DEPARTMENT OF HEALTH CARE SERVICES
Behavioral Health Stakeholder Advisory Committee (BH-SAC)
April 29, 2021
9:30 a.m. – 12:30 p.m.

MEETING SUMMARY

Behavioral Health Stakeholder Advisory Committee (BH-SAC) Members Attending: Barbara Aday-Garcia, California Association of DUI Treatment Programs; Jei Africa, Marin County Health Services Agency; Sarah Arnquist, Beacon Health Options; Ken Berrick, Seneca Family of Agencies; Michelle Doty Cabrera, County Behavioral Health Directors Association of California; Carmela Coyle, California Hospital Association; Jessica Cruz, NAMI; MJ Diaz, SEIU; Alex Dodd, Aegis Treatment Centers; Steve Fields, Progress Foundation; Sarah-Michael Gaston, Youth Forward; Sara Gavin, CommuniCare Health Centers; Brenda Grealish, California Department of Corrections and Rehabilitation; Andy Imparato, Disability Rights California; Kim Lewis, National Health Law Program; Robert McCarron, California Psychiatric Association; Farrah McDaid Ting, California State Association of Counties; Maggie Merritt, Steinberg Institute; Deborah Pitts, University of Southern California Chan Division of Occupational Science and Occupational Therapy; Jonathan Porteus, WellSpace Health; Hector Ramirez, Consumer Los Angeles County; Kiran Savage-Sangwan, California Pan-Ethnic Health Network; Cathy Senderling, County Welfare Directors Association of California; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Chris Stoner-Mertz, California Alliance of Child and Family Services; Mandy Taylor, California LGBTQ Health and Human Services Network, a Health Access Foundation program; Catherine Teare, California Health Care Foundation; Gary Tsai, MD, Los Angeles County; Rosemary Veniegas, California Community Foundation; Bill Walker, MD, Contra Costa Health Services; Stephanie Welch, California Health and Human Services; Jevon Wilkes, California Coalition for Youth.

BH-SAC Members Not Attending: Vitka Eisen, HealthRIGHT 360; Britta Guerrero, Sacramento Native American Health Center; Veronica Kelley, San Bernardino County; Linnea Koopmans, Local Health Plans of California; Aimee Moulin, UC Davis/Co-Director, California Bridge Program; Jonathan Sherin, Los Angeles County Department of Mental Health.

DHCS Staff Attending: Will Lightbourne, Jacey Cooper, Palav Babaria, Kelly Pfeifer, Jim Kooler, Marlies Perez, Jeffrey Callison, Norman Williams, Morgan Clair.

Public Attending: There were 191 members of the public attending.

Welcome, Introductions, and Today's Agenda
Will Lightbourne, DHCS Director

Director Lightbourne welcomed members to the April meeting of the BH-SAC. He reviewed

the agenda and thanked the California Health Care Foundation for their ongoing support of the committee.

Director's Update
Will Lightbourne and Jacey Cooper, DHCS
Slides: https://www.dhcs.ca.gov/services/Documents/BH-SAC-presentation-042921.pdf

Director Lightbourne informed members that the Governor's May Revision will be out in approximately three weeks. State revenue is better than was projected at this time last year, and the federal American Rescue Plan Act will bring additional resources to state and local governments. One item of interest for BH-SAC is the commitment of Medicaid resources for mobile crisis resources. That would not become available until spring 2022. President Biden's proposed American Families Plan also has implications for both Medi-Cal and Medicare, and DHCS is tracking this because DHCS is in the process of launching the Office of Medicare Innovation and Integration.

The federal Administration has indicated its intention to continue the COVID-19 public health emergency (PHE) in 90-day increments through 2021. In California, COVID-19 infection rates are slowing and vaccination efforts are accelerating, although there are remaining concerns in communities of color and low-income communities. The Governor has indicated that the Blueprint for a Safer Economy, with its tiered guidelines for safely reopening, will expire in mid-June. Over time, DHCS and other government business practices will resume in person. Many DHCS staff will continue to work virtually, and meetings such as BH-SAC will continue virtually through 2021.

Consultants are working internally across DHCS to identify opportunities and develop targets to close disparities and improve equity. The intention is to reference DHCS equity goals in the draft Medi-Cal managed care plan (MCP) procurement Request for Proposal (RFP) in June and then improve upon it based on stakeholder feedback for the final procurement RFP later in the year. DHCS consolidated its equity work and quality oversight and created a position to lead this work, the Chief Quality Officer and Deputy Director of Quality and Population Health Management. Dr. Palav Babaria was hired for this new role. Babaria introduced herself and offered brief highlights of her history and experience working in the safety net, recently with the Alameda Health System. She said her role there included oversight of behavioral health practices and integration of behavioral health, substance use, and specialty mental health.

Cooper provided an update on the 1115 and 1915(b) waivers. DHCS is seeking two federal waivers to implement CalAIM. Public comment is open until May 6, 2021. Cooper reported that the new 1115 waiver is more limited than past waivers due to budget neutrality. An 1115 waiver is needed for expenditure authority to continue multiple programs, and there are new programs in the 1115 waiver as well. Proposals in CalAIM for justice-involved individuals include in-reach 30 days prior to release from incarceration. DHCS is also re-engaging with CMS on traditional healers and natural helpers within the Drug Medi-Cal Organized Delivery System (DMC-ODS). There's also a proposal to provide access to the Providing Access and Transforming Health (PATH) Supports model to support the transition of Whole Person Care pilots to Enhanced Care Management (ECM). The details are posted on the CalAIM webpage.

Cooper reviewed the consolidated 1915(b) waiver. She noted that the 1915(b) waiver process relies on a template proposal. California has had a 1915(b) waiver for specialty mental health services and is now proposing a consolidated 1915(b) waiver with the following elements:

- Medi-Cal Managed Care
- Dental Managed Care
- Specialty Mental Health Services (SMHS)
- Drug Medi-Cal Organized Delivery System (DMC-ODS)

The 1915(b) waiver also clarifies what has been referred to as "medical necessity" in behavioral health and mental health services. The waiver clarifies responsibility between MCPs and mental health plans (MHPs) and looks to the federal medical necessity criteria and expectations to align with the documentation requirements. DHCS heard extensively from counties and providers that the current regulations on documentation hinder access to care and drive unnecessary administrative functions that should be removed to streamline and improve access. The waiver also includes treatment services during an assessment period prior to diagnosis as a no wrong door to facilitate treatment of co-occurring diagnoses. Finally, there is an attachment that outlines using the 1115 waiver to request Institution for Mental Disease (IMD) expenditure authority and traditional healers and helpers. The base authority for DMC-ODS will transition from an 1115 to a 1915(b) waiver and expand peer support services, contingency management, and Medication Assisted Treatment.

Written comments can be sent to DHCS. In addition, public comment webinar sessions will be held on April 26, April 30, and May 3. Cooper reviewed the timeline for the initial draft submission (June 2021) to CMS that will incorporate public comment. CMS will first conduct a completeness review, followed by a 30-day federal comment period. DHCS will work directly with CMS to obtain approval by the end of 2021.

Questions and Comments

Lewis: Do you anticipate modifications prior to submission to CMS?

Cooper: There is a six-week period to incorporate public comments and fine tune the proposal. We have to document public comments as part of the federal submission and indicate our response. Following the completeness review, there will be a federal 30-day comment period.

Savage-Sangwan: Can you share more about the tribal traditional healers in ODS and if you see potential to apply this broadly in county mental health services? We have been interested in how other types of providers may help close disparities in communities of color. How can you accomplish that kind of integration into behavioral health?

Cooper: DHCS has been discussing this with CMS. It was denied in the 1115 waiver

extension request, and we are bringing it back to consider adding as culturally appropriate services for beneficiaries in California. CMS has indicated this will be challenging. If CMS approves this, we would explore opportunities in mental health and other services.

Pfeifer: DHCS is committed to exploring with CHCF – there is a compelling need, given the tragically high overdose rates. We will collaborate with tribes to define the role of natural healers and culturally specific practices, and ensure that the practices are only available through Indian health providers. We are hoping this will start conversations for other cultures as well because of the importance of culturally and community-defined practices.

Teare: Can you offer a timeline for other changes, such as the medical necessity and payment changes outside the waiver?

Cooper: There are a number of items to roll out between now and the end of 2021. I don't have a full schedule here, but we will be transparent. Kelly Pfeifer has been meeting with workgroups, and we are fine tuning those pieces to inform policy changes.

Kelly Pfeifer, DHCS: We published a grid of each component of the medical necessity proposal in the waiver proposal document and how it is being addressed in CalAIM; we will share more information as available.

Doty Cabrera: We endorse the work being done on community-defined practices in Medi-Cal and have ideas for how we can begin to do this outside of Medi-Cal. For sustainability, it makes sense to ensure reimbursement through Medi-Cal for both mental health and substance use disorders. Latinx and Asian Pacific Islanders are underserved in Medi-Cal across MCPs and specialty behavioral health. Can you talk about the work of the consultants on disparities? I want to make sure that consultants are also considering behavioral health systems.

Lightbourne: Yes, the consultants are looking across services; it is not limited to physical health. There is a focus on behavioral health.

Diaz: Director Lightbourne mentioned there will be a consultant report released in May, and it will inform the draft RFP. Could you provide details on the report, release, and other analysis or recommendations to be included? Will that be made public?

Lightbourne: The draft will be released in early June. Because of the timing of the consultant report, it will point the way to closing equity gaps with the expectation that more specifics will be included in the final RFP. We will circulate the report to this group and look forward to gathering input.

Implementation of SB 803: Peer Support Specialists
Marlies Perez, DHCS
Slides: https://www.dhcs.ca.gov/services/Documents/BH-SAC-presentation-042921.pdf

Perez offered an overview on Peer Support Specialists (PSS). Senate Bill (SB) 803 was enacted on January 1, 2021, and requires DHCS to seek federal approval to establish PSS as a Medi-Cal provider type and establish peer certification standards. DHCS is proposing

to add PSS as a unique provider type and to allow counties to opt in to provide this resource. A PSS must be self-identified as having experience with the process of recovery from mental illness or substance use disorder, either as a consumer of services or as the parent or family member of a consumer. A PSS helps beneficiaries engage in the recovery process and reduce the likelihood of relapse. California is one of the last states to implement PSS. There are peers throughout California providing these types of services with other funding sources. The timeline for setting certification standards is aggressive in order to have this accomplished in time for the waiver approval. Two listening sessions are complete, and in July DHCS will disseminate initial notices on the PSS certification program standards. There will be technical assistance sessions held with counties this summer and fall to prepare for implementation in January 2022, following federal approval.

SB 803 required extensive stakeholder engagement. In addition to listening sessions and public input, DHCS engaged in meetings with a diverse set of organizations, such as the California Association of Mental Health Peer Run Organizations (CAMHPRO), California Behavioral Health Planning Council, and California Council of Community Behavioral Health Agencies. The listening sessions were attended by more than 900 participants, and feedback summaries are posted on the website. DHCS is working through both the 1115 and 1915(b) waivers to establish the benefit, billing, coding, and related items for PSS in the three carved out behavioral health programs - State Plan DMC, DMC-ODS, and Specialty Mental Health Services (SMHS).

Questions and Comments

Lewis: How does this apply to youth under age 21 since Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) is in place and not optional? Counties already provide PSS through a rehab option or targeted case management. It will be important to have this service available to all adults as a State Plan benefit, but I also want to ensure we are not creating confusion about the obligation to have PSS continue for youth as non-optional services.

Perez: To clarify, DHCS is not changing anything around the EPSDT obligation to provide services that youth need, and that includes peer services.

Lewis: I want to clarify that this means it will continue to be provided without certification. How might certification impact existing services?

Perez: Under the SMHS system, some services are being provided under “other qualified providers.” DHCS will provide guidance on how that piece works. We haven’t finalized everything yet, but we are working on this and will be transparent about our efforts as we roll this out.

Imparato: You mentioned we are one of the last states to do this. What are the lessons from other states?

Perez: Georgia and Pennsylvania have great models. The Substance Abuse and Mental

Health Services Administration (SAMHSA) released a lot of guidance on peers. We have been working with CAMHPRO, an organization that represents peers, and are hearing from peers themselves. Some states did not have that voice.

Veniegas: Thank you for this. In 2015, we met with eight states on the inclusion of PSS in Medi-Cal. The elements you outlined – administrative support, thought leadership, integration, and the inclusion of lived experience – align with the recommendations of that group. If there is an opportunity to support additional meetings, you can count on the California Community Foundation. There is a report from 2014 that I'll forward that summarizes many of the lessons learned across the other 40 or so states that have PSS under Medicaid.

Ramirez: I want to thank DHCS for the listening sessions. As for other states where there was an absence of Black, Latino, Native, and other people of color from system impacted communities, in the listening sessions I attended, I noted an absence of those voices, tribal communities, and people with disabilities. I encourage DHCS to reengage and ensure the listening sessions represent the majority of the people of California, and that services are accessible and disability-focused.

Perez: Thank you and we are not finished yet. Any groups that feel they have not been able to provide feedback, we are open to hearing their input.

Perez continued with slides offering information on initial DHCS policy recommendations for each area required by statute. She emphasized that these are not final decisions, but are shared in the spirit of transparency. DHCS is open to more input from any group interested in engaging.

- Training: Initial recommendation is for 80 hours of training for certification.
    - There may be additional job training from employers in addition to certification training. Most input suggested more than 40 hours of training is needed, with 60-80 hours recommended from stakeholder organizations.

- Continuing education: Initial recommendation is 20 hours of training every two years; 40 hours if re-certifying.
    - Most feedback was aligned with this recommendation.

- Core competencies: 16 core competencies were required by state statute. The initial recommendation is that no additional competencies should be required.
    - Input included adding storytelling within a resiliency framework, digital literacy, structural competency, and team and interprofessional practices as a standalone competency. DHCS will weave the guidance into the 16 core competencies listed in statute. CAMHPRO provided a document that outlines training for the 16 competencies and maps it to SAMHSA core competencies.

- Areas of specialization: Crisis services, forensic, homelessness, and parent peers are the initial areas recommended for specialization.
    - Others could be added as we move forward.

- Range of responsibilities: Structured, scheduled interactions and activities that promote socialization, recovery, self-advocacy, relapse prevention, development of natural supports, and maintenance of community living skills.
    - Input from listening sessions highlighted wellness, community integration, disability rights, role modeling, and housing. There was a recommendation to include Georgia billing practices.
- Scope of practice requirements: The state statute and CMS requirements are recommended without additions at this time. Requirements from federal and state statute that cannot be changed are that the PSS must be 18 years of age and have a high school diploma.
- Practice Guidelines: DHCS recommendation is to adopt SAMHSA practice guidelines.
- Supervision standards: DHCS recommendation is that PSS supervisors should be a behavioral health professional and receive peer supervisor training.
    - Input was varied and included comments on the need to ensure that supervisors receive training on how to supervise a peer; ensure that supervisors could be peers or clinicians; and Pennsylvania supervision standards could serve as a good model.

Questions and Comments

Tsai: Most people in the substance use workforce have lived experience and are providing Medi-Cal reimbursed services. We use registered substance use counselors. We meet with the 30 substance-use counselor certifying bodies on a regular basis and have learned a great deal from them. Currently, registered substance use counselors can provide Medi-Cal reimbursable services with a minimum of 9.5 hours of training. PSS standards will be above the registered counselor standards. There is institutional history on how the 9.5 hours was arrived at, and my understanding is that it was never intended to be a long-term floor. There is a critical need to invest time and resources specifically in the substance use workforce as health and social service systems integrate.

Africa: In hearing about the certification requirements, it seems the onus is on peers. I want to push back about the responsibility of the organization to embrace peers and create leadership ladders for them. There is a responsibility to ensure that PSS with lived experience can be Behavioral Health Directors one day. That is missing. I also think that we need discussion to operationalize recovery socialization because there is not much uniformity in how it is being described. Providing some flexible guidelines so that it does not look different across counties is important. Finally, as leaders we should think about how systems can embrace and elevate PSS to ensure they become part of our leadership.

Ramirez: The certification standards should not make it difficult for people doing this work, particularly for people of color. I didn't see any agency that provides peer services among those giving input. For example, I recommend that Mental Health America, with 75 years of experience, should be engaged to offer new ideas to reflect in the recommendations.

Stoner-Mertz: It is important to look at what already exists in EPSDT, particularly the rehab option, and not only for peers. Parent partners have become a rich component of programs serving youth through wrap-around programs, and we depend on them. I also agree that the onus is on us in the system to create an environment that is welcoming and does not limit PSS to entry levels, but encourages leadership and career ladders. I have not heard how we will address the issue that, for many peers, their primary language is not English. The technical assistance related to this will be critical.

Cruz: For the many of us working on peer certification, the intent is to have the definition of peers include the family, parent partner, and caregiver. In many of the presentations, by not having an organization or people representing parents and caregivers as one of the key stakeholders, it shows that the focus is not on the families, individuals, parents, and caregivers who have been doing this work side by side with counties. To ensure there is a career ladder. I see a barrier in the oversight where the person supervising the peer must be a clinician. Please let me know if you did not receive the letter from NAMI and Alliance for Children and Families submitted with specific recommendations. As a group that represents parents/families and caregivers, we think those recommendations should be part of the public comment, and I didn't see it reflected in what was presented today.

Perez: DHCS received the NAMI letter and 40 to 60 more letters. Today is a short presentation so pieces may seem to be missing, but they are included. For example, we are working with Parents United and other partners on parent peers. We think that is important.

Cruz: Just to be clear, there is a difference between parent peers and family members. Parent peers are usually for individuals who are under age 18, while family members are for individuals over 18. I don't want to lose sight of the family members and their role as peers.

Doty Cabrera: We found the process to be rich in terms of stakeholder engagement. Our recommendation is that there would be the option for either a clinician or a trained peer to do supervision. I want to underscore the career comments made by others to say that county behavioral health has lifted up an infrastructure of peer services outside of Medi-Cal reimbursement. This discussion is to pull more of what is done outside of Medi-Cal into Medi-Cal billing, wherever appropriate. The standalone benefit will create sustainability for these services. There will be some peer programs that we believe will continue outside of Medi-Cal. This benefit is voluntary for counties because we weren't able to secure ongoing reimbursement for the whole state. We view peers as an actual treatment modality.

Fields: I want to add my voice to previous comments that we don't want to replicate going backwards on the hierarchy of skills and capabilities as we move into new areas and new territory. We have hired peers since 1978 in crisis residential treatment programs as the front door of the acute care system. Peers have moved up the career ladder to program director levels and leadership in our agency, and we need to continue to broaden professionalism. Perhaps we need to use the Mental Health Rehab Specialist category, for which there is a credentialing process for supervision.

Perez reviewed additional slides. DHCS must develop a code of ethics, and she noted that

there is consensus on the recommendation to modify CAMHPRO's "Working Well Together" code of ethics. In addition, there must be a biennial renewal process, and DHCS does not have additional recommendations to what is outlined in statute. DHCS must also develop a complaints and corrective action process and is recommending approval of existing procedures:

- Counties investigate complaints in a specified timeframe.
- Substantiated allegations require either education hours, suspension, and/or revocation.
- Appeal process determined by county or an agency representing the county.

DHCS will recommend a process for peers already employed to become certified, grandmothering that includes reciprocity between counties and with other states. Perez reviewed the recommendations for county pilot program plans, fee schedules, periodic reviews, and reports. She commented that although PSS will begin this year, it is going to be a culture shift that requires time and technical assistance.

Questions and comments

Gavin: CommuniCare has six peer advocates employed, as we call our peer specialists, in multiple systems. I echo the comments about supporting inclusion and advancement. I am concerned about some of the bureaucracy associated with this. Many of the peers we employ were previous clients who gained training and confidence and who may find the proposed process cumbersome. I want to highlight health care as an environment to focus on for peer development. As we are integrating systems, especially in federally qualified health centers (FQHC), we are seeing clients navigate many systems, and peers are critical. Reimbursement structures in behavioral health are based on credentials and education. Peers come to work and use their lived experience, and that is valued, important, and hard. I would love to see a reimbursement structure that supports and aligns with that.

Perez summarized and offered final comments. DHCS has been meeting with peer-run organizations and have heard many peers share their stories on their resiliency. Their recovery is inspiring to DHCS. We recognize peers are special and an important aspect of how we deliver behavioral health care.

Questions and comments

Taylor: I am excited that DHCS is ensuring input from consumer organizations. I want to highlight that there are many communities who are getting peer support, yet do not participate in those organizations, people who may have felt harmed by the mental health system. I suggest contacting LGBTQ centers as most of them provide peer support. Communities of color also have community-based centers where consumers may not be plugged into formal systems. People will be more likely to access supports if they see themselves represented.

Mobile Crisis Response: New Opportunities in the American Rescue Plan Act of 2021

Kelly Pfeifer
Slides: https://www.dhcs.ca.gov/services/Documents/BH-SAC-presentation-042921.pdf

Pfeifer began the presentation with comments that the moment for this opportunity is important because, as a nation, we are grappling with equity and the fact that our crisis response system is profoundly unjust. When a person of color has a mental health crisis, the chance that it could escalate into a deadly encounter is much higher than it is for whites. People of color are also disproportionally put into the criminal justice system instead of treatment. California does not have an adequate crisis response across our state, but many counties are participating in a learning collaborative around how to implement the Crisis Now model. It is deceptively simple and operationally complex because the basic idea is to deliver on the promise that anyone, wherever they live, deserves prompt care with trained professionals.

- *Who to call*: The federal government is launching a 988 line in July, 2022 as an alternative to 911 for a mental health or substance use crisis.

- *Who to respond*: Implementation in other states demonstrated that 90 percent of calls could be managed on the phone. For calls that need an in-person visit, a mobile crisis trained team should be deployed, including a trained peer support specialist and a licensed professional.

- *Where to go*: Crisis-receiving facilities with a robust system of home-like environments that have trained professionals and peers to deescalate the situation until the individual is able to gather themselves and go back to their community.

California has a 988 implementation grant from Vibrant Health led by Didi Hirsch Mental Health Services. There will be a draft report in August and a final report by the end of the year. The American Rescue Plan Act is an opportunity to implement a Medicaid benefit of mobile crisis services. There would be 85 percent federal match funding. The funding cannot supplant existing services, and we are waiting for guidance on the specifics.

Finally, we are excited that the Governor's budget includes $750 million General Fund financing for the last element – where to go – for counties and tribes to create partnerships with providers and to implement new treatment services. DHCS is completing a county-by-county gap analysis that will be completed in November to help target resources.

Questions and comments

Doty Cabrera: We are excited about the 85 percent match for mobile crisis response. It is very important to clarify the non-supplantation definition because most counties do have a patchwork of services. We contemplate 988 as a public benefit for all Californians, not only those on Medi-Cal. Everyone could then link up with a crisis mobile unit. Broader infrastructure is needed to support having those mobile crisis teams ready. We have significant workforce shortages and don't have clinicians waiting for phone calls. So, I would say that the 85 percent match is encouraging. It will be a stretch to get to that

broader Medi-Cal capacity. We need to be realistic and understand that there is a long way to go to have this widely available as a public benefit.

Berrick: How do we integrate kids and families into mobile response? Most crises in schools are met by a school police officer or a police response that, for many, ends in expulsion or juvenile hall – bypassing the help they need. So, integrating youth is crucial. Second, having mobile response without the full continuum can be counter-productive. Having that continuum includes new options, like drop-in centers with support and onsite stabilization in larger venues like high schools to avoid expulsion. This is a game changer, and I could not be more excited about it.

Porteus: Many think of us as a FQHC and behavioral health provider in Northern California. We are also the suicide prevention line for 50 counties and, as mental health providers, we are excited about this option for crisis response. I think we all share the concern about how to roll it out in a state where only 10 out of 58 counties have a 24-hour crisis presence. We are grateful to all the entities working on this thoughtful way to transition to a more integrated model.

Taylor: I would like to see integration in the process, as counties and tribes are applying for this funding. I want to see DHCS require a commitment that applicants do not use any funding for law enforcement agencies. That is what often happens now as a crisis response, and sometimes they propose an interdisciplinary team through the police system. It is not a safe option for many communities. I would also like to see a requirement for a cultural competency foundation, not a last minute after thought. Queer, the trans community, Black, indigenous, and people of color experience disproportionately negative outcomes in a crisis. They have less access to resources and are more likely to have law enforcement involved and be incarcerated instead of receiving treatment. Finally, I would like to see that we do not supplant community-based organizations that are already doing this work. Many locations have local mutual aid efforts or community response teams, particularly in communities of color and trans communities. I want to make sure that funding does not go to build new systems based on a medical model instead of supporting systems that are in place and are culturally affirming and culturally supportive.

Lewis: This is another instance where we need to be clear about existing obligations of county mental health and Medi-Cal crisis services. We need to build on the existing obligations for youth to have access to services when medically necessary, and that are not necessarily being met. There is a lack of clarity about who is doing what, even with EPSDT requirements. We hope this is an opportunity both for federal funding to expand services as well as clarify and shore up existing services to create a full continuum of services everywhere. The best practice is to have crisis planning as part of treatment, implemented by someone who knows them, not by calling 911 or the police. When people have a crisis plan and know who to call, they get better results.

Savage-Sangwan: I want to emphasize that interdisciplinary teams is not about police and social workers, not about expanding this model that keeps people from getting the right kind of services. This is a core racial justice issue in mental health, and I would encourage the planning group for 988 to include racial justice organizations to have this perspective considered.

Fields: This is an important opportunity to use the 85 percent match to do something new. I want to emphasize for the gap analysis, as they consider the elements of crisis response, that there are varying definitions of crisis residential or community placement. We need standardization to make sure there is an ecology of the three parts of the system. Mobile crisis historically turns into case finding for hospitals because the person needs a place that can handle an acute crisis, and counties often do not have a true alternative environment to the hospital. You can't disengage this from the early intervention models that go with the 988 number. It is important that the application demonstrates they have a place for people to get the interrelated services needed for success.

Tsai: This is a pivotal opportunity to intervene at an important time in people's lives. I want to flag that the match is time-limited. I am interested in DHCS' thoughts on sustainability related to that. Also, on the planning funds, are we imagining that we will need phased improvements to refine crisis and mobile crisis response?

Pfeifer: There are lots of unanswered questions. There are 12 quarters of enhanced federal match, and we do not know what the plan will be following that.

Ramirez: In LA County, most crises are met by law enforcement. We recommend that families do not call 911 in a psychiatric situation because it can lead to harm and trauma. This is an opportunity to transform to a community-driven system, and California can lead. We cannot continue to use law enforcement.

Berrick: No county I know of has been able to scale up mobile response for youth or any population in crisis in a way to make it available on demand. I hope counties that have stepped forward to meet needs are not damaged by this clause.

Coronavirus Response and Relief Supplemental Appropriations Act SAMHSA Funding
Marlies Perez
Slides: https://www.dhcs.ca.gov/services/Documents/BH-SAC-presentation-042921.pdf

Perez began by reporting the significant increase in overdose-related deaths nationally and in California. Nationally, drug overdose deaths are predicted to increase by 24 percent. In California, drug-related deaths increased by 20 percent. Fentanyl was a factor in 36 percent of overdose deaths, an increase of 89 percent from the prior year. The funding being presented is pre-ARPA and was included in the second stimulus package in

December 2020. The focus today is on funding through SAMHSA. DHCS received $238 million for substance use and $108 million for mental health as an additional time-limited allocation over two years. Perez offered information about proposed statewide projects that are pending SAMHSA approval. The funding will conclude in 2023. Counties, tribes, providers, non-profits, and consultant organizations are eligible entities.

Questions and Comments

Taylor: I want to suggest the term "pregnant people" to be more inclusive.

Veniegas: First, consider guaranteeing that administrative costs are covered under relief funding and find ways to reduce the administrative burden and enhance equity support. Under CARES, administration was not covered. Also, as we look to include justice-experienced individuals in programs, having a background check is a barrier to their involvement.

Walker: There is a plethora of expanded funding. In particular, related to the county projects in the last presentation, is there information on timelines, applications, distribution, and how this will be added to existing county programs?

Perez: DHCS has a draft supplemental application. We will meet with counties for input prior to releasing it. There is no exact timeframe, but projects include billing as of July 2021.

California's Response to Overdose Crisis during COVID-19
Kelly Pfeifer
Slides: https://www.dhcs.ca.gov/services/Documents/BH-SAC-presentation-042921.pdf

Pfeifer reviewed detailed data related to the overdose crisis. DHCS developed an issue paper posted on the DHCS website. A few years ago, California was proud of how it had flattened overdose death rates, while dramatic increases were occurring across the country. However, the pandemic has been devastating for individuals struggling with SUD, and we are seeing huge increases in overdose rates. Pfeifer reviewed the increases for overall overdose deaths as well as deaths due to fentanyl, cocaine, and stimulants. People are using substances alone due to the pandemic and, with unwitnessed overdoses, we are missing opportunities for overdose reversal with naloxone. With social isolation, there may be more despair, and it may be harder for people to get to treatment. We are pushing telehealth to make treatment accessible. The motto is "treatment starts here." Whether a person accesses the health care system, criminal justice system, or mental health and SUD treatment community, the goal is they are compassionately screened, assessed, and directed to effective treatment.

There has been a massive culture shift to Medication Assisted Treatment (MAT), with more than 650 access points and 55,000 people being treated. There is also a significant expansion of naloxone, with more than 31,000 overdose reversals. CalHOPE is the

pandemic-related response to normalize the stress and anxiety and offer a warm line, virtual crisis counseling, peer support, and a media campaign. DHCS is working to build capacity in the system through school behavioral health, a 988 response, and proposals to expand services and leverage new funding as presented throughout the meeting. Finally, CalAIM is an important effort to redesign Medi-Cal to streamline access, promote integration, reform payment, and expand DMC-ODS to new counties. For stimulant use disorder, the only truly effective treatment with strong outcomes is contingency management, yet it is still a hard sell with the community. We welcome your comments.

Questions and Comments

Veniegas: Five years ago, we didn't imagine many of the services and supports currently in place; five years from now, I hope access to medication for opioid use disorder, PSS, and mobile crisis response are in place. For the items that cannot yet be included in the next submission to CMS, what opportunities exist under these funding sources to gather the preliminary data, so that 12 quarters from now, we have the preliminary data to go into the next cycle of waivers? I hope we will think of these as braided funding opportunities as opposed to siloed funding opportunities.

Teare: As we look nationally, MAT and buprenorphine is not equally accessible across race and ethnicities. Where and when might we see that data for California?

Pfeifer: That is challenging. Buprenorphine is dispensed through the pharmacy benefit, and race is not a category that is collected by pharmacies when filling prescriptions. DHCS is working on equity, although it will be hard to produce data on buprenorphine by race. We are trying to improve our data and to stratify data by race and ethnicity wherever we can to make sure inequities are addressed.

Tsai: We are concerned about the overdose numbers for Los Angeles County and are planning more investment in harm reduction options, including syringe exchange. We are able to use federal block grant funding for some harm reduction, yet there are federal limitations. One of the best ways to get to the 90 percent of people who would benefit from substance use services, and are not getting it, would be to have flexible funding for harm reduction. I mention this for planning purposes to find ways for counties to partner with the state for flexible funding for harm reduction initiatives.

Public Comment

Steve McNally: I am a family member not involved in any organization. I appreciate the openness of DHCS and ask that for complex topics you provide process maps and summary exhibits to make it easier to understand and participate. There are many generalities being discussed without reference to specific situations. Recovery is not siloed, but we have to deal with many siloed organizations. The more we can do to leverage funds, identify the warm handoffs, and who owns recovery in a leadership or secondary position is helpful. It is difficult for a patient-centered philosophy to be seen at

the local level.

Le Ondra Clark Harvey, California Council of Community Behavioral Health Agencies: I think mobile crisis response is wonderful, and we also have to recognize that there are other modalities for providing crisis services. In particular, the culturally responsive modalities for certain populations as representatives from CPHEN and the LGBTQ health and human service networks so eloquently put it. I look forward to continuing to work together.

Sherry Daley, California Consortium of Addiction Programs and Professionals: Congratulations on the great work. It is exciting to see the federal and state government spring into action. On PSS, we are monitoring this and happy to see the standards. We are standing by to integrate them into our certification program, assist counties in the grandmothering, and promote the new standards to invite people into the field to get certified as quickly as possible. We have a workforce bill with a $9 million allotment specifically for the SUD workforce. I am glad to see that workforce is something included in block grant funding. How do we coordinate between the legislative ask and this new money?

Alex Kahn, California Chronic Care Coalition; We are excited to see the waiver request to extend Medi-Cal coverage to prisoners within 30 days of release. We believe this is a critical step to addressing the needs of one of California's most vulnerable populations. We want to voice concern with DHCS' disparate treatment of FDA-approved MAT options in the revised CalAIM proposal. As a patient-centered organization, we believe in a system of care that provides access to effective and appropriate treatment, based on patient choice, and ensures informed patient decision-making. The choice of SUD medication should be based on shared decision-making and a patient's preferences, goals, and motivations. DHCS' proposal continues to differentiate between FDA-approved injectable, naltrexone, and other FDA-approved MAT treatment by requiring coverage of two of the three while classifying injectable naltrexone as optional. This runs contrary to the no-wrong-door model. When all three MAT options are accessible, we can ensure long-term progress in the fight against addiction. We would urge DHCS to reconsider that policy and create parity for all FDA-approved MAT options.

Pfeifer: All medications used in MAT are available through pharmacies without pre-authorization. DHCS does not differentiate between the types of medications available to treat addiction.

Stacie Hiramoto, Racial & Ethnic Mental Health Disparities Coalition: REMHDCO supports the comments made by Mandy Taylor, Kiran Savage-Sangwan, and Michelle Cabrera in support of racial, ethnic, and LGBTQ communities, the needs that we have and the concerns that we have.

Tiffany Carter, Cal Voices: I want to give a brief statement on peer certification to emphasize that peers must have the same lived experiences as those they are supporting. Cal Voices has been doing this work for 75 years. We supported creating the advanced national peer certification. We do peer support and peer advocacy, and we are the only testing site in California for the national certification. We welcome collaborating to provide

support moving forward with this initiative.

Next Steps and Final Comments; Adjourn
Will Lightbourne

Director Lightbourne thanked stakeholders and state staff for an outstanding meeting.

The dates for 2021 quarterly meetings are:

- July 29, 2021 – 1:30 p.m. – 4:30 p.m.
- October 21, 2021 – 9:30 a.m. – 12:30 p.m.