(Lao Family Community of Stockton),* **Seng Yang** *(Hmong Cultural Center of Butte County),* **Rona Yee** *(Cambodian Community Development, Inc.),* **Jane Yi** *(Asian Community Mental Health Services),* **David Yim** *(Asian Pacific Planning and Policy Council [A3PCON] and Special Service for Groups – Older Adults Program),* **Nette You** *(Cambodian Community Development, Inc.),* and **Judy Young** *(Vietnamese Youth Development Center).*

CRDP Steering Committee:
Dixie Galapon *(San Diego/Orange County Regional Lead),* **Terry S. Gock** *(Los Angeles Regional Lead),* **D.J. Ida** *(CRDP Statewide Facilitator),* **Beatrice Lee** *(Bay Area Regional Lead),* **Laura Leonelli** *(Sacramento Regional Lead),* and **Susan Vang** *(Central Valley Regional Lead).*

Office of Health Equity, California Department of Public Health:
Marina Augusto *(Acting Deputy Director)* and **Kimberly Knifong**.

Other CRDP SPWs:

African American SPW *(Led by the African American Health Institute of San Bernardino County),* **Latino SPW** *(Led by the UC Davis Center for Reducing Health Disparities),* **Native American SPW** *(Led by the Native American Health Center),* **Lesbian, Gay, Bisexual, Transgender, & Questioning SPW** *(Led by the Equality California Institute and Mental Health America of Northern California),* **CRDP Facilitator/Writer** *(Led by the California Pan Ethnic Health Network),* and *the* **California MHSA Multicultural Coalition** *(Led by the Mental Health Association in California/Racial and Ethnic Mental Health Disparities Coalition [REMHDCO]).*

Mental Health Services Oversight and Accountability Commission:

David R. Pating *(MHSOAC Commissioner; Chief of Addiction Medicine, Chemical Dependency Recovery Program, Kaiser Permanente).*

County Ethnic Service Managers and Staff:

Myriam Aragon *(Riverside County),* **Felix Bedolla** *(Napa County),* **Clayton Chau** *(Orange County),* **Connie Cha** *(Fresno County),* **Gigi Crowder** *(Alameda County),* **Pete Duenas** *(Stanislaus County),* **Piedad Garcia** *(San Diego County),* **Jesse Herrera** *(Monterey County),* **Jo Ann Johnson** *(Sacramento County),* **Sharon Jones** *(Merced County),* **Veronica Kelley** *(San Bernardino County),* **Gladys Lee** *(Los Angeles County),* **Edwin Lemus** *(San Bernardino County),* **Sanjida Mazid** *(Solano County),* **Imo Momoh** *(Contra Costa County),* **Janine Moore** *(Riverside County),* **Nelson Jim** *(San Francisco County),* **Moises Ponce** *(Riverside County),* **Barbara Ann White** *(City of Berkeley),* **Deane Wiley** *(Santa Clara County),* and **Chong Yang** *(Stanislaus County).*

Others:

Hon. Mike Eng *(California Assembly Member, 49th District),* **Rachel Guerrero** *(Former Chief, Office of Multicultural Services, California Department of Mental Health),* **Michael Guitron** *(Director of Information Systems, Pacific Clinics),* **Adrienne Hament** *(California Mental Health Planning Council),* **Larke Nahme Huang** *(Senior Advisor, Substance Abuse and Mental Health Services Administration [SAMHSA]),* **Lydia Ko** *(Team Coordinator, Asian Pacific Family Center – East),* **Daphne Kwok** *(Chair, President Obama's Advisory Commission on Asian Americans and Pacific Islanders),* **Susan Mandel** *(President/CEO, Pacific Clinics),* **Kim Saing** *(Center for Human Services,)* **Anne Saw** *(Associate Director, Asian American Center on Disparities Research, UC Davis),* **Winston Tseng** *(Research Sociologist, UC Berkeley),* **Simon Wai** *(Program Director, Asian Pacific Family Center – East),* **Wendy Wang** *(Corporate Director of Community Education, Outreach, and Public Policy, Pacific Clinics),* **Randolph Lee Welty** *(Web Designer, Pacific Clinics),* and **Nolan Zane** *(Chair, Department of Asian American Studies; Director, Asian American Center on Disparities Research, UC Davis).*

Focus Group facilitators:
Elma Bataa, Alex Baty, Olivia Byler, Supatra Chowchuvech, Sally Jue, Pa M. Khang, Napaporn Limopasmanee, Natasha Molony, Loa Niumeitolu, T. Sitra, and **Paul Thao.**

In particular, we would like to thank all our 198 focus group participants who shared their experience, time, and wisdom with us to ensure that direct voices from the community were represented in the report. We are immensely grateful for their trust and join them in their hope that this report will lead to significant changes in helping those in need receive the care they deserve.

EXECUTIVE SUMMARY

BACKGROUND OF THE MHSA AND CRDP

THE MENTAL HEALTH SERVICES ACT

California voters passed Proposition 63, now known as the Mental Health Services Act (MHSA), in November 2004 to expand and improve public mental health services and establish the Mental Health Services Oversight and Accountability Commission (MHSOAC) to provide oversight, accountability and leadership on issues related to pubic mental health.

At that time, California's public mental health funding was insufficient to meet the demand for services and was frequently portrayed as a ~~"f~~ail-first" model. However, with the inception of MHSA, there was the alternative ~~"h~~elp-first" model that promised to transform exiting public mental health system. MHSA consists of five components: (1) Community Services and Supports (CSS) – provides funds for direct services to individuals with severe mental illness; (2) Capital Facilities and Technological Needs (CFTN) – provides funding for building projects and increasing technological capacity to improve mental illness service delivery; (3) Workforce, Education and Training (WET) – provides funding to improve the capacity of the mental health workforce; (4) Prevention and Early Intervention (PEI) – provides historic investment of 20% of the MHSA funding for outreach programs for families, providers, and others to recognize early signs of mental illness and to improve early access to services and programs to reduce stigma and discrimination; (5) Innovation (INN) – funds and evaluates new approaches that increase access to the unserved and underserved communities, promote interagency collaboration and increase the quality of services.

THE CALIFORNIA REDUCING DISPARITIES PROJECT

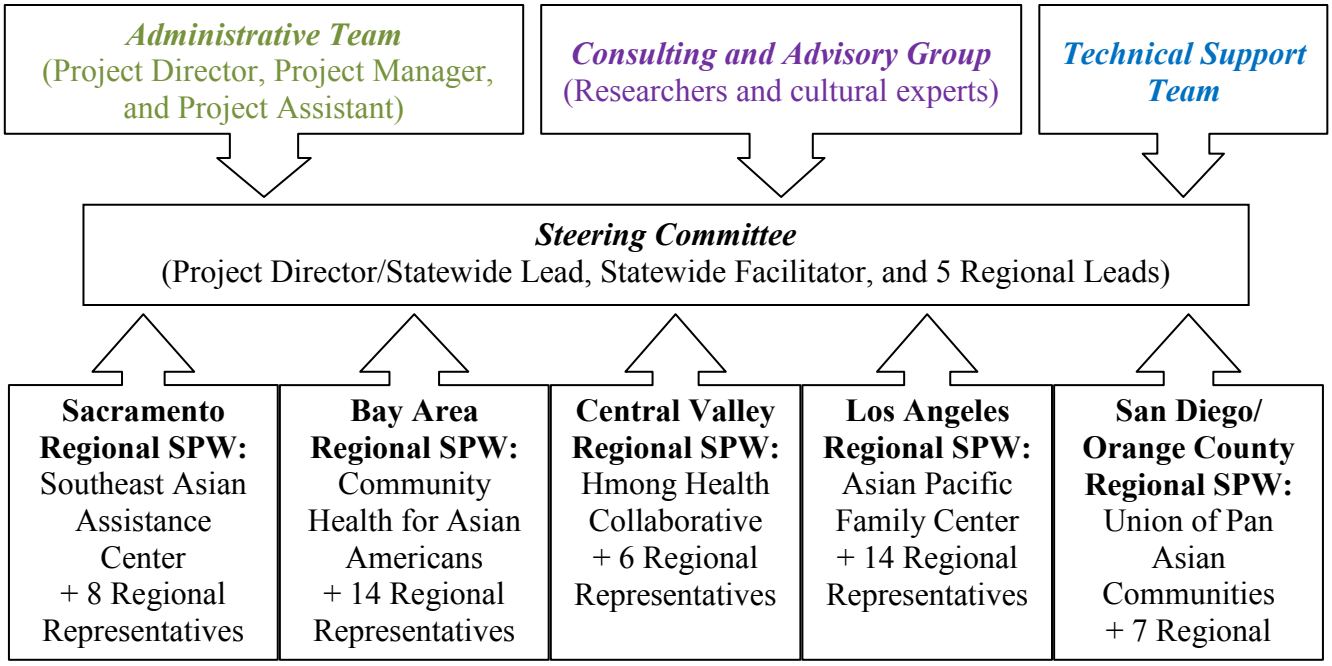
In response to the call for national action to reduce mental health disparities and seek solutions for historically underserved communities in California, the Department of Mental Health (DMH), in partnership with Mental Health Services Oversight and Accountability Commission (MHSOAC) called for a key statewide policy initiative as a means to improve access, quality of care, and increase positive outcomes for racial, ethnic, and cultural communities. In 2009, DMH launched the two-year statewide Prevention and Early Intervention (PEI) effort with state administrative funding and created this California Reducing Disparities Project (CRDP).

CRDP is funded from the PEI portion of the Mental Health Services Act (MHSA). It was administered by the Office of Multicultural Services (OMS) of the California DMH since 2010. MHSA is designed with the unserved, under-served, and inappropriately served in mind. CRDP is one of the best examples illustrating this spirit. CRDP is one of a kind and is the largest investment in the nation to look into diverse community perspectives on mental health disparities.

CRDP is divided into seven components. Five of these components covered the five major populations in California: African American,

Asian/Pacific Islanders (API), Latinos, Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ), and Native Americans. Each of these five populations formed a Strategic Planning Workgroup (SPW) in developing population-specific reports (strategic plans) that will form the basis of a statewide comprehensive strategic plan to identify new approaches toward the reducing of disparities. In addition to these five SPWs, there is the California MHSA Multicultural Coalition (CMMC) to inform the integration of cultural and linguistic competence in the public mental health system. The final component of the CRDP is the Strategic Plan writer/facilitator to integrate the five population reports into a single strategic plan to illustrate community-identified strategies and interventions that will address relevant and meaningful culturally and linguistically competent services and programs.

Figure II-1: ***Asian Pacific Islander (API) Strategic Planning Workgroup (SPW) - Leadership & Organizational Structure***



SUMMARY OF THE CRDP API-SPW

LEADERSHIP AND ORGANIZATIONAL STRUCTURE

To ensure that the input from the ethnically diverse and geographically dispersed Asian American, Native Hawaiian, and Pacific Islander (AANHPI) communities in California were adequately included in the strategic planning process, a multi-tiered leadership and organizational structure in the form of an API Strategic Planning Workgroup (hereafter called –API-SPW") was created, as illustrated above.

The Steering Committee and Regional Strategic Planning Workgroups

The Steering Committee provided leadership, oversight, and progress monitoring for the project. The responsibilities of the Steering Committee were to refine and integrate regional community-driven concerns and solutions before presenting them at the statewide API-SPW meetings for further review, discussion, and decision-making. Including the five regional lead agencies and the statewide lead agency, there were a total of fifty-five member agencies, organizations, and individuals forming five Regional Strategic Planning Workgroups in California. Each of the five regions was led by an agency with established involvement in local communities. These regional workgroups met regularly to discuss disparity issues and to identify community-driven responses to these disparities. A total of thirty-six meetings were held, including five statewide meetings, thirty regional meetings, and one statewide project conference.

OVERVIEW OF THE ISSUES

The AANHPI populations are among the fastest growing racial groups in the United States, according to the 2010 Census. 32% of the Asian population and 23% of the NHPI population in the U.S. reside in California, where the AANHPI communities represent 15.5% of the state‘s population. Even though AANHPIs are thought to have low prevalence rates for serious mental illness and low utilization rates of mental health services according to some literature, there is evidence that has shown otherwise. For example, as reported by the Asian & Pacific Islander American Health Forum based on the 2008 data by the Center for Disease Control, NHPI adults had the highest rate of depressive disorders and the second highest rate of anxiety disorders among all racial groups. AANHPI women ages 65 and over consistently have had the highest suicide rate compared to other racial groups. AANHPIs may have more reluctance towards seeking help due to reasons such as stigma, language barrier, lack of access to care, and lack of culturally competent services. Moreover, even though AANHPIs are often grouped as one, many differences exist among various ethnic subgroups in areas such as language, culture, religion, spirituality, educational attainment, immigration pattern, acculturation level, median age, income, and socioeconomic status. However, the heterogeneity among the AANHPIs is rarely recognized or reflected in research and data collection, and the lack of disaggregated data continues to worsen the issues of disparity in mental health services for AANHPIs.

EXISTING ISSUES AND CHALLENGES

NATURE OF DISPARITIES

Despite the diversity in the AANHPI populations and the uniqueness of each geographic region, there are many more similarities than differences as far as barriers contributing to mental health service disparities are concerned. Many of these barriers are interrelated, as one barrier frequently and consequently would add disparities to another. The following is the list of barriers identified by the API-SPW:

Lack of Access to Care and Support for Access to Care

- Logistical challenges such as transportation, hours of operation, and location.
- ~~"~~Medical necessity" may not take cultural specific conditions and symptoms into consideration.
- Lack of proper insurance and affordable services.

Lack of Availability of Culturally Appropriate Services

- Challenges in finding culturally appropriate services.
- Long waiting period to receive culturally appropriate services.
- Current billing guidelines do not allow sufficient time to establish rapport and trust needed for culturally competent care.
- Culturally appropriate service components, such as interpretation and integration of spirituality, are often not ~~"~~billable."

Lack of Quality of Care

- Linguistic and cultural match is important, yet often unavailable.
- Even with cultural and/or linguistic match, quality of care may still be inadequate as availability of bicultural and bilingual staff does not automatically make a program culturally appropriate.
- Cultural factors as determined by the community often are not included in the definition of quality of care.

Language Barrier

- Many AANHPIs have limited proficiency in English and thus the lack of services and workforce needed in API languages becomes a barrier to access, availability, and quality of care.
- Interpretation services are often ineligible for reimbursement and therefore may be unavailable due to funding restrictions.
- It can be challenging to find interpreters with sufficient familiarity with mental health terminology to effectively communicate the information in culturally acceptable terms.
- Many of the promotional and informational materials are not translated or the translation is not always culturally or linguistically appropriate.

Lack of Disaggregated Data and Culturally Appropriate Outcome Evaluation

- Lack of disaggregated data results in difficulties in establishing, assessing, and addressing needs.
- Many strategies have been developed by the AANHPI community, and yet there have been few resources made available to help the community assess the effectiveness of such community-driven responses from the perspective of the AANHPI community.
- Due to cultural differences, conventional assessment tools developed based on Western cultures may not be appropriate for evaluation of community-driven programs and strategies.

Stigma and Lack of Awareness and Education on Mental Health Issues

- The issue of stigma remains significant and deters many AANHPIs from seeking needed services.
- In many AANHPI languages, there is no proper translation for ~~"~~mental health" without some kind of negative connotation.

- There is a lack of resources to support culturally appropriate strategies to reduce stigma and to raise awareness of mental health issues in the AANHPI community.
- There are insufficient resources to support stigma-reduction efforts such as educating and collaborating with community partners like primary care providers, spiritual leaders, and schools.

Workforce Shortage

- The development and retention of culturally competent workforce continues to be a major challenge.
- Current training models often do not encourage or include experience working with the AANHPI populations, let alone in a culturally competent program.
- Limited job opportunities and lack of supportive work environment also contribute to the shortage of workforce.
- Outreach workers are usually not supported with adequate training and resources under the current systems despite their importance and effectiveness in outreach and engagement.

MANIFESTATIONS OF DISPARITIES IN THE AANHPI COMMUNITIES

The structure of the API-SPW was designed to include representations from as many AANHPI communities as possible. Additional efforts were also made to include voices directly from the community members through focus groups. A total of 23 focus groups were conducted in five regions to capture perspectives and sectors of the AANHPI communities that may not be well represented by the 55 workgroup members. A total of 198 AANHPI community members participated in the focus groups:

Table II-1: ***Focus Group Participants – Gender and Age***

Female	Male	< 18	19-25	26-59	60+
118	80	13	27	118	40

Due to stigma towards mental illness and given the cultural preference for a holistic view of ―health,‖ the API-SPW deliberately chose the term ―wellness‖ for the focus group discussions. The following are summaries of the responses from the focus group participants:

Definition of ―Wellness‖

As indicated by the participants, ―wellness‖ would mean: (1) being physically healthy and active, (2) being emotionally well, (3) having good social relationship and support, (4) having good family relationship, (5) being financially stable, and (6) feeling at peace/spirituality.

Factors Affecting ―Wellness‖

As indicated by the participants, factors that would negatively affect ―wellness‖ were: (1) adjustment issues such as living in a new, fast-paced environment and language difficulty, (2) family issues, (3) financial issues, (4) sense of hopelessness, and (5) health issues and high cost of healthcare.

Manifestation of Metal Health Issues

When asked how one can tell ―wellness‖ is being compromised, the participants suggested considering the following signs: (1) acting out towards others, (2) expression of hurtful feelings, (3) sense of hopelessness, (4) poor health/eating habits, (5) disobedience, and (6) turning inwards.

Available Resources

The participants named resources they would turn to first when help is needed: (1) spirituality, such as healers, religious ritual/practice, and religious centers, (2) loved ones, (3) physical activities, (4) traditional medicine, (5) physicians, (6) mental health professionals, (7) community-based organizations, (8) family/friends, and (9) don't know where to go.

Barriers to Seeking Help

The participants identified the following barriers when they attempted to seek help for themselves or for their family: (1) lack of culturally competent staff and services, (2) issues related to stigma, shame, discrimination, confidentiality, and reluctance to "bear the truth," (3) lack of language skills, (4) lack of financial resources, (5) transportation, (6) complexity of healthcare systems and paperwork, (7) not comfortable with non-AANHPI providers, and (9) unfamiliarity with Western treatment model.

Strategies to Address Unmet Needs

The participants were asked to name services that would meet some of their needs if they could be made available: (1) programs for a specific culture, issue, topic, or age group, (2) social/recreational activities, (3) services in primary language, (4) availability and affordability, (5) more outreach effort to counteract stigma, (6) inclusion of family, and (7) culturally sensitive/competent staff.

COMMUNITY-DEFINED STRATEGIES

CORE COMPETENCIES

While it may have been a widely accepted notion that cultural competence is required when working with the AANHPI communities, the definition of "cultural competence" may still need to be further clarified. The definition of "cultural competence" may also vary from culture to culture and from ethnicity to ethnicity. As the API-SPW set out to define core components of cultural competence, the workgroup agreed on common elements and developed a list of core competencies, which was divided into eight categories with each category further divided into three levels, as shown in Table II-2. The three levels were devised to highlight the importance to conceptualize cultural competence beyond the individual level, as it would take recognition and support from organizations and systems to make cultural competence possible and meaningful. While the API-SPW realized that some may view this list as too overreaching, it was hoped that this list would serve as a guideline when one considers what constitutes cultural competence. Details of each component can be found in Section VI of the report.

Table II-2: ***Summary of Core Competencies***

	PROVIDER LEVEL	AGENCY LEVEL	SYSTEMS LEVEL
Professional Skills	▪ Must have training to provide culturally appropriate services and interventions. ▪ Ability to effectively work with other agencies and engage with community. ▪ Clear understanding of PEI strategies and relevant clinical issues. ▪ Knowledge about community resources and ability to provide proper linkage.	▪ Employ, train, and support staff that possess the necessary professional skills. ▪ Capacity to provide needed linkage to other agencies.	▪ Recognize the importance and provide support for the development and retention of professionally qualified and culturally competent workforce. ▪ Support the capacity to provide linkage.
Linguistic Capacity	▪ Proficiency in the language preferred by the consumer OR ▪ Ability to work effectively with properly trained interpreter.	▪ Employ, train, and support staff that possesses proficiency in the language preferred by the consumers. ▪ Provide language appropriate materials. ▪ Provide resources to train interpreters to work in mental health setting.	▪ Recognize the importance and provide support for the development and retention of linguistically qualified workforce. ▪ Provide resources to support bilingual staff and reimbursement for the service, including interpreters. ▪ Provide resources for preparing and printing bilingual materials.
Culture-Specific Considerations	▪ Respect for and clear understanding of cultural/historical factors including history, values, beliefs, traditions, spirituality, worldview, sexual orientation, gender identity, gender differences, cultural beliefs and practices, and acculturation level/experiences. ▪ Recognize the importance of integrating family and community as part of services.	▪ Provide ongoing training and supervision on cultural and language issues. ▪ Board members should reflect the composition of the community. ▪ Culture-specific factors should be considered and incorporated into program design. ▪ Support the integration of family and community as part of the service plan. ▪ Develop policies that reflect cultural values and needs of the community including physical location, accessibility and hours.	▪ Actively engage ethnically diverse communities. ▪ Funding should allow culture-specific factors to be considered and incorporated into services appropriate for that cultural community.
Community Relations & Advocacy	▪ Ability to effectively engage community leaders and members. ▪ Ability to form effective partnerships with family. ▪ Willingness and ability to advocate for needs of the consumers.	▪ Capacity to effectively engage the community. ▪ Credibility in the community. ▪ Capacity and willingness to advocate for systems change aiming to better meet community needs.	▪ Encourage and support culturally appropriate efforts for community outreach and community relationship-building. ▪ Recognize the importance and provide support for collaboration with community leaders. ▪ Promote cultural competency.

	PROVIDER LEVEL	AGENCY LEVEL	SYSTEMS LEVEL
Flexibility in Program Design & Service Delivery	▪ Flexibility in service delivery in terms of method, hours, and location. ▪ Understand and accommodate the need to take more time for AANHPIs to build rapport and trust.	▪ Capacity to allow flexibility in service delivery (e.g.: more time allowed for engagement and trust building for consumers/ family members; provide essential services to ensure access to services, such as transportation, available hours of operation, and convenient location). ▪ Program design should consider community-based research, culture, and traditional values so it will make sense to the consumers. ▪ Willingness to look for innovative venue for outreach, such as ESL (English as a Second Language) classes.	▪ Recognize the importance and support more time needed for engagement and trust building. ▪ Recognize the importance and support essential ancillary services needed to ensure access to services. ▪ Recognize the importance and support flexibility in service delivery. ▪ Encourage and support programs that include community-based research and/or community-designed practices. ▪ Flexibility in diagnostic criteria to accommodate cultural differences. ▪ Provide support for innovative outreach.
Capacity Building	▪ Ability to empower consumers, family members, and community. ▪ Capacity to collaborate with other disciplines outside mental health.	▪ Capacity to educate the community on mental health issues. ▪ Capacity to collaborate with other sectors outside mental health, such as primary care and schools. ▪ Plan in place to groom the next generation leaders and staff for the future. ▪ Capacity to provide cultural competence training to mental health professionals and professionals from other fields.	▪ Provide support for capacity building within the agency and within the community. ▪ Provide support for future workforce development. ▪ Encourage and support outreaching and educating the community on mental health issues. ▪ Provide support for cultural competency training. ▪ More involvement of the community in the policy-making process. ▪ Provide support for a central resource center.
Use of Media		▪ Capacity to utilize ethnic media and social media for outreach.	▪ Encourage and support the use of ethnic media and technology for outreach.
Data Collection & Research		▪ Collect disaggregated data. ▪ Work with researchers and evaluators to assess effectiveness of programs and services.	▪ Provide support for disaggregated data collection. ▪ Support ethnic/cultural specific program evaluation and research. ▪ Support research to develop evidence-based programs (EBPs) for AANHPI communities.

SELECTION CRITERIA FOR PROMISING PROGRAMS AND STRATEGIES

One of the major tasks given to the API-SPW was to identify community-defined promising programs and strategies to reduce existing disparities in the AANHPI community. Over the years, despite limited resources, programs and strategies were developed to respond to the unmet needs in the community. However, not every program or strategy had been necessarily effective or culturally appropriate. Moreover, the challenge remains as to how to adequately assess the effectiveness of a culturally competent program or strategy. Therefore, based on the core competencies defined by the API-SPW, the focus group findings, and the decades of experiences serving the AANHPI community, the API-SPW set out to establish criteria to be used as the parameters for selecting culturally competent promising programs and strategies to serve the AANHPI populations. While recognizing this list may be somewhat ambitious given the limited resources available, the API-SPW aimed to create a list as comprehensive as possible. This list served as a guideline for the API-SPW to identify and collect community-defined promising programs and strategies. It was also hoped that this list would be used in the future to determine whether a program or a strategy is culturally appropriate for the intended population. The following is a summary of the criteria established by the API-SPW:

Table II-3: ***Selection Criteria for Promising Programs and Strategies***

PROGRAM DESIGN	
Goals/Objectives	• Does the program have clearly stated goals and objectives?
PEI-Specific	• Is the focus of the program primarily on prevention and early intervention (PEI)?
Focus on Addressing API Community-Defined Needs	• How well does the program clearly identify and address needs in the API community (as voiced by community members, leaders, and stakeholders)? • Did the program have input from the community in the design and evaluation of the program? • Does the program have relevance in supporting the overall wellness in the community?
Addressing Culture/ Population-Specific Issues	• Is the program designed for a specific target population such as gender, ethnic group, cultural group, and age group? • How well does the program integrate key cultural elements into its design (e.g.: oral history, spiritual healers, other cultural components or practices)? • How well does the program demonstrate sensitivity to cultural/linguistic/historical issues (e.g.: immigration, level of acculturation, spirituality, historical trauma, cultural identity, etc.)?
Community Outreach & Engagement	• How well does the program outreach to the community in a culturally appropriate manner (e.g.: staff who are sensitive to working with the community, use of bilingual materials, use of ethnic/mainstream media and social media, etc.)? • How well does the program promote wellness through outreach, education, consultation, and training? • How well does the program use consumers, family members, and community members in their outreach efforts?
Model	• How well does the program promote wellness and follow a strength-based model (e.g.: increase life management skills, increase ability to cope and make healthy decisions, improve communication between family members, etc.)? • How well does the program strengthen and empower the consumers and community members? • Is the program design based on a theory of change that reflects cultural values or has some cultural relevance? • Does the program provide a reasonable logic model? • How well does the program describe its various components and are they related to the stated goals and objectives?
Replicability	• Can the program demonstrate how it can be replicated (across communities that are ethnically and geographically diverse)? • Does the program have the capacity to offer training and development to other agencies if resources are made available? • Does the program have the capacity to offer culturally and linguistically appropriate PEI strategies?

Advocacy	• How well does the program empower the consumers and community members to advocate for their needs? • How well does the program address or contribute to systems change (e.g.: promote social justice, reduce disparities, reduce stigma and discrimination in the area of mental health, etc.)? • How well does the program help to generate community actions in moving towards wellness in the community?
Capacity Building	• How well does the program develop and form community-wide collaboration with other community stakeholders (e.g.: primary care, social services, schools, spiritual leaders, traditional healers, faith-based organizations, and law enforcement)? • How well does the program lead to strengthening and empowering the community (e.g.: enhance social supports in the community, help to reduce stresses in the community such as acculturative stresses or generational cultural conflicts, develop and support leadership and ownership of the community)?
Sustainability	• How well does the program leverage existing resources available in the community? • How will the program be self-sustainable when funding ends?
Accessibility	• How well does the program address barriers to accessibility (e.g.: hours of operation, location, child care, language, transportation, etc.)?
PROGRAM EVALUATION/OUTCOME	
Program Evaluation/ Outcome	• Has the program been evaluated? • Do the outcomes support the program goals and objectives? • How were participants, providers, and cultural experts involved in the evaluation process (e.g.: testimony/endorsement/self report/satisfaction survey from consumers/families/community, observations and reports from service providers, consensus of cultural experts)?
AGENCY CAPACITY	
Staffing	• Does the program have staff that possesses the necessary professional and/or relevant skills to effectively do their job? • Does the program have staff who are culturally and/or linguistically competent? • Do the board and management of the organization reflect the community the program is intended to serve?
Staff Training & Development	• Does the program offer ongoing support and training for its staff?
Organizational Capacity	• Does the program/agency have established history of working in the community? • Is the program operated under an agency that has been consistently providing good and reliable services to the community?

NOMINATION/SUBMISSION/REVIEW OF COMMUNITY-DEFINED PROGRAMS AND STRATEGIES

With the selection criteria established, the API-SPW started the process of nominating, submitting, and reviewing community-defined, culturally appropriate programs and strategies. The process took about six months to complete. Fifty-six promising programs and strategies were submitted and reviewed by twenty-six peer reviewers. Complete submissions can be found in the Appendix Section in the API Population Report. As the needs and history of each AANHPI community vary, the programs and strategies in response may also vary in the stages of development. Therefore, four categories of submissions were devised to include programs and strategies at various stages of development, as shown in Table II-4.

The fact that almost half of the programs were in Category 1 indicates that while programs have been developed in response to community needs, many simply lacked the resources for evaluation. There are also many innovative strategies worth considering. This strongly speaks to the need to have more resources allocated to support evaluation of existing programs and to help expand innovative strategies to more comprehensive programs. The 56 submissions covered all age groups from children, youth, young adults, adults, to older adults. Together, they also served 24 distinctive ethnic groups: Afghani, Bhutanese, Burmese, Cambodian, Chamorro, Chinese, Filipino, Hmong, Indian, Iranian, Iraqi, Iu-Mien, Japanese, Korean, Lao, Mongolian, Native Hawaiian, Nepali, Punjabi, Samoan, Thai, Tibetan, Tongan, and Vietnamese. The types of promising programs and strategies collected were of a wide variety, including outreach through recreation, LGBTQ, school-based, gender-based, problem gambling, community gardening, training, suicide prevention, parenting, Alcohol and Other Drugs prevention, integrated care, faith-based, family, senior, violence prevention, youth, consultation, and support/social services. The large number of consultation programs collected may reflect workforce shortage and the need for collaboration. It should also be noted that this list was not exhaustive. More programs and strategies could have been included had there been more time and resources.

Table II-4: ***Number of Programs/Strategies per Category***

Category	Description	Number of Programs
1	General submission of existing programs	27
2	Submission of existing programs that have been evaluated	5
3	Innovations/suggested strategies	19
4	Already recognized programs	5

SYSTEMS ISSUES AND IMPLICATIONS ON PUBLIC POLICY

Over the last two years, the API-SPW has actively listened to AANHPI community representatives, community members, and community experts regarding the current state of disparities in California. Therefore, the disparities in mental health services documented in this report were primarily based on personal experiences observed and shared by the AANHPI community. Despite limited resources, the AANHPI communities had developed responses to many unmet needs, and the 56 community-defined promising programs and strategies collected through this project were good examples of such efforts. However, to effectively and timely reduce these disparities, support and leadership from policy makers at the local, county, and state level are essential. The following are recommendations for policy considerations on how to reduce existing disparities in the API community:

ACCESS, AFFORDABILITY, AVAILABILITY, AND QUALITY OF SERVICE

Recommendation
Increase access by supporting culturally competent outreach, engagement, and education to reduce stigma against mental illness and to raise awareness of mental health issues.

Given the unfamiliarity with Western-culture based mental health concepts and the stigma against mental illness in the AANHPI community, effective outreach must incorporate cultural factors, leverage existing community resources, and include community participation.

Therefore, to reduce mental health service disparities in the AANHPI community, the API-SPW recommends:

- Provision of resources and system support for culturally competent education to reduce stigma against mental illness and to raise awareness of mental health issues in the AANHPI community through established community networks.
- Support for culturally competent outreach and engagement efforts with the AANHPI community through established networks.
- Support for culturally competent collaboration with other community stakeholders.

Recommendation
Increase access by modifying eligibility requirements, by including ancillary services supporting access, and by providing affordable options.

Due to cultural differences, the manifestation of symptoms for AANHPIs with mental health issues may be different from those common in Western culture, making eligibility requirements such as meeting the medical necessity inappropriate for the AANHPI populations. Lack of adequate insurance continues to be a barrier to care for many AANHPIs. Moreover, there are other barriers such as lack of transportation and interpretation, which makes it critical for any providers and policy makers to include ancillary supportive services to make access possible.

Therefore, to reduce mental health service disparities in the AANHPI community, the API-SPW recommends:

- Support for more flexibility in establishing eligibility for services such as modifying the requirement to meet medical necessity.
- Support for inclusion of ancillary services as part of the service plan, such as interpretation and transportation.

Recommendation
Increase availability and quality of care by supporting the development and retention of a culturally competent workforce.

A culturally competent program can only be effective if those providing services are culturally competent. Mental health careers are not as well recognized or pursued in the AANHPI communities. Culturally competent training has not been sufficiently emphasized in the current training model. Providers currently serving the AANHPI community can use more ongoing training and peer support as the community relies heavily on them for services. Lastly, cultural competence training should also include those who serve AANHPIs such as healthcare providers, school, and law enforcement.

Therefore, to reduce mental health service disparities in the AANHPI community, the API-SPW recommends:

- Support for promotion of mental health careers through outreach to AANHPI youth and their parents.
- Support for mandating or at least including cultural competency as part of mental health career training at various academic levels from certification to advanced degrees.
- Support for creating mentorship for future workforce.
- Support for ongoing training and technical assistance for providers serving the AANHPI community, both in mental health and other fields.

Recommendation
Increase availability and quality of care by supporting services that meet the core competencies and promising program selection criteria as defined by the API-SPW.

Availability of culturally competent services remains a major barrier, which affects quality of care and access to care. While it may be up for debate as to what exactly constitutes ~~–e~~ultural competence," the API-SPW has developed a list of core competencies and a list of promising program selection criteria as a starting point based on input from the community.

Therefore, to reduce mental health service disparities in the AANHPI community, the API-SPW recommends:

- Support for existing culturally competent programs to continue serving the API community.
- Support for the development of new culturally competent programs to respond to unmet and emerging needs in the community.
- Support for replication of community-defined programs and strategies, including technical assistance and training.
- Support for a written review of evidence-based practices as it relates to AANHPIs by providing training and resources for agencies to do so.

- Support for culturally competent models that contribute to building the alternative to mainstream mental health models for the AANHPI community.
- Support for programs that complement County MHSA/PEI plans, preferably models that have significant community involvement, design, and implementation.

OUTCOME AND DATA COLLECTION

Recommendation
Reduce disparities by collecting disaggregated data to accurately capture the needs of various AANHPI communities, by supporting culturally appropriate outcome measurements, and by providing continuous resources to validate culturally appropriate programs.

A major challenge the AANHPI community faces is the lack of disaggregated data despite the heterogeneity among various ethnic groups. Though the AANHPI communities have responded to their needs by developing successful promising programs, very few of them have been evaluated, let alone been evaluated properly using culturally appropriate measures.

Therefore, to reduce mental health service disparities in the AANHPI community, the API-SPW recommends:

- Support for mandating collection of disaggregated data to respect the diversity of AANHPI communities.
- Support for developing culturally appropriate outcome measurements to properly assess the effectiveness of programs aiming to serve the AANHPI community. Financial and technical resources are needed to develop AANHPI-relevant measures to ensure the efficacy of these measures.
- Support for validation of existing culturally competent programs, including technical support. The CRDP Phase II funding will be important in providing resources and opportunities for validation of community-defined programs.
- Support for culturally appropriate services in AANHPI communities to become either promising or best-practice PEI programs.

CAPACITY BUILDING

Recommendation
Empower the community by supporting community capacity building through efforts such as leadership development, technical assistance, inclusion of community participation in the decision-making process, and establishment of infrastructures that can maximize resource leveraging.

There are always more needs in the community than what available resources can possibly support. Thus, it makes sense for the systems to develop policies to help build community capacity to respond to community needs.

Therefore, to reduce mental health service disparities in the AANHPI community, the API-SPW recommends:

- Support for community capacity building such as leadership development so the community can be empowered to respond to its needs.
- Support for community capacity building such as technical assistance to develop, refine, and validate promising programs.

- Support for inclusion of community participation in the decision-making process as the community understands its own needs and such inclusion can also empower the community to find its own solutions.
- Support for establishing or maintaining community infrastructures so resources can be shared and leveraged.
- Provision of resources and support for maintaining a statewide infrastructure where agencies can share resources and provide peer training.
- Support for computer technology, such as social networks, podcast, and web-based blogging, to be used for outreach to AANHPI youth.

GLOSSARY

AANHPI	Asian American, Native Hawaiian, and Pacific Islander
ACA	Affordable Care Act
Acculturation	The process of adopting the cultural traits or social patterns of another group
Administrative Team	Consists of the Project Director, Project Manager, and Project Assistant
API-SPW	Asian Pacific Islander Strategic Planning Workgroup
Asian	Defined by the 2010 Census as a person having origins in peoples of the Far East, Southeast Asia, or the Indian subcontinent
CBOs	Community-Based Organizations
CDC	Center for Disease Control
CHIS	California Health Interview Survey
Consulting and Advisory Group	Consists of researchers, cultural experts, and county Ethnic Service Managers that provide inputs to CRDP API-SPW
CRDP	California Reducing Disparities Project
Disaggregated data	Instead of using API as a whole group, look at granular data by smaller subgroups (e.g., Southeast Asian) or even by ethnic groups (e.g., Samoan).
Disparity	Inequality or differential service (quality) received not due to differences in needs or preferences but due to one's demographic, geographic, or other background factors. It often can be examined through five dimensions: availability, accessibility, affordability, appropriateness, and acceptability.
DMH	California Department of Mental Health
DSM	Diagnostic and Statistical Manual of Mental Disorders, a manual used to give guidelines for diagnosing mental disorders
ESL	English as a Second Language
Gradient of Agreement	A system used to express disagreement while allowing for dialogue to continue
H.E.C.T.E.R.R.	Developed by the CRDP API-SPW Project Director as a membership

Principles	participation guideline to ensure a sense of safety and fairness for all API-SPW members so that they would be at ease to share their experience and knowledge on AANHPI mental health concerns and to propose creative and effective local solutions.
LEP	Limited English proficiency
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Queer
LGBTQQI	Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, and Intersex
MHSA	Mental Health Services Act
MHSA OAC	Mental Health Services Act Oversight and Accountability Commission
Model Minority	A ethnic minority group that succeeds economically, socially, and educationally
Monolingual	Non English-speaking individuals
Native Hawaiian and other Pacific Islander	Defined by the 2010 Census as a person having origins in peoples of Hawaii, Guam, Samoa, or other Pacific Islands
NHPI	Native Hawaiian and Pacific Islander
OAC	Oversight and Accountability Commission
OMS	Office of Multi-cultural Services
PEI	Prevention and Early Intervention
PTSD	Post-Traumatic Stress Disorder
Regional SPWs	CRDP API-SPW consists of 54 member agencies, organizations, and individuals organized by 5 geographic regions: Sacramento (9 members), Bay Area (15 members), Central Valley (7 members), Los Angeles (15 members), and San Diego/Orange County (8 members)
SAMHSA	Substance Abuse and Mental Health Services Administration
Steering Committee	API-SPW‘s Steering Committee consists of the Project Director/Statewide Lead, Statewide Facilitator, and 5 Regional Leads

First, Do No Harm:

Reducing Disparities for Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Populations in California

The California LGBTQ Reducing Mental Health Disparities Population Report

Stakeholder Recommendations 235

Acknowledgements

Writers

Pasha Mikalson, MSW

Seth Pardo, PhD

Jamison Green, PhD

Project Staff

Pasha "Poshi" Mikalson, MSW
Project Director
Mental Health America of Northern California

Nicole Scanlan
Project Coordinator
Mental Health America of Northern California

Seth Pardo, PhD
Data Analyst
Executive Director, Professional Education & Research Consulting

Daniel Gould, LCSW*
LGBT Health and Human Services Network Deputy Director
Equality California Institute
** Former Staff Member*

Laurie Hasencamp
Interim Executive Director
Equality California Institute

Susan Gallagher, MMPA
Executive Director
Mental Health American of Northern California

Contributors

Asian American & Native Hawaiian/Pacific Islander section
R. Anthony Sanders-Pfeifer, PhD—Alameda County Behavioral Health Services and Contra Costa County Behavioral Health Services

Black/African American/African Ancestry section
Gil Gerald, President/CFO—Gil Gerald and Associates, Inc.

Parents, Children and Families section
Judy Appel, JD—Executive Director, Our Family Coalition
Renata Moreira, MA—Our Family Coalition

Domestic Violence section
Susan Holt, PsyD, CCDVC—LA Gay and Lesbian Center

HIV and AIDS section
Brian D. Lew, MA—HIV Prevention Services Branch, Office of AIDS

Majority Rules—Anti-LGBTQ Initiatives section
Nicole Scanlan—Mental Health America of Northern California

Native American section
Nazbah Tom, MFTI—Native American Health Center

Older Adults section
Dan Ashbrook—Director, Lavender Seniors of the East Bay
Michelle Eliason, PhD—San Francisco State University
Dan Parker, PhD

Youth section
Bernadette Brown, JD—National Council on Crime & Delinquency
Hilary Burdge, MA—Gay-Straight Alliance (GSA) Network
Karyl E. Ketchum, PhD—California State University, Fullerton
Carolyn Laub—Executive Director, GSA Network
Caitlin Ryan, PhD, ACSW—Family Acceptance Project
Dave Reynolds, MPH—GSA Network
Geoffrey Winder—GSA Network

Report Design
Aimee Yllanes Design

Strategic Planning Workgroup
John Aguirre
National Alliance on Mental Illness (NAMI) California

Delphine Brody
California Network of Mental Health Clients

Hilary Burdge, MA
GSA Network

Gil Gerald
Gil Gerald & Associates/LGBT Tri-Star

Betsy Gowan, MFT
Butte County Department of Behavioral Health

Jamison Green, PhD
Center of Excellence for Transgender Health, UCSF

Joanne Keatley, MSW*
Center of Excellence for Transgender Health, UCSF

Danny Kirchoff
Transgender Law Center

Carolyn Laub*
GSA Network

Justin Lock*
Mental Health America of Northern California

Dennis Mallillin, MFTI
Asian and Pacific Islander Wellness Center

Hector Martinez
Mental Health America of San Diego

Sheila Moore, LCSW
Gay and Lesbian Elder Housing (former)
Jewish Family Services of Los Angeles (current)

Dan Parker, PhD*
The LGBT Community Center of the Desert—Palm Springs

Denise Penn, MSW
American Institute of Bisexuality

Jessica Pettitt
I Am Social Justice

Rev. Benita Ramsey
Riverside County Department of Mental Health

Dave Reynolds, MPH*
Trevor Project & GSA Network

Nazbah Tom, MFTI
Native American Health Center

Michael Weiss
Humboldt County Department of Health and Human Services

** Former SPW Member*

Advisory Groups

African American/Black/African Ancestry

Gil Gerald—facilitator
Bartholomew T. Casimir, MFTI
Linda Hobbs
Jabari Ahmed Malik Morgan
Larry Saxxon
4 anonymous members

Asian American & Native Hawaiian/Pacific Islander

Dennis Mallillin, MFTI—facilitator
Eddie Alvarez
Ben Cabangun, MA
Stephanie Goss
Justin Lock
Patrick Ma
Hieu Nguyen
Lina Sheth
Lance Toma, LCSW
1 anonymous member

Bisexual/Pansexual/Fluid

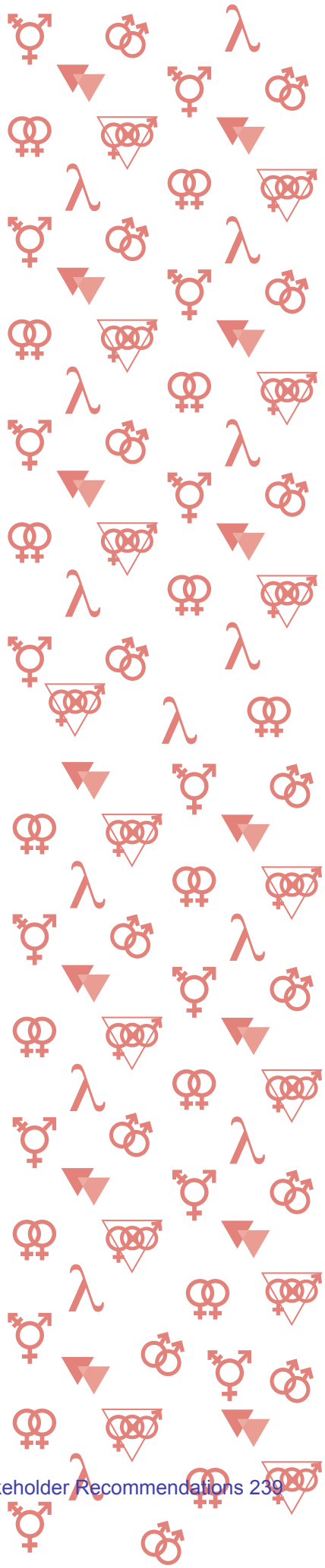
Denise Penn, MSW—facilitator
Heidi Bruins Green, MBA
James Walker
6 anonymous members

Consumer/Clients/Survivors and Family Members

Delphine Brody—SPW Liaison
Justin Lock—(former facilitator)
Eden Anderson
Karin Fresnel
Abby Lubowe
Kathryn (Kate) White
Stephen Zollman
7 anonymous members

County Staff

Betsy Gowan, MFT—facilitator
Sharon Jones
Stephanie Perron
Victoria Valencia
R. Anthony Sanders-Pfeifer, PhD
Nicola Simmersbach, PsyD, MFT
Noel Silva
3 anonymous members



Latino

John Aguirre—co-facilitator
Hector Martinez—co-facilitator
Joanne Keatley, MSW—(former facilitator)
Angelica Balderas
Jorge Fernandez
5 anonymous members

Native American Two-Spirit/LGBTQ

Nazbah Tom, MFTI—facilitator
Carolyn Kraus
Karen Vigneault
3 anonymous members

Older Adult

Sheila Moore, LCSW—facilitator
Dan Parker, PhD—(former SPW liaison)
David Cameron
Rick Khamsi
Richard Levin, MFT
Glenne McElhinney
Nora Parker
Patty Woodward, EdD
Paul D. Zak, LCSW
3 anonymous members

Research and Data Analysis

Pasha Mikalson, MSW—facilitator
Heidi Bruins Green, MBA
Sue Hall, MD, PhD, MPH
Jamison Green, PhD
Rose Lovell
Shelley Osborn, PhD
Seth Pardo, PhD
Nicole Scanlan
3 anonymous members

Rural

Michael Weiss—Facilitator
Slade Childers
Eden Joseph
Rick Khamsi
Pat Rose
Kathryn "Kate" White
3 anonymous members

School-Based

Lawrence Shweky, LCSW—facilitator
Hilary Burdge, MA—SPW liaison
Carolyn Laub—(former SPW liaison)
Dave Reynolds, MPH—(former SPW liaison)
Kate Mayeda
Jabari Ahmed Malik Morgan
9 anonymous members

Transgender

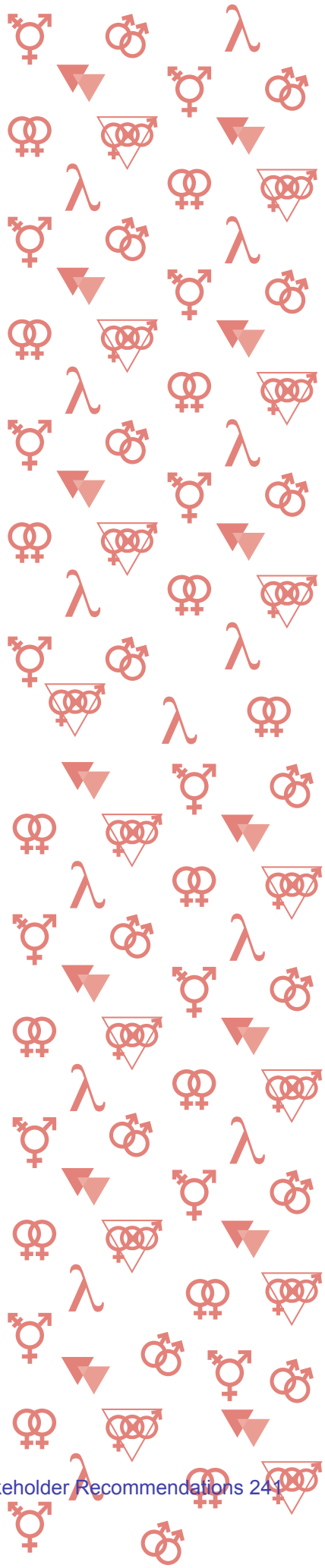
Danny Kirchoff—facilitator
Rachel Bowman
Delphine Brody
Porter Gilberg
Jamison Green, PhD
Zander Keig, MSW
Aydin Kennedy
Connor Maddox
Asher Moody-Davis
9 anonymous members

Youth

Justin Lock—facilitator
Dave Reynolds, MPH—(former facilitator)
Eden Joseph
Patrick Ma
Hieu Nguyen
7 anonymous members

Women's Issues

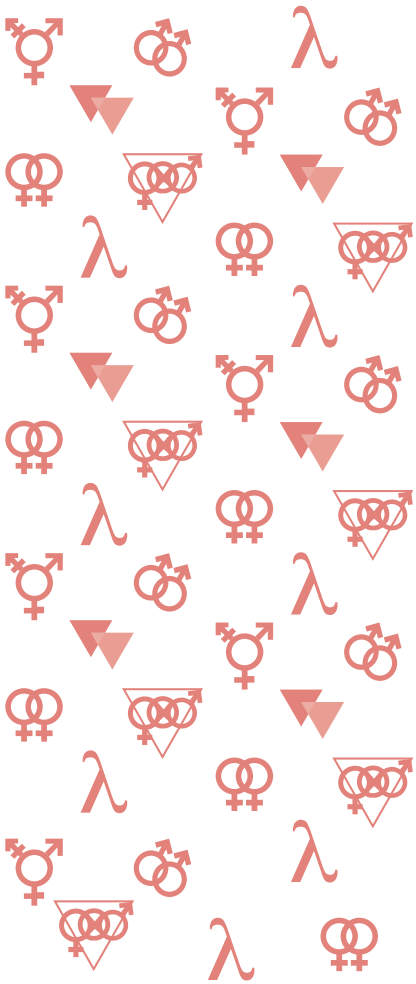
Jessica Pettitt—facilitator
Antonia Broccoli, LCSW
Porter Gilberg
Carol Hinzman
Kristen Kavanaugh
Kyree Kilmist
Victoria Valencia



Executive Summary

In collaboration with Equality California Institute and Mental Health America of Northern California, the Strategic Planning Workgroup (SPW) of the Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ) Reducing Disparities Project was charged by the former California Department of Mental Health (DMH) to seek community-defined solutions for reducing LGBTQ mental health disparities across the state of California. The project is funded through the Prevention and Early Intervention (PEI) component of the Mental Health Services Act (MHSA).

The LGBTQ Reducing Disparities Project was an enormous undertaking. Like the other underserved groups—African American, Asian and Pacific Islander, Latino, and Native American—targeted for assessment in the larger California Reducing Disparities Project, LGBTQ people exist in every geographic and economic range. Unlike the other groups, however, LBGTQ people are also found in every racial and ethnic group. Furthermore, each population represented by the acronym LGBTQ has its own needs as well as its own issues of diversity. Age, gender, sex assigned at birth, socioeconomic status, education, religious upbringing, and ethnic and racial backgrounds all play a role in how an individual experiences their sexual orientation and gender identity. For this reason, this report includes significant discussion of the literature that provides a necessary background to inform mental health professionals' understanding of LGBTQ lives.



There is a myth that LGBTQ is one community, once we get beyond the "gay" we still need to support one another—we are more than just labels. We are individuals.

Desert Valley Community Dialogue participant

Methodology

In accessing California's widespread and diverse population, the methodology used by the LGBTQ Reducing Disparities Project involved extensive engagement of community members and subject matter experts from across the state through Advisory Groups and a Strategic Planning Workgroup (SPW). Because of the wide diversity of the target population, and the difficulties inherent in achieving access to various subgroups within it, the project utilized a multi-method approach. Community Dialogue meetings were held in 12 communities, drawing over 400 people. The information gathered in these live sessions, along with extensive Advisory Group and SPW input, guided the development of the online LGBTQ Reducing Disparities Community Survey, which was the primary research tool used to gather quantitative information

We injure ourselves by saying we are a community, we are many communities.

Desert Valley Community Dialogue participant

about LGBTQ-identified Californians. This method was chosen to complement the in-person outreach of the Community Dialogue meetings, as well as the continual input from Advisory Group and SPW members. The online survey provided an avenue for reaching populations traditionally hidden or invisible. Over 3,000 California residents ($N = 3,023$) who identify somewhere on the LGBTQ spectrum responded to the Community Survey (CS), surpassing the initial goal of 2,500 respondents.

One of the major concerns raised by using an online process as a survey tool is one of access. Those who may be facing the most severe disparities may also not have access to, or be reached by, a survey tool that is totally Internet-based. Many agencies and programs serving hard-to-reach LGBTQ populations promoted the CS and allowed clients access to computers so their voices could be heard. Every recommendation made in this report should be viewed with the diversity of the LGBTQ communities in mind.

Findings

This report's findings illuminate the diversity of the target population, and the difficulties its members experience with respect to accessing and receiving appropriate mental health care. For example, CS respondents were asked how much they agreed with the following statement: "I have experienced emotional difficulties such as stress, anxiety or depression which were directly related to my sexual orientation or gender identity/expression." Over 75% somewhat or strongly agreed that they had. The Trans Spectrum group reported the highest rate of agreement (89%). Queer-identified individuals, Native Americans, and youth also reported higher rates than other subgroups. Even though older adults had the lowest rate, almost two-thirds of the group still somewhat or strongly agreed.

Other important findings include:

- Overall, approximately three quarters (77%) of CS respondents indicated they had sought mental health services of some kind. Trans Spectrum individuals reported seeking services at an even higher rate (85%).
- CS participants were asked to indicate which mental health services they needed or wanted, but did not receive. Individual counseling/therapy, couples or family counseling, peer support

Overall, approximately three quarters (77%) of CS respondents indicated they had sought mental health services of some kind. Trans Spectrum individuals reported seeking services at an even higher rate (85%).

Community Survey Findings

groups and non-Western medical intervention were ranked by all subgroups as 4 of the top 6 services they reported seeking, but not receiving. All subgroups (except youth) also ranked group counseling/therapy among the top six services they sought, but did not receive. For the general CS sample (all subgroups combined), Western medical intervention was ranked sixth of those services sought, but not received. Queer, youth, older adult, and people of color (POC) subgroups all indicated seeking but not receiving ethnic/community-specific services. Notably, Trans Spectrum respondents ranked "counseling/therapy or other services directly related to a gender transition" and Latino respondents ranked "suicide prevention hotline" as the number six service they sought but did not receive.

- CS respondents were provided a list of problem areas that was developed from Community Dialogue feedback and Advisory Group discussions. CS respondents were asked to indicate whether each area listed was a problem for them in the past 5 years. Concerns most frequently reported as a severe problem by all or most subgroups were:
    1. Did not know how to help me with my sexual orientation concerns—*all subgroups*.
    2. Did not know how to help me with my gender identity/ expression concerns—*all subgroups*.
    3. My sexual orientation or gender identity/expression became the focus of my mental health treatment, but that was not why I sought care—*all subgroups.*
    4. Made negative comments about my sexual orientation—*most subgroups*.
    5. Did not know how to help same-sex couples—*most subgroups*.
    6. Did not know how to help mixed-orientation couples (e.g., one partner straight/one partner gay or one partner lesbian/one partner bisexual)—*most subgroups*.
- It should be noted that "Made negative comments about my gender identity/expression" was also one of the most frequently reported severe problems by Trans Spectrum, Queer, youth, Asian Americans, Native Hawaiians & Pacific Islanders (AA & NHPI), Black, Latino and urban subgroup respondents. Trans Spectrum

respondents were 4 times as likely (P < .001) to have this problem than non-Trans Spectrum respondents. In addition, they were 5 times more likely to have mental health providers who "did not know how to help me with my gender identity/expression concerns."

- CS participants were asked how satisfied they were, in general, with the mental health service(s) they had received in the past 5 years. Only 40% of LGBTQ respondents stated they were "*very* satisfied," although satisfaction rates differed among subgroups. Older adults reported the highest rate (60%) and youth the lowest (23%) for "very satisfied". Trans Spectrum (31%), Bisexual (32%), Queer (25%), AA & NHPI (24%), Latino (36%), Native American (29%) and rural (35%) subgroups all had even lower rates of "very satisfied" than the overall sample.
- Respondents who reported having only Medi-Cal had *more difficulty* accessing the services when they needed and wanted them than those who reported having private insurance, Medicare, another type of government insurance (e.g. VA, Tri-Care, Indian Health) and/or a combination of the above. Only 45% of Medi-Cal respondents were able to access couples or family counseling compared to 69% of those with private insurance. Only 40% were able to access Western medical interventions compared to 75% with private insurance and 84% with Medicare. Finally, only 37% were able to access peer support groups compared to 77% with private insurance, 71% with other governmental insurance, 91% with Medicare and 81% of those with some combination of the above.

Respondents who reported having only Medi-Cal had more difficulty accessing the services when they needed and wanted them than those who reported having private insurance, Medicare, another type of government insurance (e.g. VA, Tri-Care, Indian Health) and/or a combination of the above.

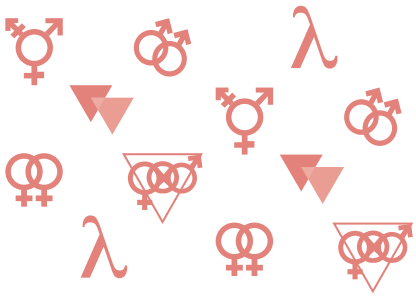
Community Survey findings

Researchers also conducted the LGBTQ Reducing Disparities Provider Survey (PS) to complement the Community Survey. The PS allowed the Research Advisory Group to develop questions specifically intended to assess barriers providers may face in providing culturally appropriate, sensitive and competent care to membes of LGBTQ communities. In addition, the PS included questions to address the intersection of being both LGBTQ and a service provider.

The PS was made available to mental, behavioral and physical health care professionals, educators, administrators, office staff, support staff, and *anyone who comes in contact with clients, patients, students and/or family members, whether or not they provide services specifically for LGBTQ individuals*. Over 1,200 (N = 1,247) providers working

or volunteering in California completed the PS, including over 350 providers who also identified as LGBTQ.

Using an adaptation of the Gay Affirmative Practice (GAP) Scale developed by Catherine Crisp (2006), researchers were able to assess the extent to which the provider respondents engage in principles consistent with gay affirmative practice. The most significant finding here is that training matters; the higher the number of trainings specific to LGBTQ issues, the higher the GAP scores. In general, LGBTQ providers took more trainings than heterosexual providers, but sexual orientation does not predict greater competence. Regardless of sexual orientation, increased numbers of trainings attended resulted in more affirming providers.



Regardless of sexual orientation, increased numbers of trainings attended resulted in more affirming providers.

Provider Survey findings

Demographic information should be collected for LGBTQ people across the life span, and across all demographic variations (race, ethnicity, age, geography) at the State and County levels.

First, Do No Harm: Recommendations

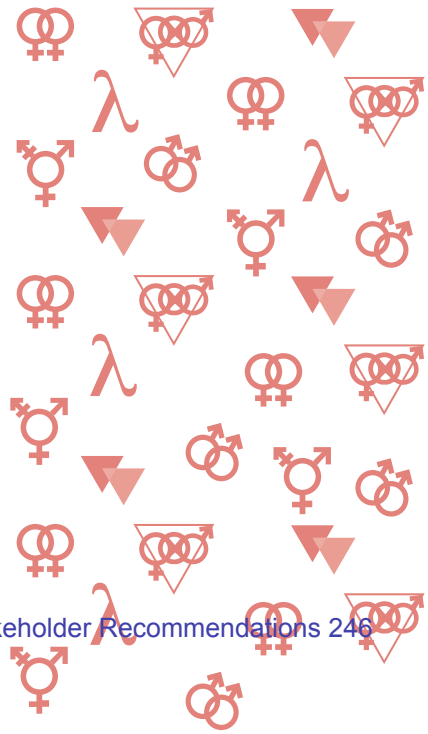
Statewide workforce training and technical assistance should be required in order to increase culturally competent mental, behavioral and physical health services.

First, Do No Harm: Recommendations

Recommendations

Two central concepts have come out of this research. LGBTQ people are being harmed daily by minority stressors such as stigma, discrimination, and lack of legal protection, prior to entering mental health services. Further, there is a profound lack of cultural competence, knowledge and sensitivity among providers who are expected to work with them once they access services. Among the recommendations contained in this report, some of the most important are:

- Demographic information should be collected for LGBTQ people across the life span, and across all demographic variations (race, ethnicity, age, geography) at the State and County levels. Standardization of sexual orientation and gender identity measures should be developed for demographic data collection and reporting at the State and County levels. Race, ethnicity, culture and age should be considered and the measures differentiated accordingly.
- Statewide workforce training and technical assistance should be required in order to increase culturally competent mental, behavioral and physical health services, including outreach and engagement, for all LGBTQ populations across the lifespan, racial and ethnic diversity, and geographic locations.
- Training of service providers in public mental/behavioral and physical health systems should focus on the distinctiveness of *each* sector of the LGBTQ community—lesbians, gay men, bisexual, transgender, queer and questioning—within an



Stakeholder Recommendations 246

overarching approach to mental health throughout the lifespan for the racial, ethnic and cultural diversity of LGBTQ communities. Cultural competency training, therefore, cannot only be a general training on LGBTQ as a whole, but also needs to include separate, subgroup-specific training sessions (e.g., older adult, youth, bisexual, transgender, Black, Latino, etc.).

- Development and implementation of *effective* anti-bullying *and* anti-harassment programs should be mandated for all California public schools at all age and grade levels and should include language addressing sexual orientation, perceived sexual orientation, gender, gender identity and gender expression issues. In addition, implementation of evidence-based, evaluated interventions that specifically address physical bullying and social bullying should be mandated for all California public schools at all age and grade levels.
- All locations where State or County funded mental/behavioral and physical health care services are offered should be required to be safe, welcoming and affirming of LGBTQ individuals and families across all races, ethnicities, cultures, and across the lifespan.
- State and County mental/behavioral health and physical health care departments should create an environment of safety and affirmation for their LGBTQ employees.

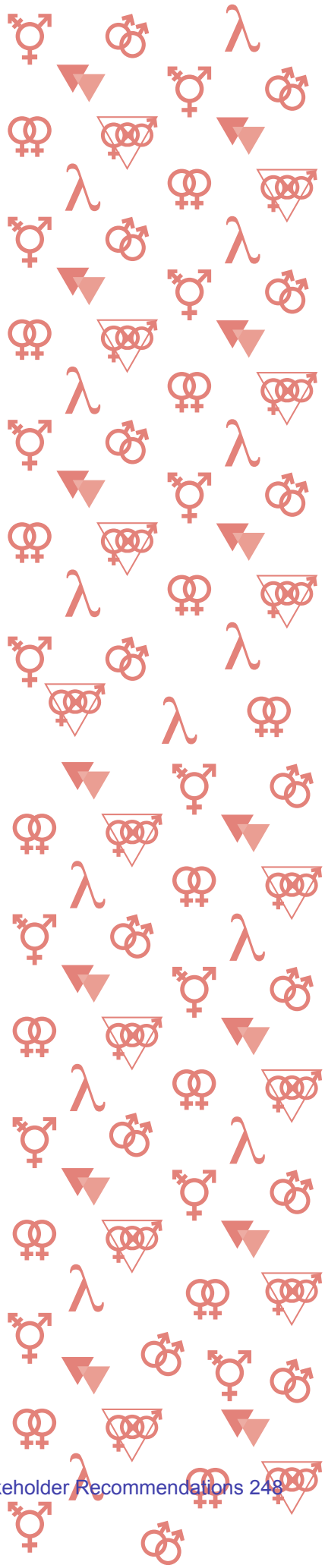
All locations where State or County funded mental/ behavioral and physical health care services are offered should be required to be safe, welcoming and affirming of LGBTQ individuals and families across all races, ethnicities, cultures, and across the lifespan.

First, Do No Harm: Recommendations

Conclusion

The need for culturally competent mental health services is great, but greater still is the need to eliminate the multiple harms that contribute to negative mental health throughout LGBTQ communities. This report represents a snapshot in time of certain LGBTQ people living in California. Not everyone that could—or should—be included is in the picture. In many ways, LGBTQ cultural competency work is still in its infancy, with growth and changes occurring rapidly. This report, therefore, cannot and should not be the final word in reducing disparities for LGBTQ Californians. The work begun by the LGBTQ SPW, including community engagement, advocacy, data collection, and community-based recommendations, needs to be continued, and the LGBTQ Reducing Disparities Project should remain funded beyond the dissemination of this report. Nevertheless, the authors of this report are extremely proud of the accomplishment of the long list of contributors and volunteers who worked on this project and made this landmark

document possible, and they hope the entirety of the information it contains will educate and inspire its readers to continue working to eliminate the mental health disparities and harm LGBTQ populations continue to experience.



Appendix E

Parity recommendations made by the California Coalition on Whole Health

California Coalition for Whole Health

American Association for Marriage and Family Therapy – California Division

AEGIS Medical Systems, Inc.

Alcohol and Drug Policy Institute

California Association of Addiction Recovery Resources

California Association of Alcohol and Drug Educators

California Association of Alcohol and Drug Program Executives

California Association of Social Rehabilitation Agencies

California Coalition for Mental Health

California Institute for Mental Health

California Mental Health Directors Association

California Mental Health Planning Council

California Opioid Maintenance Providers

California Pan-Ethnic Health Network

California Psychiatric Association

California Society of Addiction Medicine

County Alcohol and Drug Program Administrators' Association of California

Mental Health Systems

National Alliance on Mental Illness - California

National Alliance on Mental Illness – Sacramento

National Asian Pacific American Families against Substance Abuse

National Association of Social Workers California Chapter

Patient Advisory and Advocacy Group

Psych-Appeal

Regional Task Force on the Homeless

Santa Cruz County Health

San Mateo County Mental Health

Southeast Asian Assistance Center (and Hmong Health Collaborative)

Tarzana Treatment Centers

Turning Point Community Programs

The Village Family Services

POSITION STATEMENT

The California Coalition for Whole Health (CCWH) represents the state's most prominent mental health and alcohol and drug stakeholder organizations. Comprised of county directors, physicians, providers, consumers and family members, CCWH provides consensus recommendations for legislation and action by the California Health Benefits Exchange required to implement the Affordable Care Act (ACA 2010) in California. The ACA explicitly includes mental health and substance use disorders (MH/SUD) as one of 10 categories of service that must be covered as essential health benefits. This inclusion reflects the clear understanding that meeting the needs of individuals with MH/SUD is integral to achieving the "triple aim" objectives of health care reform:

- Reduce the cost of care
- Improve the experience of care
- Improve health of individuals and communities

Consistent with these aims, CCWH asserts: "There can be no health without behavioral health."

Effective care for MH/SUD is premised on the understanding that these disorders are chronic conditions for which ready access to both acute and continuing care is essential. Similar to hypertension, asthma and diabetes, MH/SUD can be successfully treated through effective acute and long-term care. Half of all individuals with chronic medical conditions also have co-occurring MH/SUD, resulting in higher costs and poorer outcomes. When MH/SUD is treated, the total cost of care for these individuals – and their families – is greatly reduced and overall health is significantly improved.

To realize the savings associated with improved health outcomes, insurance benefits for individuals must provide *all* medically necessary care across a continuum that meets changing care needs over time. The most appropriate and efficient levels of care can and should be determined using nationally recognized professional standards and include rehabilitative as well as residential services. With a robust continuum of care ranging from risk assessment and prevention, to early detection, effective intervention and maintenance treatment, individuals with MH/SUD can lead healthy and productive lives.

Health Plans need clear guidelines and regulations from the California Health Benefits Exchange and other oversight agencies to assure compliance with the Mental Health and Substance Abuse Parity Act (Parity 2008), which preempts disparate application of "non-quantitative" treatment limits for MH/SUD. Under Parity, medical necessity definitions and criteria, utilization management practices and provider network management practices cannot be more restrictive for MH/SUD than for medical or surgical conditions. Moreover, health plans must assure the availability of an adequate number of qualified providers, across all levels of care, who are within reasonable geographic access and are available to see new patients in a timely manner. For persons with MH/SUD conditions, any delay in access results in *de facto* denial of care.

Given these findings, CCWH believes the Kaiser Small Group Health Plan, as selected by AB1453 and SB951, provides a reasonably effective and efficient benchmark template as required by the ACA and can serve as a starting point to define essential health benefits for MH/SUD. This plan provides many levels of medically necessary care, although the range of services within those levels should be enhanced. Supplementation of these benefits will be required to provide medication-assisted addictions therapy, such as methadone as a treatment modality, in order to comply with parity and medical necessity standards. In addition, residential mental health benefits, extent of coverage for mental health case management, prevention and wellness benefits and recovery benefits must be clarified.

With full access to medically necessary care for MH/SUD, provided optimally in integrated health systems and settings, California stands ready to realize substantial financial savings through improved population health. There is good evidence -- from both commercial health plans as well as public health systems -- of overall cost-effectiveness and improved health when MH/SUD is appropriately treated.

With the above recommendations, CCWH believes that effective and efficient coverage of mental health and substance use disorders is within reach for California. Stakeholder Recommendations 250

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CALIFORNIA COALITION FOR WHOLE HEALTH SUMMARY POSITIONS

1. The Affordable Care Act (2010) includes Mental Health and Substance Use Disorders (MH/SUD) among its 10 essential categories. The ACA also mandates that MH/SUD benchmark coverage must be provided at parity, compliant with the Mental Health Parity and Addiction Equity Act (2008).

2. Essential Health Benefits must provide all medically necessary care to achieve optimal health and social outcomes at reduced cost. Levels of care and services necessary to treat MH/SUD should be determined utilizing industry-standards such as the American Society of Addiction Medicine's ASAM Patient Placement Criteria or the American Association of Community Psychiatrists' Level of Care Utilization of Services for Psychiatric and Addiction Services (LOCUS) tool. This should include intensive habilitative and rehabilitative care, residential services and other services that reduce the need for hospitalization or institutional placement for those with severe conditions consistent with the state Medi-Cal "rehab option" and targeted case management plans.

3. MH/SUD must be provided at parity, as required by state and federal law. This means California Health Benefits Exchange regulations and policies must ensure that non-quantitative management and treatment limitations are comparable to those for medical and surgical conditions. Non-quantitative limitations include, but are not limited to, medical necessity definitions and criteria, utilization management practices, formulary design, provider network management and step therapy or fail first protocols (DHHS: MHPAEA 2008 FAQ 5/9/2012). The Affordable Care Act also mandates that network adequacy must be demonstrated for MH/SUD coverage (DHHS: HBEX Final Rules 3/12/12).

4. Realizing the benefits of providing medically necessary services, CCWH endorses the Kaiser Small Group Plan as the benchmark for the Essential Health Benefits. This plan provides many medically necessary levels of MH/SUD care although the range of services require enhancement to fully meet federal MH/SUD parity with the following supplements:

a. SUD services must include Medication-Assisted Treatment, including methadone maintenance benefits.

b. Benefits for MH/SUD residential care, case management and prevention, wellness and recovery must be clearly defined.

c. Formulary benefits must include *all medically necessary classes of medications and provision for non-formulary medications* when medically necessary.

5. At all levels, the California Health Benefits Exchange must meet the needs of MH/SUD consumers. Assertive outreach and enrollment services, including patient navigators, should be provided at the point of service and other locations, with sensitivity to the needs and vulnerabilities of MH/SUD consumers. Easy access to assistors and navigators versed in MH/SUD coverage should be a key component of such efforts.

6. Health Plans must assure the availability of an adequate number of qualified providers, across all levels of care, who are within reasonable geographic access and available to see new patients in a timely manner. All essential community providers should be included in provider networks, including, specifically, community clinics along with county providers and other community service organizations. For persons with MH/SUD conditions, delay in access results in *de facto* denial of care.

7. The vision for MH/SUD care in California must promote integrated care for MH/SUD into primary care medical homes and systems of care that link MH/SUD specialty and primary care services. There can be no real health without effective treatment of mental health and substance use disorders.

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California Whole Health Coalition
Essential Health Benefits
Consensus Principles and Recommendations

Ultimately, the success of national health care reform will be judged on its ability to meet the Federal "triple aim" challenge to

- enhance the health of populations
- improve the experience of care
- control costs

The Affordable Care Act's (ACA) inclusion of mental health and substance use disorder (MH/SUD) benefits as *Essential Health Benefits (EHB) at parity with other medical care/services* demonstrates a clear understanding that meeting individuals' MH/SUD needs is integral to achieving these three goals; it has been said that "there is no health without mental health".

However, the mere inclusion of these services alone will not advance the triple aim. A rational approach to managing access to these services will be required to realize the gains of including treatment for these conditions in any and all health benefit packages. *There is a strong business case, supported by experience and the health services/economics research, that demonstrates efficiencies in care and improved outcomes when patient needs are well matched with the most appropriate, medically necessary and least restrictive/least costly level of care.*

Essential Health Benefits and model insurance policies must include a robust continuum of MH/SUD services—provided in a manner consistent with established guidelines for effective and efficient person-centered care. Timely access to these benefits and services is essential for improving and maintaining Americans' overall health and reducing the excessive health care costs that result from the all too frequent, less than adequate treatment of these conditions.

Today, in most instances and in many insurance plans and programs, not all required levels of care are offered, restrictions are placed on the type and number of services provided and the location in which they can be provided, and medical necessity criteria for managing utilization uses a range of medical

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necessity criteria that are applied without adequate consistency. Determinations of essential health benefits and their administration in health care reform offer an opportunity to address and correct these problems.

The California Coalition for Whole Health (CCWH) offers several recommendations regarding the breadth and scope of MH/SUD benefits and services that should be included as Essential Health Benefits for California's Insurance Exchange based upon a core set of principles or guidelines specified in the sections below.

Introduction

CCHW proposes a paradigm to consider EHBs that is built around three distinct but related and often confused key concepts that require clarification. They are:

- levels of care
- treatment / services / activities / medications
- medical necessity / utilization management

These three concepts refer to components of coverage and benefits as they are administered in most health plans and insurance programs. However, there is a lack of clarity about each term and a tendency to mix them together as if they were the same term or concept. However they do not, per se, address other critical issues such as

- integration and coordination of primary care and services for MH/SUD
- the need to be Patient Centered
- consideration of MH/SUD as "chronic" medical conditions--like diabetes and hypertension – that require both episodic care and long-term disease management

All of this can make a discussion of EHB recommendations confusing and difficult to understand or translate into policy and insurance benefit packages.

CCWH recommends that decisions made by the California Health Benefits Exchange and the California Legislature about essential MH/SUD benefits address these concepts and concerns and consider the range of benefits available consistent with this paradigm. Specifically CCWH recommends that the full continuum of levels of care be available along with a comprehensive array or services or treatments. Utilization or medical necessity decisions—both about levels of care as well as types of services—should be based on uniform and standardized criteria and, whenever possible, should be evidence based.

The following pages include a description of the meaning of each term and how it should be applied in benefit design and the definition of EHBs. This brief paper is accompanied by several appendices which provide more detailed/specific guidance about what levels of care should be offered, what services should be available, and how decisions about the medical necessity of those services should be made.

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Level of Care

The term *level of care* (LOC) refers to both the location of services as well as the intensity of services often tied to a particular setting. Services can be provided in people's homes or other locations in the community, in outpatient and office based settings, in day-treatment centers, in non-hospital residential sites, free-standing psychiatric hospitals, and medically based general hospitals. As one advances in this continuum from outpatient to inpatient, the intensity and complexity of care increases, as does the cost of services. In 24-hour care, the need to provide room and board and 24/7 staffing can be significant factors in the higher costs associated with these LOCs.

Determining the most appropriate treatment setting for an individual, at any point in time during the course of their treatment and recovery, can be facilitated by using one of several sets of established and internationally recognized criteria or algorithms. Providing services at the lowest/most efficient level of care and in the least restrictive setting are two over-arching and guiding principles in making LOC determinations. Inevitably, this must be balanced against the need to assure the individual's and community's safety as well as the severity/complexity/acuity of their treatment needs.

Appendix A includes a table that allows for comparison of Levels of Care from two respected professional organizations: The American Society of Addiction Medicine has created the ASAM Patient Placement Criteria (PPC-2R) for substance use disorder treatment services and the American Association of Community Psychiatrists has developed the LOCUS (Level of Care Utilization System) for mental health. The two placement systems are strikingly consistent. While there are some differences—especially in the ASAM level III category—overall they could probably be merged into one continuum of care for both MH/SU. Each of these organizations has also developed criteria that describe specifically the characteristics of each LOC and scorable algorithms for making an LOC determination for each patient at any point in the course of their treatment/recovery.

Level of Care is dynamic and a patient's needs change over time. Efforts to be efficient as well as honor the principle of least restrictive setting require regular if not frequent review of patient needs and re-assessment of the most appropriate treatment setting. This will be discussed further in the section on Medical Necessity that follows.

Treatment / Services / Activities / Medications

The terms treatment/services/activities/medications refer to specific medical and psychosocial interventions intended to relieve a patient's distress and support their ongoing recovery and pursuit of well being. Appendix B includes a comprehensive list of interventions or services that are used in providing MH/SU treatment. This list is taken largely from the American Medical Association's reference commonly known as the "CPT" or Current Procedural Terminology. The CPT assigns a five-digit code to a defined clinical activity and these codes are then used for billing to insurance and are recognized by Medicare, Medicaid and commercial insurers. In some instances, Medicaid programs have created local five-digit/alpha-numeric codes to specific services that may be unique to a state's Medicaid program

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such as targeted case management and some rehabilitative services. In addition, medications and related services must include a comprehensive prescription formulary of FDA approved drugs for pharmacotherapy of both the mental health and substances use disorders.

For example, group psychotherapy, is a core mental health and substance use disorder treatment modality. It can be provided in any number of settings from outpatient offices, to day treatment programs and residential/inpatient facilities. This makes clear the distinction between level of care and services. Some individuals may require several sessions of group therapy a day in a setting away from their usual home environment in order to help them maintain sobriety at a particularly vulnerable time in their recovery, while others may do well with weekly group meetings to help them solve problems and sustain their abstinence. Although in some of the more intensive treatment settings, such as partial hospital or residential care, group therapy may be "bundled" with a number of other services and interventions into a "program", there remains a clear and important distinction between levels of care and treatment benefits.

Any definition of Essential Health Benefits must address and specify the various levels or sites where care can be provided as well as specify what treatments and services, regardless of the setting, are a covered benefit included in an insurance policy.

Medical Necessity / Utilization Management

These terms refer to the process of determining what treatments are indicated, what the intensity of services should be, and what is the safest and most efficacious setting in which treatment can be offered.

There are five factors that should be considered in determining medical necessity—they are distinct but also inter-related. The questions for any decision related to implementation of an individualized and person-centered treatment plan should include

1. is the treatment **indicated?** i.e., is there a diagnosed medical condition with identifiable symptoms which is causing impairment and/or distress?
2. is the treatment **appropriate?** appropriateness pertains to matching both the treatment setting and the treatments….questions of safety are often times linked to the issue of appropriateness; for example, is it appropriate for someone with an imminent risk of suicide to be treated outside of a 24 hour care setting?
3. is the treatment **efficacious?** i.e., is there reasonable evidence that the intervention is *likely* to produce the desired results? to some degree appropriateness and efficacy overlap
4. is the treatment **efficient?** i.e. is the intensity and setting of treatment as well as the volume of services warranted or could the same outcome be achieved with fewer resources at lower cost?
5. Is the treatment **effective?** i.e., was the initial determination of efficacy correct? Is the treatment showing benefit that warrants its continued application?

Questions 1 through 4 apply largely—but not exclusively – to the initiation of treatment. Decisions about the continuation of services should rely more heavily on questions about effectiveness. All too often

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treatments or services without demonstrable benefit are continued without modifications and this is generally not consistent with good utilization management.

The determination of medical necessity must be individualized for each patient in a dynamic fashion over the course of an episode of illness and treatment. If inpatient care is warranted, how many days are required at this level of care before it is medically appropriate and safe to continue the treatment with that intensity or can treatment safely proceed at a lower level of care? Often times a number of factors are part of that determination for an individual. A person with strong social supports and stable housing may be able to safely receive treatment in a partial hospital while someone else with the same symptoms and distress may be at greater risk and require continued inpatient care because they lack those supports and resources.

Conclusion

Essential Health Benefits are not merely a matter of what treatments are available or what kinds of facilities or settings are included. In order to efficiently achieve optimal outcomes that appropriately balance each patient's needs, strengths, risk, and costs, flexibility in terms of treatment settings as well as services is required. Inherent in any benefits package must be an individualized but also standardized approach to determining the medical necessity of services over time so that valuable resources are flexibly and wisely used in an accountable fashion to assure positive and lasting treatment outcomes.

To do less runs the risk of undermining the value, quality and effectiveness of including MH/SUD care to help achieve positive health outcomes for individuals, families and communities. Accordingly, we recommend the following:

- The benchmark plan should include the availability of mental health and substance use disorder treatment at all levels of care and must include a comprehensive formulary for medication assisted treatment to include maintenance medications for the treatment of opioid and alcohol dependence as well as other substance use disorders.
- Standardized and nationally recognized tools for determining level of care and making medical necessity determinations should be required of all plans
- Pharmacy benefits should be un-restricted and free of "fail-first" requirements for treatment authorization
- All CPT services should be available when medically necessary
- All medically necessary services should be provided at parity

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APPENDIX A

LEVELS OF CARE	
ASAM Placement Criteria	**LOCUS/AACP**
Level 0.5 *Early Intervention Services* ➢ Directed at patients not meeting criteria for a substance use disorder ➢ For assessment & education	**Level 0** *Basic Services* ➢ Basic services are designed to prevent the onset of illness or to limit the magnitude of morbidity associated with already established disease processes. ➢ May be developed for individual or community application, and are generally carried out in a variety of community settings
OMT *Opioid Maintenance Therapy* ➢ Not restricted to outpatient treatment modality	
Level 1 *Outpatient Services* ➢ 1d – Ambulatory Detox *without* extensive on-site monitoring ➢ Outpatient Treatment – traditional level 1	**Level 1** *Recovery Maintenance Health Management* ➢ Clients who are living either independently or with minimal support in the community ➢ Treatment and service needs do not require supervision or frequent contact **Level 2** *Low Intensity Community Based Services* ➢ Clients who need ongoing treatment *but* who are living either independently or with minimal support in the community ➢ Treatment and service needs do not require intense supervision or very frequent contact ➢ Traditionally been clinic-based programs
Level 2 *Intensive Outpatient/Partial Hospitalization Services* ➢ 2d – Ambulatory Detox *with* extensive on-site monitoring ➢ 2.1 – Intensive Outpatient	**Level 3** *High Intensity Community Based Services* ➢ Treatment to clients who need intensive support and treatment *but* living either independently or with minimal support in the community ➢ Service needs do not require daily supervision *but* treatment needs require contact several times per week ➢ Programs of this type have traditionally been clinic-based programs
Level 2 *Intensive Outpatient/Partial Hospitalization Services* ➢ 2.5 – Partial Hospitalization	**Level 4** *Medically Monitored Non-Residential Services* ➢ Services provided to clients capable of living in the community either in supportive or independent settings *but* treatment needs require intensive management by a multi-disciplinary treatment team ➢ Have traditionally been described as partial hospital programs and as assertive community treatment programs

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Level 3 *Residential/Inpatient Services* 3.1 – Clinically-managed, low intensity residential treatment (Half Way, Supportive Living) 3.2d – Clinically managed, medium intensity Residential Treatment (Social Detox) 3.3 – Clinically-managed, medium intensity Residential Treatment (Extended Care) 3.5 – Clinically-managed, medium/high intensity Residential Treatment (Therapeutic Community) 3.7d – Medically-Monitored Inpatient Detox Services 3.7 – Medically-Monitored Intensive Inpatient Treatment (traditional level 3 ASAM)	**Level 5** *Medically Monitored Residential Services* ➢ Residential treatment provided in a community setting ➢ Traditionally have been provided in non-hospital, free standing residential facilities based in the community. ➢ Longer-term care for persons with chronic, non-recoverable disability, which has traditionally been provided in nursing homes or similar facilities, may be included at this level
Level 4 *Medically-Managed Intensive Inpatient Services* ➢ 4d – Medically-Managed Inpatient Detoxification Services ➢ 4 – Medically managed inpatient treatment	**Level 6** *Medically Managed Residential Services* ➢ Most intense level of care in the continuum ➢ Traditionally been provided in hospital settings ➢ Could be provided in freestanding non-hospital settings

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Appendix B

MENTAL HEALTH CPT CODES	
Code	**Service Description**
90801	Psychological Diagnostic Interview Examination (Includes report prep time 90885)
90802	Interactive Diagnostic Interview (with language interpreter or other mechanisms
90804	Psychiatric Therapeutic Procedures (individual psychotherapy, insight oriented, behavior modifying, and/or supportive, in an office or out-patient facility), 20-30 minutes face-to-face with the patient
90805	... with medical evaluation and management services
90806	... 45-50 minutes face-to-face with the patient
90807	... with medical evaluation and management services
90808	... 75-80 minutes face-to-face with the patient
90809	... with medical evaluation and management services
90816	Individual medical psychotherapy, 20 – 30 minutes for Inpatient (Outpatient = 90804)
90818	Individual medical psychotherapy, 45 – 50 minutes for Inpatient (Outpatient = 90806)
90821	Individual medical psychotherapy, 75 – 80 minutes for Inpatient (Outpatient = 90808)
90847	Family Psychotherapy with patient Present (90846 without patient present; 90849 Multiple-family group psychotherapy)
90853	Group psychotherapy
90887	Review Testing: Psychological or School (not time related)
96101	Psychological testing, interpretation and reporting per hour by a psychologist (Per Hour)
96102	Psychological testing per hour by a technician (Per Hour)
96103	Psychological testing by a computer, including time for the psychologist's interpretation and reporting (Per Hour)
96105	Assessment of Aphasia
96111	Developmental Testing, Extended
96115	Neurobehavioral Status Exam (Per Hour)
96116	Chart Review, Scoring and Interpretation of Instruments, Note-Writing
96118	Neuropsychological testing, interpretation and reporting per hour by a psychologist
96119	Neuropsychological testing per hour by a technician
96120	Neuropsychological testing by a computer, including time for the psychologist's interpretation and reporting
96150	Health & Behavioral Assessment – Initial
96151	Reassessment
96152	Health & Behavior Intervention – Individual
96153	Health & Behavior Intervention – Group
96154	Health & Behavior Intervention – Family with Patient
96155	Health & Behavior Intervention – Family without Patient
97770	Cognitive Rehabilitation
99211	Evaluation & Management – Office Visit (OV) minimal
99212	Evaluation & Management – Office Visit (OV) problem focused
99213	Evaluation & Management – Office Visit (OV) expanded focus
99214	Evaluation & Management – Office Visit (OV) detailed
99215	Evaluation & Management – Office Visit (OV) highly complex
99354	Prolonged Physician Services (face-to-face), first 60 minutes
99355	... each additional 30 minutes
99358	Prolonged Physician Services (without face-to-face), first 60 minutes

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MENTAL HEALTH CPT CODES	
Code	**Service Description**
99359	... each additional 30 minutes
99374	Physician Supervision (Work provided in a 30-day period to supervise multi-disciplinary care modalities of patients to include development and/or review of care plan, review reports, communications, etc., 15-29 minutes
99375	... 30+ minutes
99401	Preventive Counseling, 15 minutes
99402	Preventive Counseling, 30 minutes
99403	Preventive Counseling, 45 minutes
99404	Preventive Counseling, 60 minutes
99441	Telephone evaluation and management services provided by a physician to an established patient, parent or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion.
99442	... 11-20 minutes of medical discussion.
99443	21-30 minutes of medical discussion.
98966	Telephone assessment and management services provided by a qualified non-physician health care professional to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management services or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion.
98967	... 11-20 minutes of medical discussion
98968	... 21-30 minutes of medical discussion
99361	Team Conference (with or without patient present), 30 minutes
99362	Team Conference (with or without patient present), 60 minutes
99371	Team Conference (with or without patient present), brief call
99372	Team Conference (with or without patient present), immediate call
99373	Team Conference (with or without patient present), complex call
99401	Preventive Counseling, 15 minutes
99402	Preventive Counseling, 30 minutes
99403	Preventive Counseling, 45 minutes
99404	Preventive Counseling, 60 minutes
X0371	Non-Medical Case Management: Group Home Per Day
X0372	Non-Medical Case Management: Community-Based Per 1/2 Hour Unit
X0660	Medical Case Management Mental Health, Community-Based Per 1/2 Hour Unit

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Gossary of Acronyms

Acronym	Label
ACA	Affordable Care Act
ADPI	Alcohol and Other Drug Policy Institute
CADPAAC	County Alcohol and Drug Program Administrators Association of California
CalOMS	California Outcomes Measurement System
CASRA	The California Association of Social Rehabilitation Agencies
CCCMHA	California Council of Community Mental Health Agencies
CDSS	California Department of Social Services
CHEAC	County Health Executives Association of California
CHIS	California Health Interview Survey
CIMH	California Insitute for Mental Health
CMHDA	California Mental Health Directors Association
CMS	Centers for Medicare and Medicaid Services
COD	Co-Occurring Disorder
CPCA	California Primary Care Association
CRDP	California Reducing Disparities Project
CSAC	County Supervisors Association of California
CSI	Client and Service Information (System)
DADP	Department of Alcohol and Drug Programs
DHCS	Department of Health Care Services
DMC	Drug Medi-Cal
DMH	Department of Mental Health
EPSDT	Early, Periodic Screening , Diagnosis and Treatment
FQHC	Federally Qualified Health Center
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
MH	Mental Health
MHSOAC	Mental Health Services Oversight and Accountability Commission
MHSA	Mental Health Services Act
OSHPD	Office of Statewide Health Planning and Development
SUD	Substance Abuse Disorder