NAMI California
National Alliance on Mental Illness

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February 9, 2015

Mari Cantwell
Chief Deputy Director of Health Care Programs
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

Re: 1115 Waiver and Housing Strategies

Dear Ms. Cantwell:

National Alliance on Mental Illness (NAMI) California is a grassroots organization of families and individuals whose lives have been affected by mental illness. We have 67 local affiliates, spread throughout all regions of California, providing education and support, and advocating for lives of quality and respect for our constituents. Most prominently, we provide evidence-based mental health programs, and training on facilitating these programs in localities. We thank you for your commitment to the 1115 waiver process, and for making housing for vulnerable populations a priority for California. While not a formal member of the Housing Workgroup, NAMI California has attended the workgroup meetings as a member of the public, and we thank you for this opportunity. Based on the discussions in the workgroup and the experiences of our members, we offer the following recommendations for the success of the housing portion of the 1115 waiver:

1. **The eligible population should be expanded to include chronically homeless individuals who have been diagnosed with a mental illness but not also a chronic medical condition and/or substance use disorder.**

Individuals living with serious mental illness who are experiencing chronic homelessness may be utilizing emergency rooms and other high cost health services for essential treatment. However, many of these individuals could benefit from housing and care coordination, to the point where their use of the health care system would change and become more manageable. For this reason, they are precisely the target population for this demonstration whether or not they have a co-occurring condition.

Additionally, while integration of mental and physical health care is significantly improving in recent years, many individuals with serious mental illness and particularly those who face economic or other barriers do not receive

adequate screening and care for physical health conditions. A 2006 study published in the Journal of Internal Medicine showed that persons with schizophrenia were significantly more likely to have one or more chronic conditions compared with controls. However, because persons with schizophrenia were also less likely to have frequent medical visits or receive detailed examinations, these conditions were often undiagnosed[1]. Therefore, this demonstration should include those whose sole diagnosis is a mental illness, understanding that the many remaining barriers to care may leave these individuals without accurate diagnoses for other conditions.

Lastly, the condition of homelessness increases the risk of an individual developing or exacerbating a substance use disorder, as well as many medical conditions[2]. We should not exclude individuals with mental illness from housing based services until they develop another medical condition. Rather, we should offer housing based services now, to both prevent future health complications and promote recovery for the individual.

2. Include peers and peer services in the covered housing based health care services.

The housing-based case management services that DHCS has proposed including as covered services in this demonstration include pre-tenancy support, tenancy support and care coordination. NAMI California believes that peer specialists are effective providers for many of the proposed services, and that a peer specialist program must include individuals living with mental illness (consumers) and family members. Family members have valuable experience and perspective to bring to recovery and wellness. Additionally, a peer specialist program should provide meaningful employment and a career ladder so that consumers and family members working in mental health care have the opportunity to utilize their skills to fully contribute. In currently operating peer specialist programs, peers perform duties that include wellness, resilience and recovery coaching; navigating systems and community services; assisting in the development of individual wellness plans; and outreach to potential beneficiaries. In fact, peer specialists have been shown to be more effective than traditional providers in reaching populations that are historically underserved by the health care system[3]. For the chronically homeless population, it is particularly important to take this factor into account and consider the use of a peer specialist program. Additionally, the workforce development section of 1115 waiver strives to attract new health care professionals, address scope of practice limitations and develop innovative ways to address whole person care. Peer specialist services would help meet these goals.

3. Include clinical services in housing-based mental health care services.

NAMI California believes that the tenancy support and care coordination services proposed by DHCS are essential for individuals living with mental illness. We also encourage DHCS to consider including housing based clinical services for this population. Coordinating care between primary care and behavioral health, as well as facilitating

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[1] Carney, Caroline P., Laura Jones, and Robert F. Woolson. "Medical Comorbidity in Women and Men with Schizophrenia." *Journal of General Internal Medicine* 21.11 (2006): 1133-137. Web.
[2] Wright, J. D. (1990) “Poor People, Poor Health: The Health Status of the Homeless.” *Journal of Social Issues* 46 (1990): 49–64. Web.
[3] Repper & Carter.“A Review of the Literature on Peer Support in Mental Health Services”. 2011.

transportation to appointments, are services that will increase access to care. However, offering primary care and mental health care services on site will promote recovery and optimal health outcomes. We recognize that there are financial and other considerations for offering these services. We also know that chronically homeless individuals with mental illness face numerous barriers to accessing timely and quality mental and primary health care. Providing these treatment options within the housing based services framework could have a significant impact on the lives of these individuals, and on costs in the health care system.

4. **Use funds from savings pool to finance development of crisis residential facilities.**

While long term housing is a crucial component of housing development for individuals with mental illness, NAMI California also encourages the development of crisis residential facilities. Crisis residential facilities meet the need of providing intensive services for people with mental illness who are experiencing acute psychiatric episodes. These facilities offer a safe and effective alternative to jails, emergency rooms and in-patient psychiatric hospitals. Using recovery focused tools including crisis stabilization, peer mentoring, medication monitoring and discharge planning. Crisis residential facilities meet the essential components of the 1115 waiver by reducing hospitalizations of high cost users, and instead stabilizing these individuals through community based services. We understand that current funds will not be used for housing development, but encourage DHCS and county entities to consider the development of crisis residential facilities with funds from the savings pool created by this process.

5. **Create linkages with in-patient psychiatric facilities to provide services upon discharge to individuals at risk of homelessness.**

NAMI California is pleased that DHCS has expanded the potential eligible population for this demonstration to include individuals who have experienced periods of in-patient hospitalization of at least 30 days during the previous 24 months. We encourage DHCS, counties and health care plans to create linkages with in-patient facilities to ensure that individuals being discharged who are at risk for homeless receive the full range of services offered under this demonstration. Individuals who are recently discharged from an in-patient psychiatric facility are at particular risk for re-hospitalization without proper discharge planning and supportive services[4]. The services offered by this demonstration, with the addition of clinical services, could help an individual continue his or her recovery and avoid unnecessary hospitalization. However, this needs to be included in discharge planning.

Thank you for your consideration of our recommendations. Should you require more information, please do hesitate to contact Kiran Savage-Sangwan, Legislative and Public Policy Analyst at Kiran@namica.org or 916.567.0163.

[4]Nelson, Anne E., Maruish, Mark E., Axler, Joel L. "Effects of Discharge Planning and Compliance with Outpatient Appointments on Readmission Rates." *Psychiatry Online* 51.7 (2000) 885-889.

Sincerely,

Jessica Cruz, MPA/HS
Executive Director
NAMI California

Cc: Jennifer Kent, Director, Department of Health Care Services
Karen Baylor, Deputy Director, Department of Health Care Services
Diana Dooley, Secretary, Health and Human Services Agency
Donna Campbell, Deputy Secretary, Health and Human Services Agency
Senator Ed Hernandez, Chair, Senate Health Committee
Assemblymember Rob Bonta, Chair, Assembly Health Committee
Marjorie Swartz, Office of President Pro Tempore Kevin De Leon
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