AGENDA

October 15 - 19, 2019
Courtyard Marriott Sacramento Midtown
4422 Y Street, Sacramento, CA 95817

Notice: All agenda items are subject to action by the Council. Scheduled times on the agenda are estimates and subject to change. If Reasonable Accommodation is required, please contact Jenny Bayardo at 916.322.0962 by October 8, 2019 in order to work with the venue to meet the request. All items on the Committee agendas posted on our website are incorporated by reference herein and are subject to action.

MEETING OBJECTIVES:

1) Learn about a new program for recovery from serious mental illness
2) Talk with Governor Newsom's Mental Health Advisor
3) Provide input, with stakeholders, to inform the Council's recommendations to DHCS for new waivers

COMMITTEE MEETINGS

Tuesday, October 15, 2019

2:00pm	Performance Outcomes Committee	Palm Room

Wednesday, October 16, 2019

8:30am	Executive Committee	Camellia Room
10:30am-12:30pm	Patients' Rights Committee	Magnolia Room
10:30am	Children/Youth Workgroup	Gardenia Room
10:30am	Reducing Disparities Workgroup	Azalea Room
12:00 Noon	**LUNCH** (on your own)	
1:30pm	Legislation Committee	Camellia Room
1:30pm	Workforce and Employment Committee	Magnolia Room

Thursday, October 17, 2019

8:30am	Housing and Homelessness Committee	Camellia Room
8:30am	Systems and Medicaid Committee	Magnolia Room
12:00 Noon	**LUNCH** (on your own)	

COUNCIL GENERAL SESSION **Palm Ballroom**

Conference Call (listen only) 1-877-951-3290
Participant Code: 8936702#

1:30pm **Welcome and Introductions**
Lorraine Flores, Chairperson

1:35pm **Opening Remarks** **Tab P**
Ryan Quist, PhD, Director of Behavioral Health, Sacramento County

2:10pm **Approval of the June 2019 Meeting Minutes** **Tab Q**
Lorraine Flores, Chairperson

2:15pm **Innovation in Recovery: A Continuum of Hope** **Tab R**
Alice J. Washington, Associate, CA Institute Behavioral Health Solutions

3:00pm **Break**

3:15pm **Public Comment**

3:20pm **Meet Tom Insel, Governor Newsom's Advisor on Mental Health** **Tab S**
Tom Insel, M.D.

4:20pm **Committee Reports**
Workforce & Employment - Deborah Pitts, Chairperson
Legislation - Monica Caffey, Chairperson
Patients' Rights – Walter Shwe, Chairperson
Housing and Homelessness – Deborah Starkey, Chairperson
Systems and Medicaid - Ronnie Kelley, Chairperson
Performance Outcomes – Susan Wilson, Chairperson
Executive – Lorraine Flores, Chairperson
Children/Youth Workgroup
Reducing Disparities Workgroup
Council Member Conference Reports

4:45pm **Update from CA Behavioral Health Boards/Commissions**
Theresa Comstock, Executive Director

4:55pm **Review Plan for Friday Morning Meeting**

5:00pm **Recess**

Mentorship Forum for Council members, including Committee Chairpersons and Chairs-Elect, will occur immediately following the recess of Thursday's General Session.

Friday, October 18, 2019

COUNCIL STAKEHOLDER MEETING
Conference Call (listen only) 1-877-951-3290
Participant Code: 8936702#

UC Davis Medical Center
Education Bldg – Lecture Hall 2222
4610 X Street, Sacramento 95817

9:00 am	**Welcome** *Veronica Kelley, Systems and Medicaid Committee (SMC) Chairperson*	
9:05 am	**Keynote Speaker** *Michelle Doty Cabrera, Executive Director* *County Behavioral Health Directors Association of California*	**Tab T**
9:35 am	**Panelist Presentations** *Leonard Finocchio, Principal Consultant, Blue Sky Consulting Group* *Margaret Kisliuk, Behavioral Health Administrator, Partnership Health*	**Tab U**
10:05 am	**Break**	
10:15 am	**Panelist Presentations Continued** *Phebe Bell, Director of Behavioral Health Services, Nevada County* *Bill Walker, Director of Behavioral Health Services, Kern County*	**Tab U**
10:45 am	**Panelist Q&A** *Noel O'Neill, SMC member*	**Tab V**
11:05 am	**Break**	
11:15 am	**Stakeholder Feedback and Discussions** *Liz Oseguera, SMC Chair-Elect*	**Tab W**
11:55 am	**Closing Remarks** *Veronica Kelley, SMC Chairperson*	
12:00 pm	**Adjourn**	

2020 Council Meeting Schedule

January 15, 16, 17, 2020	**San Diego**	**Holiday Inn Bayside**
April 15, 16, 17, 2020	**Alameda**	**Hilton Oakland Airport**
June 17, 18, 19, 2020	**Riverside**	**Mission Inn Hotel**
October 14, 15, 16, 2020	**Sacramento**	**Lake Natoma Inn**

TAB P

California Behavioral Health Planning Council
General Session
Thursday, October 17, 2019

Agenda Item: Opening Remarks from Dr. Ryan Quist, Behavioral Health Director, Sacramento County

Enclosures: Excerpt: Sacramento County 2019 SAMHSA Mental Health Block Grant

Background/Description:

The local Behavioral Health Director is invited to speak with the Council members regarding the dynamics of their county, discuss population needs, and highlight new programs implemented. To provide some context, below is some background information about the county and attached is the write-up submitted by Sacramento County for the use of their Mental Health Block Grant dollars.

Sacramento County

According to the U.S. Census Bureau, the county has a total area of 994 square miles of which 965 square miles is land and 29 square miles is water. Sacramento County includes a number of cities including Sacramento, Rancho Cordova, Folsom, Elk Grove, Galt, Isleton and Citrus Heights.

Sacramento has one of the highest LGBT populations per capita, ranking seventh among major American cities, and third in California behind San Francisco and slightly behind Oakland, with roughly 10% of the city's total population identifying themselves as gay, lesbian, transgender, or bisexual.

Sacramento County Population (2018): 1,534,893

Total Medi-Cal Eligible Beneficiaries (FY 2016-17): 621,119

Total Specialty Mental Health Service (SMHS) Recipients: (FY 2016-17): 22,520

MENTAL HEALTH BLOCK GRANT (Excerpt)
Sacramento County
Fiscal Year 2019-2020

<u>Crossroads Diversified Services, Inc. Community Support Team</u>

Statement of Purpose:
Crossroads Diversified Services, Inc. has been providing mental health supportive services in Sacramento since 1977. Crossroads has a rich history of inspiring change and improving lives for more than 40 years. The Community Support Team (CST) is one (1) of the many strategies developed to support a continuum of services and supports within Sacramento County's Suicide Prevention Project. Crossroads CST program serves Sacramento County children, youth, Transition Age Youth (TAY), adults, and older adults that are experiencing a mental health crisis, including those at risk for suicide. Crossroads CST coordinates care and collaborates with all parties involved with the individual/child/family including, as it relates to the crisis, outpatient mental health provider, parents, schools, doctors, hospitals, social services, Alta Regional Center, Alcohol and Drug Services, Child Protective Services and Probation.

Crossroads CST provides comprehensive, integrated, culturally competent, supportive services to individuals experiencing mental health crisis with the goal of (1) diverting individuals from crisis services or decreasing need for crisis services, such as acute care hospitalization, (2) decreasing risk for suicide; (3) increasing individual/family and natural support persons knowledge of available resources and supports; (4) increasing personal connection and active involvement with community supports; (5) increasing access to community resources; (6) decreasing isolation and/or lack of use of community supports.

Measurable Outcome Objectives:

1. OBJECTIVE: Maintain client engagement.

2. OBJECTIVE: Provide linkages to appropriate services, supports, and community resources in order to address unnecessary emergency department visits and inpatient hospitalizations.

3. OBJECTIVE: Service satisfaction for clients experiencing a mental health crisis in Sacramento County.

Program Description:
Crossroads CST program serves Sacramento County children, youth, Transition Age Youth (TAY), adults, and older adults that are experiencing a mental health crisis, including those at risk for suicide. The team consists of Peer/Family Support Specialists and Sacramento County Senior Mental Health Counselors (SMHC) who will provide a mobile response to community members experiencing a crisis. The composition of the

Community Support Team (CST) will be reflective of the cultural and linguistic diversity in Sacramento County. The program provides recovery-focused crisis intervention, peer support, system navigation, and linkage to community services and supports. The team assists in post discharge from acute care services or after an interaction with law enforcement, emergency rooms, etc. The CST ensures there is appropriate follow-up care, including any necessary safety plans, and will provide support and education to individuals and family members to help prevent a relapse back into crisis. CST provides follow-up contact for up to 60 calendar days and no longer than 90 calendar days after the first contact via telephone or face-to-face to confirm that adequate supports are in place or to provide additional supports and interventions to engage in services.

Target Population:
Crossroads CST provides services to adults/TAY/older adults with serious mental illness and children/youth/TAY with serious emotional disturbance that are experiencing a mental health crisis, including those at risk for suicide.

Staffing:
Crossroads CST has a MHBG budget of $142,961, to partially fund the following positions: Peer Specialists.

El Hogar Community Services, Inc. Guest House Homeless Clinic

Statement of Purpose:
El Hogar Community Services Inc. has been providing mental health supportive services in Sacramento since 1977, including offering specialized programs for elderly and homeless populations. The El Hogar Guest House Homeless Clinic (GHHC) opened in 1991. It is the primary point of access for the provision of mental health services for persons with serious mental illness or co-occurring disorders who are experiencing homelessness. GHHC collaborates with the Sacramento Continuum of Care (CoC) providers and participates in outreach efforts to help identify which program and services will best serve client needs, either from GHHC or from one (1) of the Housing Urban Development (HUD) funded programs. Individuals are assessed and referred to programs within the Mental Health Plan based on needs and preferences. GHHC Outreach workers inform individuals of orientation times and setting intake appointments. Upon enrollment, clients are provided with resources such as linkage to Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI), health services, employment/vocations services, general assistance, food resources and more. Case management services are provided by a Personal Service Coordinator. Individualized Client Plans are developed with each client to identify goals, linkage needs and strengths, based on their current situation, symptoms and unique needs. Clients who need intensive services are referred to Turning Point Community Programs- Pathways to Success after Homelessness (Pathways) or to TLCS New Directions. Each of these programs are Full Service Partnerships (FSP) with Permanent Supportive Housing (PSH) units.

GHHC provides client-centered, integrated, culturally competent recovery-focused services. GHHC staff collaborates with other service providers including: crisis residential treatment programs, inpatient psychiatric hospitals, outpatient providers, residential providers, homeless support and outreach programs, mental health court, client support programs, supported access programs (culture/language support), vocational programs (California Department of Rehabilitation Employment Cooperative), respite, treatment for co-occurring disorders and benefits acquisition/planning. GHHC also links homeless veterans to the Veterans Administration and coordinates referrals to the Primary Care Center for medical service.

On December 1, 2016, GHHC opened the Connections Lounge. The mission of the Connections Lounge is to connect individuals to needed mental health and supportive resources by acting as a drop-in-center for those experiencing homelessness. The Connections Lounge offers an opportunity for individuals to get their basic needs met such as connect to resources, light refreshments, cell phone charging stations, laundry facilities and more.

Measurable Outcome Objectives:

1. OBJECTIVE: Ninety Five Percent (95%) of clients who have no income and/or who do not have a pending application will apply for General Assistance (GA) and/or SSI within ninety (90) days of program entry date.
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2. OBJECTIVE: Sixty Five Percent (65%) of unduplicated clients will not return to psychiatric hospitalization during the contract year.
3. OBJECTIVE: Ninety Percent (90%) of unduplicated enrollees will not be incarcerated in any given year.
4. OBJECTIVE: Seventy Five Percent (75%) of enrollees will be linked to a Primary Care Physician (PCP) and/or specialty health provider within sixty (60) days.
5. OBJECTIVE: Fifty Eight Percent (58%) of unduplicated individuals contacted in the Connections Lounge with a serious mental illness will enroll in mental health services.
6. OBJECTIVE: Sixty Six Percent (66%) of enrolled individuals with a serious mental illness will receive mental health services.
7. OBJECTIVE: Seventy Five Percent (75%) of clients exited from HMIS whose data was collected will discharge to “stably housed.”
8. OBJECTIVE: Sixty five percent (65%) of clients identified as literally homeless or chronically homeless in HMIS will become stably housed within six (6) months of beginning housing specialty services.

9. OBJECTIVE: Seventy percent (70%) of clients supported with housing subsidies and support services will remain stably housed during the reporting period.

10. OBJECTIVE: Ninety percent (90%) of clients receiving housing subsidies and supports services will have a Housing Plan in their chart/Electronic Health Record (EHR).

Program Description:

El Hogar GHHC provides specialty mental health services to adults experiencing homelessness. The service approach is client-centered, integrated, culturally competent and recovery focused. GHHC provides psychiatric supports/medication, case management, vocational referral, counseling, recovery groups, outreach and engagement. Direct services are transitional until clients obtain housing and are successfully transferred to another community mental health provider or service provider where housing is available.

The program goals are: (1) To provide community-based outreach and engagement to individuals experiencing homelessness with the goal to enroll qualified individuals in mental health services; (2) To assess and link homeless individuals with mental health and/or co-occurring disorders to integrated, culturally competent services and supports based on individual needs, preferences and resources and supports available; (3) To provide timely and appropriate linkage and coordination with key services and benefits impacting a client's health and well-being (primary health, SSI, GA, Medi-Cal, etc.); (4) To support homeless individuals in obtaining and maintaining community tenure and reduce homelessness by provision of appropriate mental health services and supports; (5) Reduce and prevent homelessness and maintain housing stability while leveraging the CoC and other community resources; (6) To facilitate community housing for clients, including verifying homelessness, finding housing options for clients, and providing supports and services to help clients maintain stability; (7) To provide various mental health services and interventions necessary to reduce/prevent negative outcomes such as avoidable emergency room utilization, psychiatric hospitalization, jail/incarceration and eviction/homelessness; and, (8) To provide short-term alternative to an emergency department visit or acute hospitalization via a drop-in center for anyone experiencing homelessness.

In collaboration between Social Security Administration and Disability Determination, the Sacramento Multiple Advocate Resource Team (SMART) is also under the GHHC umbrella. This integrated approach allows clients to apply and receive SSI or SSDI benefits within an average of sixty three (63) days. GHHC outpatient clinic's hours of operation are Monday through Friday, 8:00am – 5:00pm. GHHC Drop-in Center's hours of operation are Monday through Friday, 9:00am – 3:00pm.

Target Population:

El Hogar GHHC provides services to individuals with a serious mental illness, who are experiencing homelessness, defined as persons who: (1) are age 18 and over and (2) who currently have, or at any time during the past year, had a diagnosable mental,

behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual V and (3) that has resulted in functional impairment which substantially interferes with or limits one (1) or more major life activities. Services are also available to individuals meeting above criteria who have substance use/co-occurring disorders.

Staffing:
El Hogar GHHC has a MHBG budget of $329,400, to partially fund the following positions: Program Director, Program Coordinator, Service Coordinator, Service Coordinator-Outreach Worker, Benefits Specialist, Licensed Vocational Nurse, Service Coordinator Team Lead, and Program Coordinator Connections Center.

Sacramento County Alcohol and Drug Services-DDX

Statement of Purpose:
The Sacramento County Department of Health Services (DHS), Division of Behavioral Health Services (DBHS), Alcohol and Drug Services (ADS) provides educational groups, assessment and treatment referrals for individuals with co-occurring disorders at its Adult System of Care locations. The primary function is to assess the level of substance use, abuse or addiction and match clients with services based on need with appropriate treatment levels of service recommendations and referrals. Clients who disclose or are assessed as having additional needs related to co-occurring issues are authorized to receive treatment that will best meet the goals of their dual recovery process.

The Alcohol and Drug Services program has implemented principles of integrated systems of care. There is collaboration and care coordination among internal County partners of Mental Health Services, Primary Health Services, Child Protective Services, Probation, Public Health, and the Department of Human Assistance. Care management may include collaboration with external partners such as, crisis residential treatment, intensive outpatient, homeless programs, outreach programs (homeless, jail), supported access programs (culture/interpreters), treatment for co-occurring disorders, alcohol and drug residential treatment care, benefits acquisition/planning (Medi-Cal) and direct linkages to Geographic Managed Care health services.

Measurable Outcome Objectives:

1. 100% of individuals referred from the Adult System of Care who are identified with possible co-occurring disorders will be offered an assessment.

2. 100% of ADS outpatient treatment referrals to the Mental Health Plan (MHP) will include follow up from the ADS counselor to provide comprehensive client coordination of care.

3. 50% substance use disorder outpatient treatment completion rate for co-occurring clients.

Program Description:
ADS provides assessment and triage services to clients with co-occurring disorders, who are seeking treatment services for substance use disorders. Additional services include case management, crisis intervention, brief therapy, individual counseling, group facilitation and multi-agency collaboration.

The ADS access points provide assessment and referral services on a walk-in basis. The American Society of Addiction Medicine (ASAM) criteria is used to determine level of care. ASAM criteria includes assessment of both alcohol/drug use patterns and life domains that impact client functioning, including mental health. Clients are authorized to services and referred to a network of contracted providers including modalities of service including withdrawal management, residential treatment, medication assisted treatment, outpatient and intensive outpatient treatment.

Target Population:
ADS provides services to adults with a serious mental illness, defined as persons who: (1) are age 18 and over and (2) who currently have, or at any time during the past year, had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-V and (3) that has resulted in functional impairment which substantially interferes with or limits one or more major life activities. Services are available to individuals meeting above "core target" population criteria who additionally have substance use disorders or co-occurring disorders resulting in impairments which substantially interferes with or limits one or more major life activities. Subpopulations served include persons who are homeless or at risk for homelessness, pregnant and parenting women, intravenous drug users and individuals involved in the criminal justice system. Gender specific services are also available through ADS at contracted provider sites.

Staffing:
Sacramento County Alcohol and Drug Services (ADS) has a MHBG budget of $517,193 to fund/partially fund the following positions: Senior Mental Health Counselors-DDX.

Sacramento County Probation Adult Day Reporting Centers (ADRC)

Statement of Purpose:
The Sacramento County Probation Department (Probation) Adult Day Reporting Centers (ADRC) is Sacramento's integrated one-stop re-entry center serving the comprehensive needs of Probationers making transition from jail to the community. The ADRC incorporates principles of restorative justice and is a supportive program designed to help clients gain confidence, build resiliency, and acquire the self-sufficiency skills needed to permanently exit the criminal justice system. There are three (3) regionally based ADRCs located in the north, central and south areas of Sacramento.

A Memorandum of Understanding (MOU) exists between Probation and the Sacramento County Department of Health Services – Division of Behavioral Health Services (DBHS)

for the provision of program services at the Probation Department's ADRCs. ADRC partners with additional organizations such as Department of Human Assistance, Volunteers of America, Sacramento Employment & Training Agency, Northern California Construction and Training, Elk Grove Unified School District, Department of Motor Vehicles, Child Support Services, Del Paso Blvd. Partnership, Del Paso Heights Community Association to create the one-stop shop where clients can easily access supportive services.

The Probation ADRCs have implemented principles of integrated systems of care. There is collaboration and care coordination among internal partners of Behavioral Health Services, Alcohol and Drug Services, Primary Health Services, and the County Department of Human Assistance. The care management may include collaboration with crisis residential treatment, inpatient, regional support teams, intensive outpatient, homeless residential, homeless support, outreach programs (homeless, jail), consumer support programs, supported access programs (culture/language support), vocational programs (California Department of Rehabilitation Employment Cooperative), treatment for co-occurring disorders, residential care, benefits acquisition/planning and direct linkages to Geographic Managed Care (GMC) health services.

Measurable Outcome Objectives:

1. 50% of enrolled clients needing community resources will be successfully linked within 30 days of admission to the program.

2. 80% of enrolled clients will be successfully linked with a GMC and/or Primary Care Physician within 30 days of admission to the program.

3. 80% of enrolled clients meeting MHP Target Population will be referred to the Sacramento County Access Team for continuation of services within 30 days of admission to the program.

4. 80% of enrolled clients with alcohol and drug needs will be linked to Alcohol and Drug services services/residential/detox programs within 30 days of admission to the program.

Program Description:

ADRC provides multi-service evidence based programming and intensive supervision to target moderate-and high-risk male felony offenders with a high level of needs as identified through the application of evidence-based risk and needs assessments. Probation works collaboratively with DBHS to provide mental health and substance use screening and assessment to determine service needs. Individualized client plans, including crisis/safety plans are developed. Other services include brief, focused therapeutic interventions, individual and group counseling, case management, consultation and linkage to services at the ADRC and community services as needed.

The ADRC provides a variety of services including: employment assistance, employment workshops, vocational training referrals, General Educational Development (GED)

preparation, counseling services, transportation assistance, housing referrals, health services referrals mentoring, wellness assistance, social activities and a victim restoration work program and support to family members. ADRCs are committed to providing client-centered, integrated, culturally competent recovery-focused programs. The hours of operation are Monday through Friday, 8:00 a.m. - 5:00 p.m.

Target Population:
ADRCs provides services to adults with a serious mental illness, defined as persons who: 1) are age 18 and over and 2) who currently have, or at any time during the past year, had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual-V (DSM-V) and 3) that has resulted in functional impairment which substantially interferes with or limits one (1) or more major life activities.

ADRC serves felony Probationers who are at risk of being sentenced to state prison. The target population is adults, age 18 and over with at least 18 months remaining on Probation. The majority of clients are male. They are considered to have a moderate to high risk to reoffend based on an assessment tool indicating this. Sexual offenders are not referred to the ADRC. Probation will refer clients to the DBHS clinician for assessment and evaluation regarding diagnosis and level of care need. Persons who have a serious mental health diagnosis may be enrolled into the Mental Health Plan for specialty mental health care. Referrals are made to GMC Health Systems when appropriate.

Staffing:
The Sacramento County Probation ADRC has a MHBG budget of $765,620 to partially fund the following positions: Senior Mental Health Counselors.

Saint John's Program for Real Change Wellness and Recovery Respite

Statement of Purpose:
Mental health respite services address mental health crisis with the aim to reduce psychiatric hospitalization for one or more of the five target populations identified by Sacramento County. During a client's period in respite, Saint John's Program for Real Change's work is to stabilize the mental health crisis the person is dealing with that led them to crisis respite services. Saint John's Program for Real Change works collaboratively with other departments and agencies which may be impacting the client's risk for hospitalization. Collaboration is most likely to occur with other agencies that provide mental health, substance abuse, medical, court, and housing related services. Saint John's Program for Real Change connects individuals with resources aimed at supporting basic needs, as identified by the person served. Saint John's Program for Real Change team assists clients with understanding service and support options and then assist the clients with accessing desired services. The team supports guests with actual linkage and warm contact with care providers to promote meaningful follow-up and reduce risks related to future crisis episodes. Saint John's Program for Real Change regularly collaborates with county agencies such as Department of Human

Assistance, Adult System of Care, Child Protective Services, Probation, Adult Drug Court, and Family Court. Saint John's also regularly collaborates with community agencies such as Alcoholics/Narcotics Anonymous, Methadone Clinics, Community for Peace and WEAVE, Family Law Center, and medical providers such as Kaiser Permanente.

Measurable Outcome Objectives:

1. OBJECTIVE: 90% of clients who have a planned exit from respite will have an identified mental health follow-up contact, including, but not limited to an appointment with a previously existing Mental Health (MH) provider; linkage to MH services through an existing managed care provider; a referral through the ACCESS team for Specialty Mental Health services, follow up with the Division of Behavioral Health Services (DBHS) Community Support Team, or planned contact with natural supports or services in place prior to the crisis.

2. OBJECTIVE: 80% of clients will report an "overall satisfaction" rate on the Crisis Residential Programs – Client Satisfaction Survey Form at the completion of their service provision.

3. OBJECTIVE: No more than 20% of clients will be admitted to a psychiatric hospital within thirty (30) days of service discharge.

4. OBJECTIVE: 60% of individuals served will be the result of diversions from the Emergency Departments.

5. OBJECTIVE: 80% of individuals admitted will complete a Brief COPE Inventory.

Program Description:

Saint John's Program for Real Change is a twenty-four (24) hour a day Mental Health Crisis respite service for women experiencing a mental health crisis. Services include assessment, resource linkage, treatment planning, crisis intervention, family intervention and case management are available for eligible women and women with dependent children for up to seven (7) days.

Target Population:
Women and women with dependent children.

Staffing:
Saint John's Program for Real Change has a MHBG budget of $114,988, to partially fund the following positions: Case Manager/Therapists, Intake Coordinators, Client Service Coordinators, Childcare Staff, and Program Director.

<u>Telecare Corporation, Inc., Adult Full Service Partnership</u>

Statement of Purpose:

Telecare Sacramento Adults Recovering In a Strength-Based Environment (ARISE) is a Full Service Partnership (FSP) who provides community based mental health services for adults who are experiencing the greatest level of functional impairment, resulting in long hospitalizations, frequent emergency room visits, incarceration, and co-occurring substance use disorders. Many clients referred to Telecare ARISE have experienced difficulty in accessing traditional clinic based services. Referrals are received from the County Intensive Placement Team, through the Level of Care Utilization System (LOCUS) Request Process, primarily from acute care settings. Telecare ARISE also accepts clients transferred from other outpatient providers when client could benefit from intensive services and supports.

Telecare ARISE utilizes the Strengths Model a core foundation of services. These principles of integrated services where consumers have a decision making role in identifying their life goals, needs, preferences and determining what services/supports are most helpful in their recovery process. Their approach is to provide client-centered, integrated, culturally competent recovery-focused programs.

Telecare ARISE works closely with other community partners in an effort to reduce acute hospitalizations and incarceration. The program works with other mental health service providers/programs such as crisis residential, acute care providers in the event a client requires this level of service. They assist clients to connect with community supports such as alcohol and drug services, self- help and peer-support programs. They collaborate with criminal justice institutions and collaborative courts. Telecare ARISE links clients with primary health services, housing supports, supported access programs (culture/language support), vocational programs (CA Department of Rehabilitation Employment Cooperative), treatment for co-occurring disorders, residential care, respite care, benefits acquisition/planning and more.

Measurable Outcome Objectives:

1. OBJECTIVE: 90% of newly enrolled clients will maintain housing during the contract year.

2. OBJECTIVE: 75% of clients with acute psychiatric hospitalization during contract year will not have a hospital length of stay greater than thirty (30) days.

3. OBJECTIVE: 85% of unduplicated clients who have experienced a psychiatric hospitalization will not be re-admitted to an acute psychiatric hospital within thirty (30) days from the date of discharge from the prior acute psychiatric acute care.

4. OBJECTIVE: 90% of unduplicated enrollees will not be incarcerated in any given year.

5. OBJECTIVE: 90% of enrollees will be linked to a Primary Care Physician (PCP) and/or specialty health provider within sixty (60) days of admission to program.

6. OBJECTIVE: 60% of clients with significant needs in Adult Needs and Strengths Assessment (ANSA) Life Domain Functioning will show improvement during the six (6) month reporting period.

7. OBJECTIVE: 50% of clients with strengths not yet identified in Adult Needs and Strengths Assessment (ANSA) Client Strengths will show improvement during the six (6) month reporting period.

8. OBJECTIVE: 50% of unduplicated clients with active co-occurring substance use issues will receive Alcohol and Other Drug (AOD) services.

9. OBJECTIVE: Track number of clients who are transferred to a less intensive level of care on an annual basis.

10. OBJECTIVE: Track number of successful discharges.

11. OBJECTIVE: 85% of unduplicated clients with a successful discharge will not experience recidivism to a higher level of care, or any psychiatric hospital within ninety (90) days after discharge from program.

Program Description:

Telecare ARISE provides comprehensive, flexible, client-driven, recovery-oriented, strength-based, trauma-informed, culturally and linguistically responsive, community-based specialty mental health services and FSP supports. FSP Services should be provided in accordance with the California Institute for Mental Health Full Service Partnership Tool Kits, the Adult version. Services are comprehensive, and are provided in the home, community, or office depending on client need – using a harm reduction "whatever it takes" approach – in order to assist clients in transitioning to community supports and maintaining stability in the community.

Telecare ARISE program goals include: (1) Promoting recovery as defined by Substance Abuse and Mental Health Services Administration (SAMHSA) to optimize community functioning at the least restrictive level of care; (2) Providing client-driven, recovery-oriented, trauma informed and culturally responsive approaches that address mental illness and co-occurring substance use disorders; (3) Reduce unnecessary and avoidable emergency room utilization and psychiatric hospitalization; (4) Reducing unnecessary and avoidable jail incarceration; (4) Providing timely and appropriate linkage and coordination with key services and benefits impacting clients health and well-being (e.g. Primary Care Physician (PCP), Supplemental Security Income (SSI), Medi-Cal, General Assistance (GA), etc.); (5) Promoting transition to lower level of service intensity and community integration; and (6) Reducing and preventing homelessness.

Telecare ARISE provides clients with an integrated assessment, mobile crisis intervention, self-directed care, peer supports, vocational services, and integrated mental health and substance abuse services. Treatment includes medication supports and services provided by physicians, physician's assistants, and nursing staff. To support

program participation, transportation is available for all clinic-based activities. Additionally, Telecare ARISE will have access to 15 permanent supportive housing units in partnership with Mercy Housing. They will provide on-site case management and crisis intervention to be able to assist in stabilizing housing and reducing homelessness. Telecare ARISE is committed to providing flexible, trauma informed, strength-based, client-driven, integrated, culturally competent recovery-oriented programs.

Target Population:
Telecare ARISE provides intensive services to adults who require frequent contact and support from a FSP program to maintain in the community due to the severity of their mental illness. Telecare ARISE provides services to adult beneficiaries with a serious mental illness, defined as persons who: (1) are age 18 and over and (2) who currently have, or at any time during the past year, had a diagnosable mental behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 and (3) that has resulted in functional impairment which substantially interferes with or limits one (1) or more major life activities. Services are available to individuals meeting above "core target" population criteria who additionally have substance abuse issues or co-occurring disorders resulting in impairments which substantially interferes with or limits one (1) or more major life activities.

Telecare ARISE target population includes adults and older adults with a serious mental illness who may be at risk of, or experiencing one (1) or more of the following: homelessness; involvement with the criminal justice system; a co-occurring substance use disorder; frequent psychiatric hospitalizations; frequent incarcerations, and court-ordered mental health treatment. Telecare ARISE members benefit from intensive services/supports due to experiencing frequent acute episodes or being at risk of losing community tenure. The services are field based and enrollment is not determined by specific catchment areas. Approximately 80% of clients receiving services have Medi-Cal or meet eligibility.

Staffing:
Telecare Corporation Adult FSP has a MHBG budget of $242,005, to partially fund the following positions: Personal Service Coordinators.

The Regents of the University of California SacEDAPT

Statement of Purpose:
Sacramento Early Detection and Preventative Treatment (SacEDAPT) is a Prevention and Early Intervention outpatient program of the Department of Psychiatry at the University of California, Davis Medical Center (UCDMC). SacEDAPT is a mental health provider within the Sacramento County Mental Health Plan (MHP). Consistent with the values and principles of the Sacramento County MHP, SacEDAPT educates the Sacramento community on the nature of mental disorders and the positive impact of early intervention. Their community outreach program identifies individuals prior to the onset of the most devastating aspects of psychosis, preventing deterioration and hospitalization whenever possible. Families and consumers are engaged through specific organizations

(National Alliance on Mental Illness, Mental Health Association), youth-focused programs (Boys and Girls Club, after school programs), faith-based organizations, local cable access shows, Capital Public Radio presentations, and health and wellness fairs.

SacEDAPT involves consumers in decision making role in identifying their life goals, needs, preferences and determining what services/supports are most helpful in their recovery process. Their approach is to provide client-centered, integrated, culturally competent recovery-focused programs.

SacEDAPT staff collaborate with a variety of community partners for care coordination including schools, other behavioral health providers, alcohol and drug service, youth organizations, primary health services, acute care, residential service providers, families, consumer support programs, supported access programs (culture/language support), vocational programs, treatment for co-occurring disorders, benefits acquisition/planning and more.

Measurable Outcome Objectives:

1. 70% of unduplicated clients will not return for psychiatric hospitalization within 30 days of discharge.

2. 75% of clients with acute psychiatric hospitalization during contract year will not have a hospital length of stay greater than nine (9) days.

3. 70% of clients who identified a goal to pursue education, job training, volunteering or employment will report improved functioning in educational or job training and/or employment.

4. 50% of clients served will be linked to a Primary Care Physician (PCP) and/or specialty health provider within 60 days of admission to the program.

5. 75% of clients enrolled will be engaged in an ongoing meaningful activity in any given year.

6. 75% of clients enrolled will respond agree or strongly agree on the Perception of Social Connectedness domain on the Consumer Perception Survey.

Program Description:

SacEDAPT provides prevention, assessment, specialty mental health services and supports, treatment and community outreach and education regarding the onset of psychosis. Essential elements include community outreach and education to facilitate early identification, rapid referral and gold-standard assessment, a variety of groups including Multi-Family Group (MFG), medical management, case management, and supported education and employment.

SacEDAPT takes a flexible and culturally sensitive approach to all aspects of outreach and education, initial assessment, consumer and family engagement, treatment

planning, and clinical care. The treatment team adapts to individual needs of consumers and families, including the use of home and school visits, utilization of bilingual clinicians and interpreting services. The Family Advocate and Peer Case Manager use their own experiences to engage, educate and motivate new participants. They also assist clients and families who are transitioning to other community services for on-going care and ensure a warm handoff. The duration of services is approximately two (2) years, helping to assist individuals achieve their personal, social, educational and occupational goals.

Target Population:
SacEDAPT's target population includes individuals, age 12-30, who have experienced onset of psychosis within the past two (2) years. SacEDAPT clients are diagnosed with a serious mental illness (i.e. schizophrenia, major depression with psychotic features, bipolar disorders with psychotic features or other qualifying diagnosis). SacEDAPT clients also experience functional impairments that substantially interfere with, or limit one (1) or more major life activities. Some SacEDAPT clients may have co-occurring disorders or substance use disorders.

Staffing:
SacEDAPT has a MHBG budget of $392,955, to fund/partially fund the following positions: Executive Director/Supervisor, Director of Treatment Fidelity/Supervisor, Medical Director/Psychiatrist, Psychiatrist, Clinical Specialist/Director of Operations, Clinical Specialist/Supervisor, Clinical Specialist/Intake Assessor, Family Advocate, Peer Engagement Specialist/Case Manager, and Clinic Coordinator.

TLCS, Inc., Mental Health Crisis Respite Center

Statement of Purpose:
The TLCS, Inc., Mental Health (MH) Crisis Respite Center provides mental health respite services that address mental health crises with the objective to reduce psychiatric hospitalization. The TLCS, Inc., MH Crisis Respite Center regularly coordinates care with a variety of agencies that also serve adult consumers of mental health services. Collaboration is most likely to occur with other community agencies that provide mental health, substance abuse, medical, and housing related services. TLCS, Inc., MH Crisis Respite Center connects individuals with resources aimed at supporting basic needs, as identified by the person served. The TLCS, Inc., MH Crisis Respite Center team assists consumers with understanding service and support options and then assists the individuals with accessing desired services. TLCS, Inc., MH Crisis Respite Center regularly collaborates with county agencies such as local law enforcement and Mobile Crisis Support Team, along with community organizations such as Emergency Departments, 211, Turning Point Triage Navigators, and Suicide Hotline.

Measurable Outcome Objectives:

1. OBJECTIVE: 90% of clients who have a planned exit from respite will have an identified mental health follow-up contact, including, but not limited to an appointment with a previously existing Mental Health (MH) provider; linkage to MH services through an existing managed care provider; a referral through the ACCESS team for Specialty Mental Health services, follow up with the Division of Behavioral Health Services (DBHS) Community Support Team, or planned contact with natural supports or services in place prior to the crisis.

2. OBJECTIVE: 80% of clients will report an "overall satisfaction" rate on the Crisis Residential Programs – Client Satisfaction Survey Form at the completion of their service provision.

3. OBJECTIVE: No more than 20% of clients will be admitted to a psychiatric hospital within thirty (30) days of service discharge.

4. OBJECTIVE: 60% of individuals served will be the result of diversions from the Emergency Departments.

5. OBJECTIVE: 80% of individuals admitted will complete a Brief COPE Inventory.

Program Description:

TLCS, Inc., MH Crisis Respite Center provides a 24 hours a day mental health crisis respite care to adults eighteen (18) and older who are experiencing overwhelming stress due to life circumstance resulting in a mental health crisis. Services include screening, assessment, treatment planning, crisis intervention, family support and case management. Services are available for Sacramento County adult residents for up to twenty-three (23) hours per stay.

Target Population:
Adults eighteen (18) and older who are Sacramento County residents.

Staffing:
TLCS, Inc., Mental Health Crisis Respite Center has a MHBG budget of $179,455, to partially fund the following positions: Program Manager, Assistance Program Manager, Crisis Respite Services Coordinator, and Substitute Crisis Respite Services Coordinator.

Turning Point Community Programs, Inc. Abiding Hope Respite House

Statement of Purpose:
The Turning Point Community Programs (TPCP) Abiding Hope Respite House provides mental health respite services that address mental health crises with the objective to reduce psychiatric hospitalization. TPCP Abiding Hope Respite House regularly coordinates care with a variety of agencies that also serve adult consumers of mental

health services. Referrals and transportation are routinely provided to the Department of Human Assistance and Social Security offices. Collaboration is most likely to occur with other community agencies that provide mental health, substance abuse, medical, and housing related services. TPCP Abiding Hope Respite House connects individuals with resources aimed at supporting basic needs, as identified by the person served. The TPCP Abiding Hope Respite House team assists consumers with understanding service and support options and then assists the individuals with accessing desired services. The team supports guests with actual linkage and warm contact with care providers to promote meaningful follow-up and reduce risks related to future crisis episodes. TPCP Abiding Hope Respite House regularly collaborates with community agencies such as El Hogar's Guest House Clinic, the Sacramento Native American Health Center, Wellspace, NAMI, Mather Community Campus, and the HOPE Cooperative (formerly TLCS).

Measurable Outcome Objectives:

1. OBJECTIVE: 90% of clients who have a planned exit from respite will have an identified mental health follow-up contact, including, but not limited to an appointment with a previously existing Mental Health (MH) provider; linkage to MH services through an existing managed care provider; a referral through the ACCESS team for Specialty Mental Health services, follow up with the Division of Behavioral Health Services (DBHS) Community Support Team, or planned contact with natural supports or services in place prior to the crisis.

2. OBJECTIVE: 80% of clients will report an "overall satisfaction" rate on the Crisis Residential Programs – Client Satisfaction Survey Form at the completion of their service provision.

3. OBJECTIVE: No more than 20% of clients will be admitted to a psychiatric hospital within thirty (30) days of service discharge.

4. OBJECTIVE: 60% of individuals served will be the result of diversions from the Emergency Departments.

5. OBJECTIVE: 80% of individuals admitted will complete a Brief COPE Inventory.

Program Description:

The TPCP Abiding Hope Respite House is a twenty-four (24) hour a day mental health crisis residential respite service for adults eighteen (18) and older experiencing a mental health crisis. Services include screening, resource linkage, crisis response, and care management. Services are available for eligible Sacramento County adult residents up to fourteen (14) days. Residential respite services are available for a maximum of five (5) adults at any one (1) time.

Target Population:
Adults ages eighteen (18) and older experiencing a mental health crisis.

Staffing:
TPCP Abiding Hope Respite House has a MHBG budget of $459,264, to partially fund the following positions: Program Director, Personal Service Coordinator, Rehabilitation Counselor I, On-Call Staff, and Director of Program Services.

Turning Point Community Programs, Inc. Pathways to Success After Homelessness

Statement of Purpose:
Sacramento County Division of Behavioral Health Services (DBHS) contracts with Turning Point Community Programs, Inc., Pathways to Success after Homelessness (Pathways) to provide supportive housing and mental health services for individuals with psychiatric disabilities and long-term or cyclical homelessness. A guiding principle of Pathways, a Full Service Partnership (FSP), is to help empower individuals and families experiencing homelessness and living with a psychiatric or emotional disability by providing personalized, collaborative and flexible services that engage and support individuals while they regain their status as fully participating members of the community. Additionally, Pathways provides supportive housing that ensures individuals have access to permanent, safe and affordable housing.

There is a full array of integrated services for which consumers have a decision making role in identifying their life goals, needs, preferences and determining what services/supports are most helpful to them in their recovery process. Individuals are supported to improve the quality of their life and supported with access to housing, education, psychiatric services, employment, medical and dental services. Pathways provides comprehensive, flexible, recovery-oriented, child/youth-centered, family driven, outpatient and community-based specialty mental health services, which includes FSP supports to adults and children who are homeless or at risk of homelessness. Comprehensive services are provided in the home, community, or office depending on consumer need. A harm reduction “whatever it takes” approach with a housing first orientation is used to assist consumers in maintaining community tenure. Adults and families with children are offered culturally diverse supportive services so they can stay together and be part of the community.

Pathways staff collaborate with other behavioral health services providers, alcohol and drug service providers, health providers and other organizations for care coordination. Typically this will include respite providers, residential care, regional support teams, intensive outpatient programs, homeless or at risk for homeless supports, referrals for consumer support, and supported access programs (culture/language support) as needed.

Measurable Outcome Objectives:

1. OBJECTIVE: Ninety percent (90%) of newly enrolled clients will maintain housing during the contract year.

2. OBJECTIVE: Reduce psychiatric hospitalization lengths of stay and rates of recidivism. Ninety percent (90%) of clients with acute psychiatric hospitalization during contract year will not have a hospital length of stay greater than thirty (30) days.

3. Eighty-five percent (85%) of unduplicated clients who have experienced a psychiatric hospitalization will not be re-admitted to an acute psychiatric hospital within thirty (30) days from the date of discharge from the prior acute psychiatric acute care.

4. OBJECTIVE: Ninety percent (90%) of unduplicated enrollees will not have a residence change into justice placement in any given year.

5. OBJECTIVE: Sixty percent (60%) of enrollees will be linked to a Primary Care Physician (PCP) and/or specialty health provider within sixty (60) days of admission to program.

6. OBJECTIVE: Seventy-five percent (75%) of clients enrolled will respond agree or strongly agree on the Perception of Social Connectedness domain on the Consumer Perception Survey.

7. OBJECTIVE: Fifty percent (50%) of adults will report improved functioning in educational or job training and/or employment.

8. OBJECTIVE: Fifty percent (50%) of clients identified as having significant needs in the area school behavior and achievement will improve during the reporting period.

9. OBJECTIVE: Fifty percent (50%) of clients identified as having significant needs in the area of delinquency will improve during the reporting period.

10. OBJECTIVE: Fifty percent (50%) of caregivers showing significant needs in the area of family stress will improve their ability to manage client’s needs.

11. OBJECTIVE: Fifty percent (50%) of unduplicated clients with active co-occurring substance use issues will receive Alcohol and Other Drug (AOD) services that may include harm reduction services.

12. OBJECTIVE: Five percent (5%) of enrolled clients will be transferred to a less intense level of care, on an annual basis.
13. OBJECTIVE: Sixty five percent (65%) of clients identified as literally homeless or chronically homeless in HMIS will become stably housed within 6 months of beginning housing specialty services.

14. OBJECTIVE: Seventy percent (70%) of clients supported with housing subsidies and support services will remain stably housed during the reporting period.

Program Description:
Pathways is a FSP that provides a comprehensive, integrated, culturally competent, community-based, supportive program assisting underserved and unserved adults with serious mental illness and children who meet severe emotional disturbance (SED) criteria. Pathways' program goals include: (1) Improving access to services for individuals who typically have not responded well to traditional outpatient mental health/psychiatric treatment, or for individuals that may have been unable to utilize community services due to complex co-occurring needs; (2) Providing/identifying a Primary Care Physician (PCP) to provide a comprehensive medical assessment and ongoing medical care, particularly for consumers with co-occurring medical and mental health needs; (3) Providing various services/interventions necessary to reduce/prevent negative outcomes such as avoidable emergency room utilization, psychiatric hospitalization, jail/incarceration, and eviction/homelessness; (4) Providing services that will increase the consumer's ability to function at optimal levels and as independently as possible, with the end of services in mind toward the goal of wellness; (5) Consumers will be coached, referred and linked to necessary community supports to reduce barriers to housing; (6) Maintaining community partnerships that will improve access to housing; (7) Reduce and prevent homelessness and maintain housing stability by increasing access to safe, permanent and affordable housing while leveraging the Continuum of Care (CoC) and other community resources; (8) Provide timely and appropriate linkage and coordination with key services and benefits impacting a consumer's health and well-being (primary health, Supplemental Security Income (SSI), General Assistance (GA), Medi-Cal, etc.); and (9) Facilitate community housing for consumers, support consumers in verifying homelessness, finding housing options with consumers, and providing supports and services to help consumers maintain housing stability.

Pathways staff will assess all consumers for co-occurring substance use disorder and when indicated, complete the Co-Occurring Disorders Assessment. All consumers identified as having a substance use disorder will have a treatment goal/objective included in the Client Plan to address substance use. Efforts to address substance use disorders shall include, but are not limited to, utilization of Motivational Interviewing, offering substance abuse recovery groups, self-help, linkage, harm reduction, and intensive coordination with outpatient and/or residential treatment or other external resources. If a consumer declines substance use treatment, the consumer's response will be documented and continued efforts by the clinical team will be made to address the

substance use disorder throughout services and will be reflected in the consumer's Electronic Health Record.

The Pathways outpatient clinic's hours of operation are Monday through Friday, 8:00am – 5:00pm. They provide treatment, support and case management in the community as needed. They also provide responsive crisis intervention services 24 hours per day, 7 days per week, including holidays, to consumers in need of such services.

Target Population:
Pathways' target population includes children, Transition Age Youth (TAY) age 18-25, adults and older adults. The child population served includes youth diagnosed as SED homeless or at risk for homelessness with their families/caregivers. Pathways serves adults with a serious mental illness, defined as persons who: (1) are age 18 and over and (2) who currently have, or at any time during the past year, had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) and (3) that has resulted in functional impairment which substantially interferes with or limits major life activities.

Pathways is contracted to provide services to not less than 310 and no more than 385 unduplicated consumers at any point in time. Approximately 75% of census will be consumers with moderate to high intensity service need and 25% of census will be consumers with a low to moderate service need. Pathways provides services to a minimum of 40 and no more than 45 children (and their families) meeting SED criteria. At the time of admission, consumers must meet the Housing and Urban Development definition of Homeless, Chronic Homeless, or At-Risk for Homelessness.

Staffing:
Turning Point Community Programs Pathways has a Mental Health Block Grant budget of $152,000, to partially fund the following positions: Program Director, Psychiatric Registered Nurse, Licensed Clinical Director, Licensed Clinical Team Leader, Team Leader, Family Coordinator, Assessment Coordinator, Personal Service Coordinator III, Personal Service Coordinator II, and Personal Service Coordinator I.

TAB Q

California Behavioral Health Planning Council
General Session
Thursday, October 17, 2019

Agenda Item: Approve June 2019 Meeting Minutes

Enclosures: Draft June 2019 Meeting Minutes

Background/Description:

Attached are the draft meeting minutes for member review and approval.

CALIFORNIA BEHAVIORAL HEALTH PLANNING COUNCIL MEETING MINUTES

June 19-21, 2019
Embassy Suites Santa Ana
1325 East Dyer Road
Santa Ana, CA 92705

CBHPC Members Present:

Lorraine Flores, Chairperson
Raja Mitry, Past Chairperson
Noel O'Neill, Chair-Elect
John Black
Monica Caffey
Vera Calloway
Christine Costa
Karen Hart
Celeste Hunter
Veronica Kelley
Steve Leoni
Barbara Mitchell
Catherine Moore
Kathi Mowers-Moore
Dale Mueller
Monica Nepomuceno
Liz Oseguera
Deborah Pitts
Marina Rangel
Daphne Shaw
Walter Shwe
Sokhear Sous
Deborah Starkey
Cheryl Treadwell
Tony Vartan
Gerald White
Susan Wilson

Staff Present:

Jane Adcock, Executive Officer
Jenny Bayardo
Justin Boese
Ashneek Nanua
Naomi Ramirez
Eva Smith

Thursday, June 20, 2019: Council General Session

1. Welcome and Introductions

Chairperson Lorraine Flores welcomed the Planning Council members to the meeting and invited them to introduce themselves. They stated their names and affiliated county.

2. Opening Remarks

Jeffrey A. Nagel, Ph.D., Behavioral Health Director, Orange County, gave the opening remarks. He began by speaking about the county itself.

- Orange County is changing. In 2016 the formerly conservative voters came out in support of the Democratic presidential candidate. Ten years ago there were two

threshold languages: Vietnamese and Spanish. They now have almost six, having added Farsi, Arabic, Korean, and soon, Mandarin.

- 30% of the population is receiving Medicaid/Medi-Cal.
- It is the third most populous county and the second most densely populated county in the state.

Dr. Nagel has been the Behavioral Health Director for seven months. At this point he spoke about the Peer Employee Advisory Committee. His interest is to value recovery and to increase the engagement of people with lived experience.

- His vision is that if we believe in recovery for those we serve, we must embrace peers in the workforce. It is a model of hope that is very different from what clinicians do. The peer story enables us to understand recovery better and provides enhanced hope for clients.
- He described a training that comprises a panel of people with lived experience working in the county system, who share their recovery story.
- The difference between people with lived experience and peers is that peers take their lived experience and share their stories to help others.
- Peers will play a critical role in all parts of the system; for example, proposal evaluation, employee selection panels, and new services development.
- Peer support is one of the ten Guiding Principles for Recovery at the Substance Abuse & Mental Health Services Administration (SAMHSA). Dr. Nagel described its benefits: it decreases use of inpatient services, decreases self-stigma, decreases costs to the mental health system, decreases hospitalization, and decreases criminal justice involvement.
- The Orange County system currently has approximately 120 peers in the behavioral health system.
- Dr. Nagel tries to utilize two peers per program.
- California and South Dakota are the only two states that have not moved forward with peer certification. Dr. Nagel is an advocate of SB 10 – it will professionalize, create standards, and value the role of peer.
- In 2017, Dr. Nagel assembled a group of peers who created Vision, Mission, and Values statements which he shared.
- Recovery International received a grant from the Office of Statewide Health Planning and Development (OSHPD) and asked the county to work with them on a system assessment and development of an action plan towards peers.
- Dr. Nagel shared the seven strategy areas that come out of the Mission.

- The group of peers with whom Dr. Nagel meets monthly shared that they have faced stigma within the workforce. Orange County had tokenized their involvement in the workforce, not thinking it through. In response, Dr. Nagel wants to elevate their role.
- When peers were brought into the organization, there was no career ladder or peer supervisor. Dr. Nagel is now working with HR to create the career ladder.
- They are piloting a Workplace Wellness Advocate program in each of the clinics.
- They now have a peer orientation for new employees.
- They are creating evaluation tools to look at the impact of the peer workforce.

Questions and Discussion

Ms. Moore asked about the key things that a supervisor on a team needs to know about the peer's role on a team, given that it is different from the rest of the team. Dr. Nagel answered that defining and knowing expectations for the role helps both sides to succeed. He speaks about the stigma peers have experienced because he wants people to recognize it and examine themselves.

Mr. Mitry asked how many of the 120 peers in the system are age 65 and over – that age group has so much to offer. Dr. Nagel replied that he would supply that information through Executive Officer Adcock. It is a smaller subset.

Mr. O'Neill asked if Orange County has considered any peer respite program. Dr. Nagel answered that they are looking at one funded through the Mental Health Services Act (MHSA).

Ms. Hart asked the breakdown between transition age youth peers and family/parent. Dr. Nagel answered that he would get those numbers. They just added 12 family and parent positions on the children and youth side.

Mr. Leoni thanked Dr. Nagel for acknowledging stigma within the system and trying to do something about it.

Ms. Calloway commented that in her experience, it is the clinicians that stigmatizes peers – they are not open to working with them. Dr. Nagel agreed that there is a gamut of attitudes among the clinicians and managers. As we continue to embrace this, he hoped that people will either come along or choose to find a place that matches their beliefs.

3. Approval of the April 2019 Meeting Minutes

Motion: Tony Vartan moved to accept the Minutes from April 2019; seconded by Monica Nepomuceno. Motion carried with abstentions by Daphne Shaw, Celeste Turner, Deborah Pitts, Kathi Mowers-Moore, and Marina Rangel.

4. Review and Discuss Council Recruitment Plan

Executive Officer Adcock stated that a few months ago the Executive Committee approached her about the number of vacancies, which is unusual, on the Planning

Council. The Executive Committee has developed a plan that contains a number of strategies, both short-term and ongoing, including:

- We will have tables at conferences. In the past, usually a staff member has staffed the table; we now encourage Council Members to be present to talk with people as they stop by.
- Council Members are asked to tap into their relationships with other organizations and entities in their area. When they come across someone who may be a good fit, talk about what the Planning Council does to generate possible interest.
- We are still working on diversity proportions: ethnic, cultural, gender, age.
- We are trying to go beyond the usual counties that participate, engaging the smaller counties in particular.
- Executive Officer Adcock indicated the newly developed Recruitment Plan.
- The Planning Council is much more active on Facebook now.
- We have pamphlets and brochures to distribute that describe the Planning Council.
- As members participate in conferences, they are encouraged to do workshops describing the Planning Council.

Chairperson Flores noted that with the new orientation, the mentor meeting, and the various trainings offered, it is easier for new people to come in and understand the purpose of the Planning Council as well as their role.

Mr. Mitry commented on the need to have a transition-age voice on the Planning Council.

Executive Officer Adcock commented on the need for a member who is a parent of a minor with serious emotional disturbance. Ms. Hart mentioned that some years ago when we were recruiting in this age group, we approved stipends for child care. She asked if that was still standing; Executive Officer Adcock said she would look into it. Mr. Leoni commented that those parents are often completely occupied with trying to help that child. Possibly in the years immediately following, they could serve and give their wisdom.

5. Public Comment

There was no public comment.

6. County Behavioral Health Directors Association Update

Michelle Doty Cabrera, the new Executive Director of the County Behavioral Health Directors Association (CBHDA), spoke to the Planning Council. She comes from the Service Employees International Union where she worked on behalf of the frontline workers employed by the behavioral health system.

- We need to remember how much concern exists with the public around health care issues.

- Earlier this year, Kaiser Family Foundation and the California Health Care Foundation released a poll showing that access to mental health services was the number one health-related concern among California voters.
- Interest in behavioral health has expanded. We are in a time of opportunity and we have a lot of educating to do.
- Under the Newsom administration we have an opportunity for real change. The homelessness crisis is overwhelming politicians, and they often turn directly to the public behavioral health system for answers. Suicide and community violence are other looming issues.
- There is a recognition that maybe not everyone in prison should be there. Here again, politicians are looking to behavioral health systems to be a part of the solution.
- There is tension at the state level about the MHSA and unspent funds. At the Medi-Cal level, there is a strong move to pull behavioral health services in under the Medi-Cal managed care plans. There is also concern about how the Department of Health Care Services (DHCS) is now reorganizing itself. The team working on mental health and SUD is being distributed across other DHCS teams that primarily work on Medi-Cal managed care. That culture change will have a big impact on groups such as the CBHPC.
- Next year we are going to be reorganizing the relationship between the state/counties and Medi-Cal – the 1915B Waiver and the 1115 Waiver expire in 2020.
- County Behavioral Health Directors firmly believe in the idea that we need to be better integrated, not just with physical health but also with child welfare systems, education systems, criminal systems, courts, and county welfare offices.
- We need to build out home-based services and community-based services, ensuring a strong continuum. There are people in immediate crisis who need higher levels of intervention, but we need to shift to more of a prevention-based model.
- We need to ensure that our systems evolve in terms of serving cultural and linguistic needs of individuals.

Questions and Discussion

Mr. Leoni raised an issue that many clients have: they fear that in going in for physical health care, they will receive inferior services. There is much stigma in physical health care; we need to impart a better understanding of mental illness to that side.

Mr. Shwe pointed out that in working for the External Quality Review Organization, he frequently sees the issue come up among consumers and family members that providers get changed quite often. He expressed the hope that the reforms in progress would change this. Ms. Cabrera responded that this is a workforce issue; we do not have the kind of workforce we need up and down the continuum. Behavioral health providers are

different from physical health providers in that the individual needs a provider with whom they can work and who knows them.

Ms. Moore agreed that it is particularly important with older adults that the clinician knows them. Information is lost every time the patient changes providers, for both types of health.

Mr. Mitry hoped for open dialogue with the Office of Health Equity in regards to the California Reducing Disparities Project. Ms. Cabrera noted that California is now a state where Latinos outnumber whites. She agreed that the demographic shifting will continue. We are not where we need to be in terms of both acknowledging disparities and of addressing them in our system. She emphasized the importance of using data to prove that problems exist. We need to center a lot more of our quality improvement work around disparities reduction.

Public Comment

A member of the public expressed concern about early identification and prevention for children if the parent must first go through a pediatrician. Ms. Cabrera stated that a key priority population is children. It is important to strengthen ties with schools so that we can actively seek out the children who need services, not leaving it entirely to the primary care physician.

7. Committee/Work Group/Conference Reports

Workforce and Employment Committee

Chair Deborah Pitts provided the report.

- Dr. Keisha Coker from the Los Angeles County Department of Mental Health gave an overview of the county's employment services. Part of the committee's workplan is to get a sense of employment services across the state.
- The committee took a look at Department of Rehabilitation data around the number of people they serve who identify with psychiatric disability.
- The committee looked at the Individual Placement and Support model for employment as well as the Clubhouse model of psychosocial rehabilitation and social enterprises as mechanisms by which mental health consumers can secure employment.
- For the workforce component, Executive Officer Adcock and Justin Boese updated the committee on the Workforce Education and Training (WET) 5-year Plan funding efforts.
- The committee is looking at recommending to DHCS the expansion of the definition of Licensed Mental Health Professionals, including possible provider categories and appropriate criteria.

Legislative Committee

Chair Monica Caffey provided the report.

- Executive Officer Adcock reviewed the legislative process in order to streamline processes for the number of bills the committee to consider.
- The committee supports SB 12, SB 428, and SB 582.
- Much of the focus has been on children and youth, specifically on school districts providing services within the schools and school districts ensuring that teachers are certified in youth mental health first aid (SB 428).
- The committee will support SB 8 if it is amended.
- The committee is watching SB 228, AB 1352, and AB 734.

Patients' Rights Committee

Chair Walter Shwe provided the report.

- The committee discussed AB 2316, which requires new patients' rights advocates to review training materials; counties must verify, then send notification to the Patients' Rights Committee. So far around 19 people have reviewed the training materials.
- Daphne Shaw reported on AB 333. For this year's iteration of the bill, the committee is supporting the private right of action that would *"…enforce the rights and protections afforded to county patient rights advocates and would provide that a violation does not require an administrative investigation by the Department of Industrial Relations."*
- The committee discussed SB 10, Pretrial Detention Reform.
- The committee discussed a report issued by the Denver Office of the Independent Monitor, which detailed an incident in which a 50-year old man died in custody at a Denver jail run by the Sheriff's Department.
- The committee decided to survey advocates working in the county jails.

Housing and Homelessness Committee

Chair Deborah Starkey provided the report.

- The committee received a presentation from Social Model Recovery Systems, who provide adult treatment services for persons with dual diagnosis of substance use and mental illness.
- The committee also received a presentation from Jamboree, who provide high quality affordable permanent and supportive housing and services.
- The committee discussed four legislative bills. They focused on AB 67 for the homeless integrated data warehouse. They felt that it was redundant and unnecessary.
- The Adult Residential Facility (ARF) Project is still on hold pending the outcome of AB 1766, sponsored by the Steinberg Institute.

- The committee wants to develop a white paper on best practice for innovative service models.

Systems and Medicaid Committee

Chair-Elect Liz Oseguera provided the report.

- The committee received a presentation from Michelle Cabrera of the CBHDA about their thinking for the Medicaid 2020 waivers.
- They spent time planning for the October stakeholder meeting about Medicaid.

Children's Work Group

Monica Nepomuceno provided the report.

- The work group discussed what local educational agencies are doing to meet the requirements of AB 2022, which requires schools or county offices of education to notify students and their parents or guardians, at least twice a year, on how to access available school and community-based mental health services.
- The work group followed up on their request to have Dr. Gustavo Loera from the California Health Occupation Students of America (Cal-HOSA) give a presentation to the WET Committee, and a subsequent presentation to the entire Planning Council on Cal-HOSA activities and how they might align with WET goals.
- The work group reviewed its goals to be more constructive and action-oriented. They are working on a draft recommendation for the State Superintendent of Public Instruction to find a legislative champion to author a bill to require high school students to take a mental health course.

Reducing Disparities Work Group

Chair Sokhear Sous provided the report.

- The work group plans to create a workplan and hopes to attract more members by identifying its focus.
- They spoke about the proposal to report to the full Planning Council on outcome by race, ethnicity, gender, etc. to identify the undocumented population.

Performance Outcomes Work Group

Susan Wilson provided the report.

- They are working on three basic projects including the SAMHSA responsibilities, the Data Notebook and annual reporting on performance indicators.
    - This meeting focused on the Data Notebook.
    - They are adding a consistent set of questions to the Data Notebook around key areas of the system that they feel local mental health boards should track.

- They are developing some performance indicators to track over time – a big project.

- The work group was informed that almost 50 of the 2018 Data Notebooks have been sent in.
- The 2019 Data Notebook is about trauma-informed practices.
- Ms. Wilson gave examples of questions they are developing for the Data Notebook.
- They have contracted with UC Irvine for assistance in identifying performance indicators that will help in reporting on the state of mental health in California.

Executive Committee

Lorraine Flores provided the report.

- The committee reviewed the current member roster, as well as a listing for the Executive Committee on new appointments and resignations.
- The committee discussed the Guiding Principles (#9 on today's agenda).

Chairperson Flores asked about any conferences attended by the Planning Council members.

Mr. Shwe attended a National Alliance on Mental Illness (NAMI) conference. He participated in a workshop entitled "Crisis Communication: Getting Voluntary Compliance, Cooperation and Rapport" presented by Sergeant John Wilson of the California Highway Patrol. The workshop provided an easy-to-remember systemic approach to efficiently and effectively establish rapport while getting cooperation. The system can be used in a wide spectrum of situations in which communication is essential for a positive outcome, such as crisis moments with or without mental health consumers, interviews, and interrogations.

Mr. Shwe also attended a workshop titled "Brain XP," a community created by a teenager with mental illness; it is dedicated to ending the stigma toward teenagers with mental illness.

Mr. O'Neill attended a conference on Medication-Assisted Treatment. All participants had the opportunity to be certified in the administration of Narcan, which can be applied nasally when someone is overdosing on an opioid. Speaker Dr. Waller reviewed the etiology of addiction; discussions centered around achieving an authentic dialogue between consumer and provider, and the need for trust and hope in the overall process of recovery. Ample time was spent explaining key medications. Main takeaways were that proper assessment is critical; that thoughtful referral for Medication-Assisted Treatment is very helpful for recovery; and that stigma is one of the biggest barriers for persons seeking recovery.

Mr. Mitry asked about the Narcan certification, which seemed to be a quick process. Mr. O'Neill explained that a general doctor order from the state allows Public Health Departments to distribute Narcan; that order alone authorizes people to give Narcan when

there is a need. The reason it is so easy is that it is extremely effective, and it is not harmful for a person who is not overdosing. Ms. Moore added that you do not have to be certified to administer it. There is now a law that all physicians who prescribe opioids, as well as benzodiazepines, need to at least offer Narcan to the patient and family.

Ms. Hart attended the California Mental Health Advocates for Children and Youth (CMHACY) conference. There was a great emphasis on collaborative services – we can't do it alone and need to come together as a community. A presentation on partnerships contained a noteworthy example: Handle With Care, in which education and law enforcement in West Virginia are collaborating.

Ms. Hart also attended two workshops on system of care leadership. They spoke about engagement, inquiry, explanation, exploration, teaming, advocacy, accountability, etc., and also the need for interagency leadership. One speaker from a panel on residential care spoke about having a separate program for youth who have private insurance.

Ms. Nepomuceno, Mr. O'Neill, and Ms. Flores also attended the CMHACY conference. Ms. Hart mentioned that there were lots of thoughts about humanity at this conference – the presenters spoke about creating systems that are compassionate. She came away reminded of the need for love and compassion in our lives – toward ourselves and toward each other.

Ms. Nepomuceno commented that many counties in California are adopting the Focus program, which is the same as Handle With Care. At some point perhaps Stanislaus County could present on their Focus program. Ms. Wilson noted that Shasta County has just started the program.

Ms. Costa attended the 22nd Annual Latino Mental Health Conference. In addition to cultural and linguistic competency of providers, there was a focus on training all school personnel (not just teachers) in mental health.

Ms. Rangel attended the 44th Annual Forensic Mental Health Conference. They presented the information that 50% of those who have a marijuana-related psychotic episode develop schizophrenia or bipolar disorder. The conference featured two guest speakers: exonerees who had been wrongly convicted.

Ms. Rangel also attended a Shaking Up Reentry Symposium in which Public Health, Behavioral Health, Social Services, Probation, the Public Defender, and the District Attorney's Office were represented along with many community organizations. They talked about how everyone needs to work together and figure out how to stop the revolving door in the criminal justice system. A speaker who had been through the system herself spoke about trauma-informed services.

8. Public Comment

There was no public comment.

9. Council Discussion of Revised Mission and Vision Statements and Proposed Guiding Principles

Chairperson Flores shared the proposed Vision Statement:

> *A behavioral health system that makes it possible for Californians to lead healthy and purposeful lives.*

At the last meeting, the Planning Council members agreed to develop a more precise and concise statement. The same was done with the proposed Mission Statement:

> *To review, evaluate and advocate for an accessible and effective behavioral health system.*

The proposed Guiding Principles were:

- *Wellness and Recovery. Wellness and recovery may be achieved through multiple pathways that support an individual to live a fulfilled life and reach their full potential.*
- *Resiliency Across the Lifespan. Resilience emerges when individuals are empowered and supported to cope with life events.* Mr. Mitry suggested adding *"… individuals of all ages …"* Ms. Moore suggested changing the title to *"Resiliency Across the Ages."* By a hand vote, the Planning Council agreed to add *"… individuals of all ages …"*
- *Advocacy and Education. Effective advocacy for policy change statewide starts with educating the public and decision makers on behavioral health issues.*
- *Consumer and Family Voice. Individuals and their family members are included in all aspects of policy development and system delivery.* Ms. Rangel pointed out that the supportive system is not always family. The Planning Council members agreed by a hand vote with Mr. Mitry's suggestion to strike *"their"* from the tag line.
- *Cultural Humility and Responsiveness. Services must be delivered in a way that is responsive to the needs of California's diverse populations and respects all aspects of an individual's culture.*
- *Parity and System Accountability. A quality public behavioral health system includes stakeholder input and performance measures that improve services and outcomes.* The Planning Council members agreed by a hand vote with Ms. Mitchell's suggestion to add *"parity"* to the tag line: "*A quality public behavioral health system includes stakeholder input, parity, and performance measure that improve services and outcomes."*

Motion: Tony Vartan moved to adopt the proposed Vision and Mission Statements and Guideline Principles as edited; seconded by Monica Nepomuceno. Motion carried unanimously.

10. Public Comment

Barbara Wilson, Los Angeles County, commented with regard to board and care operators: the Los Angeles County Board of Supervisors has made a motion calling for an update on the actual state of these facilities. The report will be submitted before the

Planning Council meets again. There had been a large stakeholder process. Ms. Wilson expressed gratitude to the Planning Council for their efforts to get a higher rate for board and care operators. She stated that the board and care operators have said that if they had more money, they would buy better food and hire more and better staff. The high cost of their insurances is also an issue. Could the state create an insurance fund for the operators to use, to give them a more stable rate?

Friday, June 21, 2019: Council General Session

1. Welcome and Introductions

Chairperson Flores opened the session and welcomed everyone. The attendees introduced themselves: Planning Council members as well as additional participants from local mental health boards and commissions who were present for input to the block grant.

2. California Association of Local Behavioral Health Boards/Commissions Update

Theresa Comstock, CALBHBC Executive Director, provided the update. She introduced the Governing Board members present: Benny Benavidez, Mae Sherman, Stacy Dalgleish, Jessica Bennett, Christine Haajata, and Jerry Harris. She also indicated the CALBHBC members from Southern California who were present.

Ms. Comstock referred to the CALBHBC newsletter included in the packets. It lists the topics deemed important by the local boards and commissions:

1. Gaps in the housing continuum
2. Gaps in the crisis continuum
3. Workforce shortage
4. Jails

CALBHBC is also focusing on the issue of older adults; they are identifying areas for advocacy. They would like to communicate best practices and successes to the boards and commissions.

Dr. Janet Frank from UCLA will be speaking to CALBHBC later in the afternoon.

Ms. Comstock acknowledged the Planning Council's role to advise the mental health boards and commissions; CALBHBC wants to serve as a communication pathway. CALBHBC is looking to the Planning Council for information they can share with the school districts and County Offices of Education, as well as the mental health divisions.

3. Overview of 2020-2021 Mental Health Block Grant Application

Executive Officer Adcock refreshed everyone's memory regarding the purpose and role of the Mental Health Block Grant (MHBG) and the Planning Council's responsibilities.

The Planning Council's role is to participate in the development of the state's application and to review the application prior to the state's submission to the Substance Abuse and Mental Health Services Administration (SAMHSA).

The MHBG is a flexible fund source. It supports a broad range of services specific to the needs of each county. It is often seen as a patch that fills in gaps in services that other funding sources are restricted from covering.

SAMHSA looks for information about the entire system for each state.

The population served with the MHBG has age limits for children/youth and adults; both require a mental health diagnosis; both require an impairment in functioning relevant to the age group.

Because the MHBG funds are available to be used for a very broad array of services, it is much easier to present what the block grant cannot be used for, as listed below.

- Inpatient services
- Cash payments
- Purchase of buildings, land, or equipment
- Satisfying federal match requirements
- Nonprofit entities

Ms. Ramirez reviewed the next steps.

1. Planning Council members and members of the public at the tables will discuss one required section of the MHBG application.
2. In late August, DHCS will send the Planning Council copies of the state's application. It is due to SAMHSA on September 3; the window of time for review will be very short. Ms. Ramirez will send out emails when the Planning Council receives the application. Review discussion will be done via conference call.

Review to be done by the tables was as follows.

- Table 1: **The Health Care System, Parity and Integration**; and **Person-Centered Planning**
- Table 2: **Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness**
- Table 3: **Statutory Criterion for the MHBG**
- Tables 4 and 5: **Recovery**

- Table 6: **Children and Adolescent Mental Health and Substance Use Disorder Services**
- Table 7: **Suicide Prevention**

Mr. Leoni voiced an objection to the short amount of time given to examine the material. For the next MHBG, he requested to start the application review process a year and a half in advance. Executive Officer Adcock explained that until the CBHPC receives the Guidance from SAMHSA, there is nothing that can be discussed. The annual activity is the year-end implementation report due every year on December 1. The application is every other year; SAMHSA comes out with a Guidance a few months before it is due. Today's meeting represents the first time we have done this level of engagement.

Mr. Leoni noted that we are only addressing the required sections; however, we spend a lot of time considering the issues in the optional sections. Not giving input on those optional sections makes this somewhat more of a bureaucratic exercise. DHCS is missing some big pieces.

4. Table Group Discussion of Application Sections

The groups at the tables broke into their discussions.

5. Table Report of Overall Experience and Input

Executive Officer Adcock presented two questions for those reporting out on their discussions:

How was this experience/format for you?

What were the questions and the input that your table received on your topic?

Chairperson Flores believed that the more integrated we are as a council, the better the product that we are able to provide. This was a nice integration of Planning Council members, staff, visitors, and the public, and a viable way of getting and sharing information.

Recovery: Ms. Nanua reported that her assigned group discussed the definition of Recovery. The first paragraph of the MHGB application guidance contains two descriptions that they felt reflect the consumer voice fairly well. The group agreed that recovery must be self-directed with focus on the client and what recovery means to them.

For the 10 guiding principles of recovery, the group felt that addressing trauma is important and that sometimes it is the system that is the source of the trauma. They felt that involving individuals, families and communities is important. They wanted to add "Reducing stigma" to the 10 principles.

In responding to Question #1, they felt that we need to operationalize training – making it consistent throughout the state.

Ms. Nanua relayed the group's answers to the yes/no questions and gave the wording of the descriptions requested in #3 and 4. She listed the programs and activities requested in #5. Areas of technical assistance would be telemedicine, webinars for caregivers,

database training, technical assistance for peer-run organizations, and computer literacy training.

Executive Officer Adcock pointed out that all questions were directed to the state, although in California the 58 counties plus two cities are involved in the delivery of mental health and substance use disorder services.

The Health Care System, Parity and Integration / Person-Centered Planning: a person at the table commented that if SB 10 is approved and signed, we will have peer certification.

Recovery: Toni Lynn Watson reported that the group had decided on Yes for Question 1a), No for 1b), Yes for 1c), Yes for 1d). For Question #2 they were uncertain about the question – does the state utilize the information that has been gathered by the counties?

Ms. Watson gave the descriptions for #3 and 4. For #5 they came up with the following activities: harm reduction model, instilling hope, person-centered care, trauma-informed care, housing first, and Full-Service Partnerships (FSPs). For areas of technical assistance: community-based crisis residential in communities where they live, trauma-informed care implementation, data-sharing, warm hand-offs, informing counties around the recovery model as defined by SAMHSA, peer certification, and county collaboration.

Children's Systems of Care: Ms. Wilson thought the table design of facilitation went very well – particularly effective at this table where there were people with very specific information about children.

Ms. Starkey reported that some of the data in their document was a bit outdated. For children, we do not have an integrated plan at the state or county level except for a few pockets of success. Funding is a consistent limitation, as are state and county-run systems, and siloed approaches.

Activities that are doing well are the new government structure for children in foster care based on CSOC framework, Handle With Care, a new approach coming with the governor, a new State Superintendent of Public Instruction, and a new Surgeon General.

We need to do a better job of braiding our funding using MHSA and block grant funding to sustain block grant activities.

Ms. Wilson addressed the last question regarding technical assistance. The group does not feel that we have a strong children's system of care. With decentralization, the state versus the county level – the state does not really have a good system of care outlined. We need technical assistance on how to develop these plans, as well as how to leverage and braid funding from the various sources. The group also talked about data collection systems and the difficulty of collecting reliable data, and how to transition youth into adult systems of care.

The Health Care System, Parity and Integration / Person-Centered Planning: Ms. Ramirez reported that there was a wide range of expertise at the table that was very beneficial.

Regarding the first question for Integration and Parity, they identified the Whole-Person Care pilots, Health Homes, and Housing First as ways that the state integrates. The counties also have various integration projects.

The second question asked about management of the integration. The state delegates that to the counties, who are the mental health plans.

Person-centered planning is the standard of care, but it can be challenging depending on the age of the client. Children typically have the parents included in the planning process, but for clients age 18-20 it is harder for them to want to include other people in the planning.

Criteria is in place that must be met for Medi-Cal billing.

Statutory Criterion for MHBG (Criterion 1, 3, 4 only): Ms. Bayardo reported that the table comprised half Planning Council members and half public members; the experience was quite interactive.

Available services and resources were crisis residential, transitional residential, wellness and recovery centers, crisis stabilization units, Inspire teams, field-based assessment teams, housing outreach teams, evidence-based depression management teams, post-hospitalization follow-up services, case management mental health services, Law Enforcement Assisted Diversion (LEAD) programs, crisis intervention trainings, mobile vans and other mobile access, integrated behavioral health services and co-location of services, wraparound services, school-based programs, and programs for Transition-Age Youth.

Best practices were No Wrong Door which supplies warm hand-offs and improved connecting across systems.

Case management services included linking people to case managers, and intensive case management services that include recovery assessments used to identify the level of care that is needed.

Activities intended to reduce hospitalization and hospital stays included crisis stabilization, full service partnership (FSP) programs, the Inspire program which engages and motivates individuals to receive services, 24/7 wraparound services, respite care, crisis residential care, and crisis stabilization units.

For Criterion 3 the group marked Yes for all the services.

For Criterion 4, services identified for rural populations were Inspire, Whole-Person Care, farmworker outreach programs, transportation services, telehealth, telepsych, and mobile wellness clinics, For older adults, services included peer specialists, geriatric assessment response teams, older adult service teams, onsite residential wraparound teams, behavioral health and medical geriatric clinics, collaborative partnerships, and integrated care.

Homeless services include mobile assessment units, LEAD programs, FSP, first-responder training, Whole Person Care, No Place Like Home, homeless outreach programs, assessment units at homeless shelters, and staff at Collaborative Courts.

Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI): Ms. Costa reported that there was a lot of expertise at the table and that there had been sufficient time for the discussion.

Ms. Moore reported that the participants had found the questions a bit frustrating because they ask about the state, where in actuality it is all county by county. The data we have is from counties that did turn in paperwork, and it is a year to two years old. It was also difficult to answer questions about the future as well as about numbers or counting.

The first question asks about ESMI state policies, but we have individual county policies.

Evidence-based practices include a number of examples: San Diego County has Cognitive Behavioral Therapy (CBT) for psychosis and motivational interviewing feedback; several counties have PIER services; Imperial County lists eight different peer-reviewed types of interventions; a number of counties use Recovery After an Initial Schizophrenia Episode (RAISE); and many more.

The use of evidence-based practices for individuals with ESMI is a work in progress for DHCS. There is some integration going on, and some local projects are integrating.

Coordinating varies county by county. Orange County has a particular program that integrates public and private monies in order to have access to wraparound services.

The state does collect data from the counties.

Trainings to increase capacity of providers to deliver interventions are done at the county level.

The group was unable to name the 2020-21 plans, partly because there is no plan coming out of DHCS. The others would be county by county and they are all working on it.

The group located a list of diagnostic categories for ESMI.

Suicide Prevention: Executive Officer Adcock reported that the discussion at the table had been genuine and lively.

To their knowledge, the state does not have a suicide prevention plan. DHCS has an Office of Suicide Prevention, and the Mental Health Services Oversight and Accountability Commission (MHSOAC) is actively engaged in the development of a statewide suicide prevention plan.

Each of the counties represented at the table has an emergency response plan, many of which do not address the needs of marginalized communities.

The group identified a number of excellent programs. San Bernardino's program targets the K-12 schools, and they have "A Village" for families who have lost someone to suicide.

San Diego County is quite advanced in the area of strategies supportive of Zero Suicide, with a Suicide Prevention Council.

Initiatives focused on improving the transition of patients being discharged include FSPs. They found that many youth were sent out of county for more elongated residential

treatment support, which separates them from their families and makes the support bifurcated.

Around the state the California Mental Health Services Authority (CalMHSA) has a suicide prevention program. They have initiated a number of activities, including a documentary called *The S Word* and a campaign of public service announcements created by high school and college students.

Much more is needed in the area of supports. Two particular populations of concern are African American males aged 15-24 and the trans community.

6. Public Comment

(Not addressed)

7. Closing

Chairperson Flores thanked all attendees for their participation in the Planning Council meeting, especially today's table discussions.

8. Adjourn

Chairperson Flores adjourned the meeting at 11:36 a.m.

TAB R

California Behavioral Health Planning Council
General Session
Thursday, October 17, 2019

Agenda Item: Innovation in Recovery: A Continuum of Hope

Enclosures: Innovation in Recovery Power Point Presentation

Background/Description:

Alice Washington is an associate at the California Institute for Behavioral Health Solutions. Ms. Washington was awarded a Bachelor's of Art degree from Stanford University during March of 1988. Her major was Sociology: Social Sciences. In the past few years, Ms. Washington has received a Train-the-Trainer Certificate from California State University, Sacramento. In 2013, Alice completed an A.S. in Graphic Design. She also completed a Diploma in Web Design and Interactive Media in December 2015. In 2017, Alice started a blog called Just Saying…All About That Hope where she highlights stories of lived experience associate with mental health, substance use, etc.

Copies of the presenters Power Point Presentation will be available at the meeting.

TAB S

California Behavioral Health Planning Council
General Session
Thursday, October 17, 2019

Agenda Item: Meet Tom Insel, Governor Newsom's Advisor on Mental Health

Enclosures: Article from Kaiser Health News
https://www.healthleadersmedia.com/governors-mental-health-czar-seeks-new-blueprint-care-california-0

Background/Description:

On May 21, 2019, Governor Newsom issued two important announcements that have impact on the public behavioral health system. The first is the formation of the Homeless and Supportive Housing Advisory Task Force and its co-chairs Sacramento Mayor Darrell Steinberg and Los Angeles County Supervisor Mark Ridley-Thomas.

The second is the Governor's appointment of psychiatrist and neuroscientist Dr. Tom Insel as a key advisor providing insight in developing strategies to address mental health issues. Dr. Insel is a nationally recognized leader in the science of mental health and evidence-based practices to assist people suffering from various conditions. Working with Secretary Ghaly, Dr. Insel will inform the state's work as California builds the mental health system of tomorrow, serving people whether they are living in the community, on the streets or if they are in jails, schools or shelters.

Dr. Insel served as director of the National Institute of Mental Health (NIMH), the component of the National Institutes of Health (NIH) committed to research on mental disorders. Prior to NIMH, Dr. Insel was a professor of psychiatry at Emory University, where he was founding director of the Center for Behavioral Neuroscience in Atlanta. Dr. Insel led the Mental Health Team at Verily (formerly Google Life Sciences) in South San Francisco and, most recently, has served as co-founder and president of Mindstrong Health. Dr. Insel is a member of the National Academy of Medicine.

Over the past months, Dr. Insel has met with a number of groups to hear about the strengths, needs, challenges and opportunities in California for the system serving individuals with serious mental illness. This is an opportunity for Council members to provide input as well as hear about Dr. Insel's impressions of and vision for the system.

This article was first published on Thursday, August 29, 2019 in ***Kaiser Health News.***

In a career full of twists, turns and high-powered assignments, Thomas Insel may now be embarking on one of his most daunting tasks yet — helping California find its way out of a worrisome mental health care crisis.

This year, he assumed a new role to help Gov. Gavin Newsom revamp mental health care in the state. Newsom called Insel his "mental health czar," though his position is unpaid and Insel says it grants him "no authority." Even so, he is zigzagging across California this summer, visiting mental health facilities to try to understand what works and what doesn't.

Insel's meandering career path began early. A precocious student, he enrolled in a joint B.A.-M.D. program at Boston University at age 15 and then took a one-year hiatus to volunteer in clinics across Asia. He returned to finish his medical degree and later completed a three-year psychiatry residency at the University of California-San Francisco.

As a young scientist at the National Institute of Mental Health in the 1980s, Insel researched the effects of antidepressants, then shifted gears to study the neurobiology of emotional attachment in the prairie vole, a rodent known for monogamous behavior.

His groundbreaking research revealed that the vole's devotion to a single mate was attributable to higher levels of a protein in its brain. That work — along with earlier research on anxiety in monkeys — led to a job running the Yerkes National Primate Research Center in Atlanta starting in 1994. He returned to NIMH in 2002 as its director and headed the institute, the world's largest funder of mental health research, for the next 13 years.

In 2015, Insel left NIMH to lead mental health initiatives at Verily, Google's life sciences research subsidiary. He jumped ship after a year and a half to join a startup, Mindstrong Health, which hopes to prove that the way people use their smartphones can reveal the state of their mental health — and provide opportunities to intervene. Insel also serves as board chairman of the Steinberg Institute, a Sacramento-based nonprofit focused on California mental health policy.

In May, he took a temporary leave from Mindstrong to work intensively, at Newsom's behest, on a mental health plan for the state. He intends to return to the company early next year and continue advising the governor for "as long as I can be useful."

California Healthline joined Insel on Aug. 19 as he toured Oakland's Trust Clinic, a medical and mental health center serving the city's homeless population. We sat down with him for an interview afterward. His comments have been edited for space and clarity.

Q: How would you describe the state of mental health in California and in the U.S.?

California has all the issues every other state has — incarceration, homelessness, fragmentation. More than half of people with mental illness are not getting care. There is a very shallow workforce, particularly for kids. We don't have inpatient beds where we need them.

I've spent 40 years working in this field. We have seen vast improvement in those 40 years in infectious diseases, cardiovascular care, many areas of medicine, but not behavioral health. Suicides are up about 33% since the turn of the century. Overdose deaths are skyrocketing. People with serious mental illness die about 23 years early — and we're not closing that gap. We've got to come up with better solutions now.

Q: What insights are you gaining as you visit programs around the state?

People managing these programs are heroic in what they're able to do with limited resources and tremendous demands. We have 58 mental health systems because we have 58 counties, and we have a separate system for mild to moderate mental illness. It's very fragmented — including between mental health and substance use. One family might interact with four different providers to get behavioral health care. That's not the system one would design if you're starting with the patient.

Q: How should the system be designed?

The system now is crisis-driven. The biggest transformation will come when we can identify problems and intervene earlier. That's when we get the best outcomes in diabetes, heart disease, cancer. It's equally true in behavioral health. We have to manage crisis better, keep people out of the criminal justice system, provide more continuity of care. But we also have to move upstream and capture people much earlier

in their journey. This will require building infrastructure we don't have right now: crisis residential beds, sub-acute beds, places for people to live.

Q: So how do we bring about the needed changes?

California has one advantage few states enjoy. The Mental Health Services Act (MHSA) will provide $2.4 billion this year, including for early intervention, prevention and innovation. We also have [other] funds. Every county is using those funds in the way it sees fit.

The time has come to ask: How can we reduce suicide, overdose deaths and re-hospitalization in California? One approach would be to set goals for these, i.e., reduce suicide by X% in Y years. Housing and incarceration have gotten worse over time. Should the state make a pledge to its citizens to do better in those areas?

Q: Who would ensure such a pledge is honored?

Counties are still ground zero for all this. They're our connection to schools and jails, and places where the mental health crisis is playing out. The question is, can the state do more to help them succeed? One thing I've heard from every county is that the burden for documentation means that 35% to 40% of the time is taken up with paperwork, not providing services. Can we set them loose to do what they want to do?

Q: Can technology play a role in improving mental health?

As much as one might hope there'd be an app for that — it's really complicated. In the months I've focused on creating a mental health plan for California, technology is barely in the conversation. Having said that, I do think in the future using digital tools to connect people to care will be transformative.

Q: The recent mass shootings in El Paso and Dayton, like numerous others before them, were perpetrated by angry, alienated young men. What does this say about our culture and the American psyche?

It's a complicated question. There is an element of untreated mental illness that leads to high risk of violence. That violence is usually self-directed in the form of suicide; occasionally, it's other-directed. We did better, oddly enough, when I started in the field than we're doing today in providing more comprehensive, continuous care. I think we are in a crisis, but it's a crisis of care. So whether the mass shootings are a reflection of that or not — maybe to some extent, but they're a small part of a much bigger issue. We are failing to provide care to people with brain disorders. We need to do better.

KEY TAKEAWAYS

'People managing these (mental health) programs are heroic in what they're able to do with limited resources and tremendous demands.'

'We have 58 mental health systems because we have 58 counties, and we have a separate system for mild to moderate mental illness. It's very fragmented.'

'We have to manage crisis better, keep people out of the criminal justice system, provide more continuity of care.'

'We also have to move upstream and capture people much earlier in their journey. This will require building infrastructure we don't have right now.'

Tab T

California Behavioral Health Planning Council
General Session
Friday, October 18, 2019

Agenda Item: Keynote Speaker

Enclosures: None

<u>How This Agenda Item Relates to Council Mission</u>

To review, evaluate and advocate for an accessible and effective behavioral health system.

This agenda item provides Council members the opportunity to learn about the administrative and financial structure of California's public behavioral health system including how the Medi-Cal 1915(b) and 1115 waivers play a role in service delivery. The Council will use this knowledge to advocate for an improved system of care and provide recommendations to the Department of Health Care Services (DHCS).

Background/Description:

Michelle Cabrera, Executive Director of the County Behavioral Health Directors Association of California (CBHDA), will provide an overview of the public behavioral health system in order to build foundational knowledge for the remainder of the Behavioral Health 2020 presentation. Attendees will use this information to understand the current structure and barriers within the Medi-Cal mental health and substance use delivery systems to help form recommendations on the renewing Medi-Cal 1915(b) and 1115 waivers in 2020.

As the Executive Director of CBHDA, Ms. Cabrera leads efforts to transform behavioral health service delivery in California by investing in the development of community-integrated, comprehensive, quality mental health and substance use disorder services.

Ms. Cabrera has a wealth of experience on state budget and policy as a legislative staff consultant and lobbyist. Prior to joining CBHDA, she served as the Healthcare Director for the California State Council of the Services Employees International Union (SEIU), where she advocated on behalf of healthcare workers and consumers, including county behavioral health workers. She served as a Senior Consultant for the Assembly Human Services Committee where she specialized in child welfare issues; and served as a Program Officer for the California HealthCare Foundation. Ms. Cabrera serves as a member on the National Quality Forum's Standing Committee on Disparities and serves on the Board of Directors of the California Pan-Ethnic Health Network.

Tab U

California Behavioral Health Planning Council
General Session
Friday, October 18, 2019

Agenda Item: Panel Presentations

Enclosures: Nevada County Behavioral Health Presentation
Behavioral Health 2020: Exploring Options for System Transformation Presentation

How This Agenda Item Relates to Council Mission

To review, evaluate and advocate for an accessible and effective behavioral health system.

This agenda item will educate Council members on the risks and opportunities involved in transforming the Medi-Cal mental health and substance use delivery systems through the Medi-Cal 1915(b) and 1115 waiver renewals in 2020. The Council will use this knowledge to advocate for an improved system of care to the Department of Health Care Services (DHCS).

Background/Description:

California is seeking a waiver renewal in 2020 that will move the Medi-Cal program forward through delivery system and payment transformation. The Medi-Cal Specialty Mental Health Services (SMHS) program is “carved-out” of the broader Medi-Cal program and operates under the authority of the 1915(b) waiver approved by the Centers for Medicare and Medicaid Services (CMS). The 1115 Waiver is composed of pilot programs that will allow the state to continue its pursuit of better care and improved health equity and outcomes for individuals served by the Medicaid program.

The panelists will offer small county, large county, and regional perspectives on the issues and priorities to address for improving service delivery and financing for California’s behavioral health system. Each panelist will discuss their interface with the Medicaid system, the opportunities and risks to consider with the renewing Medi-Cal waivers, and the goals to accomplish according to their perspective.

Panelists include:

- Dr. Leonard Finocchio, Principal Consultant, Blue Sky Consulting Group
- Margaret Kisliuk, Behavioral Health Administrator, Partnership Health Plan
- Bill Walker, Director, Kern County Behavioral Health and Recovery Services
- Phebe Bell, Director, Nevada County Behavioral Health Department

Council members and public attendees will have the opportunity write down questions and comments during the presentations for the Q&A portion of the event.

Copies of the presenters Power Point Presentation will be available at the meeting.

Presenter Biographies

Leonard Finocchio, Dr.P.H.

Dr. Finocchio has over 25 years of health policy development, research and implementation experience in government, academia, advocacy and philanthropy. As a principal consultant at Blue Sky Consulting Group he has led projects assessing Medi-Cal's Regional and Geographic Managed Care Models and the integration of physical and behavioral health. Previously, Dr. Finocchio was part of Governor Brown's team as Associate Director at the California Department of Health Care Services leading the implementation of the Affordable Care Act in California. He was a senior health researcher at Mathematica Policy Research. While a Senior Program Officer at the California HealthCare Foundation, Dr. Finocchio led program strategy, grant-making, and research in the areas of health services for the uninsured, Medicaid and CHIP programs, and safety net capacity. He has also held senior health policy positions at the Institute for Health Policy Solutions, Children Now and UC San Francisco HealthForce Center. Dr. Finocchio also has published articles in Health Affairs, Academic Medicine, the Journal of General Internal Medicine and the American Journal of Public Health.

Phebe Bell, MSW

Phebe Bell is currently the director of Behavioral Health for Nevada County. In this role she oversees the mental health and substance use disorder programs provided by the county. She also works closely with the many community partners who provide critical services through contracts with the county. Bell previously has served as the Tahoe Truckee Program Manager for Placer and Nevada counties, where she managed Health and Human Services offices in the Tahoe Truckee region for two counties overseeing behavioral health, public health, and social services programs. In this role she worked closely with community partners, advocating for regional needs, exploring opportunities for collaboration between the counties and ensuring smooth operations of existing offices and programs. Prior to working for the county, Ms. Bell spent over 20 years working in local nonprofits serving children, youth and families in the Tahoe area including organizations focused on domestic violence and suicide prevention.

Bill Walker, LCSW

As director of Behavioral Health & Recovery Services, Mr. Walker is responsible for the administration of publicly funded mental health, crisis, substance use disorder, and prevention services provided to adults, adolescents, and families. Additional responsibilities include oversight of a multi-million dollar budget which includes federal and state categorical funds, program planning and development, program evaluation, contract management, quality improvement, training and technical assistance, client problem resolution, strategic planning, budget forecasting, and human resources and personnel services. Mr. Walker has extensive experience working with diverse mental health and substance use populations and their loved ones. He also spent 25 years teaching the CADAAC SUD Counseling Program at California State University, Bakersfield.

Margaret Kisliuk, JD

Behavioral Health Administrator Ms. Kisliuk directs Partnership Health Plan of California's behavioral health care services including oversight of the delivery of mental health services and development of the substance use service benefit for Partnership's 550,000 members in 14 counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Sonoma, Trinity and Yolo counties. Ms. Kisliuk was previously at the Marin County Department of Health and Human Services as the Chief Assistant Director, Director of Public Health Programs and the Director of Mental Health & Substance Abuse Programs. Her previous health plan experience includes service as the CFO and Assistant Executive Director at MetroPlus Health Plan in New York.

Tab V

California Behavioral Health Planning Council
General Session
Friday, October 18, 2019

Agenda Item: Panelist Q&A

Enclosures: None

<u>How This Agenda Item Relates to Council Mission</u>

To review, evaluate and advocate for an accessible and effective behavioral health system.

This agenda item provides Council members and public attendees the opportunity to ask questions pertaining to the financing structure and service delivery for California's public behavioral health system based on large county, small county, and regional perspectives. The Council will use this knowledge to advocate for an improved system of care and make recommendations to the Department of Health Care Services (DHCS) regarding the renewing Medi-Cal 2020 waivers.

Background/Description:

The Council and pubic attendees will submit their questions to the panel through comment cards. The event facilitator will direct audience questions to the panelists.

Panelists will answer audience questions and contribute to a discussion that will enable deeper analysis of the barriers and systematic reform opportunities through the Medi-Cal 1915(b) and 1115 waivers.

Tab W

California Behavioral Health Planning Council
General Session
Friday, October 18, 2019

Agenda Item: Stakeholder Feedback and Discussion

Enclosures: California Health Care Foundation's Executive Summary of "Behavioral Health Integration in Medi-Cal" Report

How This Agenda Item Relates to Council Mission

To review, evaluate and advocate for an accessible and effective behavioral health system.

This agenda item provides the Council members an opportunity to gather feedback from collateral partners, sister organizations, and behavioral health advocates on strategies to address barriers in California's Medi-Cal mental health and substance use delivery systems. The Council will use this feedback to advocate for an improved system of care when providing recommendations to the Department of Health Care Services (DHCS) for the Medi-Cal 1915(b) and 1115 waiver renewals in 2020.

Background/Description:

The California Behavioral Health Planning Council is mandated in state law to review and report on the public mental health system, to advocate for adults and older adults with serious mental illnesses and children and youth with serious emotional disturbances and their families, and to make recommendations regarding mental health policy development and priorities.

Stakeholder processes are often a necessary component in successful policy reform. Therefore, the Council places an emphasis on gathering input on from behavioral health advocates and individuals served by the system to promote policies that contribute to an improved system of care.

Audience members will have the opportunity to deliver their comments and recommendations to the Council in verbal or written form. The Council will use this feedback to help formulate recommendations to DHCS on the Medi-Cal 1915(b) and 1115 waivers renewals.

California Health Care Foundation

Behavioral Health Integration in Medi-Cal:
A Blueprint for California

FEBRUARY 2019

Executive Summary

People with behavioral health — mental health and/or substance use disorder — conditions often experience poor health across all domains. While they have higher rates of major chronic illnesses, they are less likely to receive preventive care and often experience a lower quality of care for their physical health needs. Individuals with a diagnosis of serious mental illness (SMI) or substance use disorder (SUD) die on average over 20 years earlier than individuals without such a diagnosis, often from preventable physical illnesses. People with behavioral health diagnoses incur costs that are four times greater than those without, with the difference largely attributable to increased physical health care spending. Among the over 13 million California residents who receive care from the Medi-Cal program, 5% of enrollees account for over half of all spending — and 45% of this high-cost population has a diagnosis of SMI. And, in California as in other states, mental illnesses and SUDs are more prevalent in people with lower incomes.

This paper puts forth an ambitious framework to transform a fragmented system in California in which Medi-Cal enrollees with complex behavioral and physical health needs often fail to receive needed care that must be coordinated across multiple and disparate service delivery systems. This framework builds on areas of strength within the current structures while addressing the systemic barriers to improving care due to the current organization, financing, and administration of physical health care, mental health care, and SUD care in Medi-Cal.

The disparate funding streams and decentralized structures of behavioral health care in Medi-Cal have evolved over decades through a series of legal, political, and financial arrangements. As a result, most beneficiaries who need care for chronic physical, mental health, and SUD issues confront three systems:

- Managed care plans for physical health services and for non-specialty mental health services
- County mental health plans for specialty mental health services
- County Drug Medi-Cal for SUD services, either through the Drug Medi-Cal Organized Delivery System pilot programs or through the traditional (and more limited) standard Drug Medi-Cal programs.

The disconnected responsibilities for these services limit the incentives for each entity to invest in whole-person care as well as prevention and early intervention across the continuum of needs. Fragmentation in the current system often results in critical disruptions in care and a lack of care coordination, which lead to poor health and social outcomes as well as increased health care costs.

It is an axiom in health care that every system is perfectly designed to get the results it achieves. In Medi-Cal, if California aims to meaningfully improve outcomes for people with behavioral health needs, the systems that serve them must be redesigned. Effective redesign must address three pervasive challenges: (1) fragmentation of physical and behavioral health care for people with SMI and/or SUD, particularly for those with co-occurring chronic physical diseases; (2) disparate systems of mental health care for mild to moderate versus severe levels of need; and (3) separation of mental health and SUD services for people needing both types of services.

The recommendations in this paper were developed through a series of three meetings held between June and October 2018 and attended by leaders with deep experience in county behavioral health departments, behavioral health provider organizations, state agencies, Medi-Cal managed care plans, consumer advocacy, policy research, and philanthropy (the "work group"). The meetings were informed by presentations from leaders from other states on different approaches to behavioral health integration in Medicaid, as well as synthesized interview findings from a broad group of California stakeholders.

Integrated care. The delivery, coordination, and payment for care related to the full continuum of an individual's physical and behavioral health needs, as managed by a single accountable entity.

Guiding Principles

The work group developed a core set of guiding principles for an integrated system of physical and behavioral health care that would lead to better outcomes for enrollees.

- Provide an accessible and well-coordinated continuum of care, from prevention to recovery services.
- Deliver person- and family-centered care that is culturally responsive and advances health equity.
- Promote hope and wellness while building on individual, family, and community strengths.
- Deliver high-quality services across care settings while ensuring choice in the care provided.

With these principles in mind, and with consideration of experience in California and in other states' Medicaid programs, the work group established a clear goal to guide system redesign, as well as nine recommendations to achieve this goal.

Goal

By 2025, all Medi-Cal enrollees will experience high-quality, integrated care for physical health, mental health, and substance use needs, with all of an individual's care managed by a single entity accountable for payment, administration, and oversight.

Recommendations

1. Assign responsibility for physical and behavioral health services to Medi-Cal managed care plans, while allowing delegation to interested counties and/or regions to the extent that such partnerships meet a single statewide standard for integration, quality of care, and accountability.
2. Implement statewide integrated care for Medi-Cal enrollees through a phased process beginning in 2020 and completed by 2025, in order to foster a transition that ensures continuity of care and promotes long-term sustainability.
3. Ensure that accountable entities develop the internal capacity, expertise, and infrastructure required to effectively manage integrated physical and behavioral health care.
4. Identify immediate and long-term opportunities to reform existing state and local behavioral health funding mechanisms, statutes, regulations, and/or other policies to promote the delivery of integrated care.
5. Incorporate principles of risk and value-based payment into the financing of behavioral health services in order to align incentives with desired outcomes.
6. Engage stakeholders to ensure that accountable entities are responsive to individual and community needs, and that the new system of integrated care delivers on the promise of improved consumer and family outcomes.
7. Foster integrated physical and behavioral health care for dual eligible enrollees by promoting the alignment of Medicare and Medi-Cal benefits in accountable entities.
8. Establish standard process and outcome measures and accountable, transparent systems to monitor and evaluate the ongoing impact of integration across the state.
9. Strengthen the behavioral health workforce to ensure access to high-quality care during and after the transition to integrated care.

These ambitious recommendations aim to ensure that Medi-Cal enrollees and families receive the prevention, treatment, and recovery services needed to achieve their health and quality-of-life goals. As informed by the approaches of other states in tackling the challenges of poor health outcomes and high costs for individuals with complex physical and behavioral health needs, this paper describes an achievable statewide pathway toward integrated care delivery by 2025. California now has the opportunity to take bold action to become a national leader in improving the health and well-being of Medi-Cal enrollees. Grounded in principles of recovery, equity, choice, and transparency, these recommendations point to a system that is far more capable of producing desired outcomes for Medi-Cal enrollees with behavioral health needs, and for California as a whole.

The recommendations in this paper were universally endorsed by the members of the work group, who represent a broad array of stakeholders and regions across the state:

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Affiliations are for identification only and do not reflect endorsement by the named organizations.