

**DEPARTMENT OF HEALTH CARE SERVICES
BEHAVIORAL HEALTH STAKEHOLDER
ADVISORY COMMITTEE**

October 29, 2019

MEETING SUMMARY

Members Attending: Barbara Aday-Garcia, California Association of DUI Treatment Programs; Sarah Arnquist, Beacon Health Options; Ken Berrick, Seneca Family of Agencies; Catherine Blakemore, Disability Rights California; Michelle Cabrera, County Behavioral Health Directors Association of California; Carmela Coyle, California Hospital Association; Vanessa Cuevas-Romero, Sacramento Native American Health Center; MJ Diaz, SEIU; Alex Dodd, Aegis Treatment Centers; Vitka Eisen, HealthRIGHT 360; Steve Fields, Progress Foundation; Sara Gavin, CommuniCare Health Centers; Jim Kooler, California Friday Night Live Partnership; Linnea Koopmans, Local Health Plans of California; Kim Lewis, National Health Law Program; 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; Kiran Savage-Sangwan, CA Pan-Ethnic Health Network; Jonathan Sherin, Department of Mental Health, County of Los Angeles; Al Senella, CA 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 program of Health Access Foundation; Catherine Teare, California Health Care Foundation; Dean True, County Behavioral Health Directors Association/Shasta County Health and Human Services Agency; Gary Tsai, MD, Los Angeles County; Rosemary Veniegas, California Community Foundation; Bill Walker, MD, Contra Costa Health Services; Stephanie Welch, Department of Corrections and Rehabilitation.

Members Attending by Phone: *Jessica Cruz, NAMI California.*

Members Not Attending: Andrew Herring, California Bridge Program; Veronica Kelley, San Bernardino County; Robert McCarron, California Psychiatric Association; Frank Mecca, County Welfare Directors Association of California.

DHCS Attending: Richard Figueroa, Mari Cantwell, Kelly Pfeifer, Brenda Grealish, Marlies Perez, Jacey Cooper, Lindy Harrington, Janelle Ito-Orille, Norman Williams, Morgan Clair.

Public in Attendance: 94 members of the public attended in person and 393 phone participants.

Welcome, Introduction of BH-SAC Members, Kelly Pfeifer, MD, and Purpose of BH-SAC

Mari Cantwell, Chief Deputy Director of Health Care Programs

Kelly Pfeifer, MD, Deputy Director for Behavioral Health, DHCS

Mari Cantwell opened the meeting and welcomed DHCS Acting Director, Richard Figueroa, and asked each state staff person in new and reorganized positions to introduce themselves. She outlined the reorganization related to Behavioral Health. She introduced Kelly Pfeifer, new Deputy Director for Behavioral Health Services, as well as the Division Chiefs under that area, Janelle Ito-Orille for Licensing and Certification and Marlies Perez for the Community Services Division. There are also new divisions that are responsible for Medi-Cal Behavioral Health Policy and Financing that fall under Health Care Delivery Systems, with Brenda Grealish now in the Medi-Cal Behavioral Health Division Chief role and a new division under the Deputy Director for Health Care Financing, called LGFD, that will be responsible for BH financing among other things, that division chief position is still open. Kelly Pfeifer spoke to the opportunity to work in more integrated ways to deliver Medi-Cal services.

Richard Figueroa offered introductory comments on DHCS' new initiative, California Advancing and Innovating Medi-Cal (CalAIM). It advances specific prescriptions for individualized needs of multiple populations, older Californians, justice-involved, homeless, vulnerable children, high complexity/high cost users and those with behavioral health needs. It sets a foundation for more efficient health care by incorporating initiatives to fight the state's homeless crisis, support justice system reform, and build a platform for more integrated systems of care. There are many streams being woven together that will support the exploration of single payer principles. He offered appreciation to previous DHCS Director, Jennifer Kent and DHCS staff for thousands of hours traveling the state to listen and gather input, thinking, and writing to develop this proposal.

A Local County Innovation in Behavioral Health Services: Los Angeles County and Martin Luther King, Jr. Hospital

Jonathan Sherin, MD, Director, Los Angeles County Department of Mental Health

Slides available: <https://www.dhcs.ca.gov/102919bhsacmeetingmaterials>)

Dr. Sherin offered a presentation on a new approach in Los Angeles that brings multiple programs together to integrate care for better outcomes. The work falls into three domains: community (prevention, social support, outpatient care), crisis system (intensive treatment), and institutions (re-entry initiatives). The North Star is to build the community domain; invest in building this up to ensure communities are inclusive so that those with disabilities, including mental illness, can thrive. We haven't done this successfully yet. Communities are not designed to hold those with serious addiction/mental illness and people fall out of community into the crisis response system. This new approach should support people to return to community. However, the structures around community are entirely inadequate and people fall into institutions such as jails. We are trying to invest in this system. This is not only focused on adults.

We are pouring funding into schools, libraries, and parks to support peers and navigators to make a referral and "live handoffs" that ensure people get services and that the services are successful. People need people, a place to live, and they need purpose. We

have to go after this aggressively, both when people are stable and when they are not. We also need to expand treatment. There is a big focus on moving people from institutions back to community.

The project is centered on a campus being designed in the old Martin Luther King (MLK) hospital. The Behavioral Health Center (BHC) has multiple departments, mental health, public health, physical health, probation, and workforce development. The building has mental health beds, urgent care, acute and subacute locked, intensive outpatient, detox and probation/workforce reentry opportunities. People with lived experience are employed to cook food for the facility as training that leads to external jobs. There is a Peer Concierge to support navigation of the campus and services. We are creating a paradigm for the sickest people that invests in alternates to jail and streets so they reintegrate into the community where they belong.

We are trying to use the hospital “inventory” to create a safe locked diversion care environment instead of jail. The Board of Supervisors cancelled a plan to build new jail facilities as a statement about priorities changing. We are looking to have a network of campuses that support community across the county. An important underpinning for this concept is legislative authority, Welfare and Institutions Code (WIC) section 5768, which authorizes DHCS to permit new programs for mental health services to be developed and implemented without complying with licensing requirements. The Restorative Care Program (RCP) requested exemption from licensure under this authority as an MLK BHC prototype that Los Angeles County would like to replicate on its other healthcare campuses. It is a new, community-based comprehensive program that addresses the interrelated and complex needs of those struggling with access to care for mental illness and substance use as well as medical comorbidities and homelessness, many of whom currently end up in the criminal justice system. This integrated approach should be considered part of the CalAIM discussion. This pilot can be replicated across the state.

Mari Cantwell, DHCS: This fits within our overall approach to integrate and build a better continuum of care. There are challenges related to the licensing aspects.

Kelly Pfeifer, DHCS: There is no question that this is where we want to go. It is exactly what CalAIM is trying to do and includes our interest in the concept of co-design. We haven't figured out how to do the requested licensing that you need, yet the status quo is not right either and we want to work with you to figure this out. We want licensing and certification that keeps patients safe, creates better access, and rewards integration. It is hard to do, and we don't have the answer yet.

Questions and Comments

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers: Could you elaborate on the statute you mentioned that would make things more cost effective?

Jonathan Sherin, Department of Mental Health, County of Los Angeles: The statute is WIC 5768 and it goes back to 1990s. This proposal takes it to a new level and DHCS has been progressive in working with us on this. We want the legislature to give us more flexibility, economies of scale, and allow us to put more resources into communities to be more effective.

Vitka Eisen, HealthRIGHT 360: You are investing in a Center of Excellence and you want people to return to community. What is the vision and investment in a network of services to help people move back and integrate into community? Where are those supports in the neighborhood?

Jonathan Sherin, Department of Mental Health, County of Los Angeles: That is core to the concept. The idea is to have resources for enriched services distributed around the county in the satellite campuses I mentioned. Within the building there is full continuum including intensive detox, reintegration services to place people into community with jobs, housing and other supports. Keep services close to community, provide care, stabilize and support them to move back to their community of choice. We are investing in social determinants and have put \$200 million into housing and services; we are building support networks of kith and kin. These are the pieces of the community system so that people are less likely to fall-out of their community because there will be more housing and jobs to support them. The clinics need to be community mental health centers that are welcoming and have respite services. All of these approaches need to be in place and require huge investments over time to happen.

Steve Fields, Progress Foundation: These are exciting ideas and I applaud the value aspect of this. The LA challenge is an overwhelming task of bringing resources at the scale needed. We can have facilities in community but also services in the neighborhood. The challenge of actually living in the neighborhood gives our staff a real idea of the challenges of recovery. When you see the choices of being back in community facing your dealer, it tells you a lot. I hope we find approaches that follow your model and cut across some of the domains you spoke to incorporate choices.

Jonathan Sherin, Department of Mental Health, County of Los Angeles: I share that perspective. We are putting urgent care and crisis residential around the county as we can. The arc of IMD alternatives needs to be a big focus. The epidemic and community pushback are such that building these enriched hubs is paramount right now. It doesn't mean we don't want to bring all the resources and opportunities as we can build them. I am promoting a NIMBY tax break for the neighborhoods with services and that other neighborhoods pay. We don't have inclusive communities; it is exclusive. We need collective solutions that raise the principles you highlight.

Jim Kooler, California Friday Night Live Partnership: Where do young people who are in the community fit into this continuum – those who are in foster care or out in community?

Jonathan Sherin, Department of Mental Health, County of Los Angeles: This facility does not have resources for youth because we are overwhelmed with need. This campus is

constrained for space, but other campuses have more land and opportunity for diverse services. I have thought about whether we could have a permanent supportive housing approach for people to stay for a while and simulate community for a period of transition. Youth require a different array of resources although the approach is the same. We are reforming juvenile justice and using the same concepts. We want to break up the halls and camps and offer services in communities.

Catherine Blakemore, Disability Rights California: One thing worth discussing is that when we have a campus for short-term stays, we need to simultaneously increase the capacity in community. There are good examples for those with dual diagnosis of disability and mental health that are designed as small 4 to 6 bed facilities. There are Community Crisis Homes and Enhanced Behavioral Health Homes that are small and have protections in the law that allow them to be developed without some of the challenges. How do Full Service Partnerships (FSPs) fit into the concept?

Jonathan Sherin, Department of Mental Health, County of Los Angeles: Yes, figuring out how to do this is important. We are redesigning the portfolio of FSPs and moving toward teams responsible for populations that require performance and include incentives. The team includes more than clinicians – housing and occupational specialists and housing subsidies. The team is 10-12 people to target the sickest people, like those on conservatorship, and measures the outcomes. When someone is sick, we shouldn't just let them go into hospital or jail and fill the slot behind them. We need to hold ourselves accountable for delivering on outcomes for a population. It is creating unrest among providers. We are trying to do this with customer service concepts and part of that is to take better care of front-line. Steve Balmer gave us a grant to redesign this system to be based on outcomes with accountability to a population.

Mandy Taylor, California LGBTQ Health and Human Services Network, a program of Health Access Foundation: What is the number you will serve? Where are they referred from? How might you scale this in the future? Is there a plan for permanency under No Place Like Home to ensure they are not returning?

Jonathan Sherin, Department of Mental Health, County of Los Angeles: Unfortunately, the referral source is crisis support teams and law enforcement. We need public health resources to catch up with public safety so that we have a health care response instead of a public safety approach. We have a network of care, engaging with full continuum of services and we are partnering proactively with schools. Yes, we need rapid development and to build up quickly. I would love to see No Place Like Home expand because currently our board and care networks are closing. We need collaborative housing solutions to buy existing homes and build up community resources.

CalAIM – Advancing and Innovating Medi-Cal: 1115 and 1915(b) Waivers Concept Paper for 2020 with a discussion focused on behavioral health components

Mari Cantwell and Jacey Cooper, DHCS

Slides available: <https://www.dhcs.ca.gov/services/Documents/CalAIM-BHSAC.pdf>

Mari Cantwell commented that the presentation on CalAIM for this group will offer a high-level overview of the full proposal and then focus on the Behavioral Health aspects of CalAIM. She acknowledged that it was just released and there will be additional opportunities for detailed discussion. The work invested has been over several years to identify options and think about what we would want Medi-Cal to look like in the future through a set of realistic ideas.

Ms. Cantwell offered an overview of the proposal. There have been changes over the last 10 years, including expanded coverage in the Affordable Care Act and expansion of Medi-Cal Managed Care and a variety of pilots. As we have continued to build on the Medi-Cal program, it has increased significantly in complexity. It is difficult administratively, as well as for patients. Some beneficiaries have to access six or more separate delivery systems.

We focused on what a person needs, not just for health care, but also the social issues significantly impacting their health. We traveled the state to conduct listening sessions and gather stakeholder input to determine what we should do. This is about advancing initiatives directly in the health system, as well as issues related to health. CalAIM leverages Medi-Cal to address challenges facing vulnerable residents, such as homelessness, behavioral health care access, children with complex medical conditions, the growing justice-involved population with clinical needs, and the aging population. We are proposing a significant transformation in behavioral health and want to help counties have more clarity and less restrictive rules. This will also focus on justice-involved individuals coming out of incarceration, support the Master Plan for Aging through long-term services and supports, and advance initiatives for vulnerable children.

This is an initial set of proposals and we want to refine them over the next several months through the stakeholder process, beginning next week. The next step will include a budget review and legislative requirements. There are budget constraints and the proposal will help refine what budget is available. Another key issue is improvement in systems. Significant investment is needed in the information technology systems for state, county and partners in order to be successful. The program and policy go hand in hand with those system investments.

The three primary goals of CalAIM:

- Identify and manage member risk and need through Whole Person Care approaches and addressing social determinants of health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of system.

Jacey Cooper presented specific aspects of the proposals primarily focusing on goal one. Goal three is integrated throughout.

- Population Health Management: Managed care plans will submit annual plans
- Enhanced Care Management Benefit: This incorporates Whole Person Care and Health Homes into managed care benefit statewide.

- Mandatory Medi-Cal Application & Behavioral Health Coordination: Screening individuals for Medi-Cal prior to being released from jail is done voluntarily by many counties already; however, the department's proposal makes this mandatory and includes a warm-hand off to county behavioral health services.
- In Lieu of Services and Incentives: Services (13 are proposed) to provide clinical and nonclinical services to avoid high cost service such as inpatient stays, emergency room visits or skilled nursing facility stay.
- Mental Health IMD Waiver (SMI/SED): This would be similar to the substance use waiver currently in place. We need to assess the feasibility of pursuing this given the substantial federal requirements to demonstrate that the full continuum of services is available.
- Full Integration Plans: The department would explore integrating behavioral health, physical health and oral health into a single health plan.
- Long-Term Plan for Foster Care: This will address the fragmented systems for foster youth by looking at what other states have done and working with stakeholders.

Mari Cantwell reviewed selected topics for goal two (for the full list, see slides).

- Standardize the Managed Care Benefit and Populations: There are multiple models, benefits and populations across counties. Going forward the proposal is for two groups across the state: either a population is included in mandatory managed care or remains in fee-for-service (FFS). This will be consistent across counties and plans. Another proposal here is to standardize the benefit in managed care statewide, which includes the carving out of pharmacy services.
- Behavioral Health Proposals
 - Payment Reform: Currently services are financed as Certified Public Expenditures, a cost-based system, that is an intensive cost settlement process that takes years and is complex for counties. The first step would be to shift away from the cost-based Certified Public Expenditure-based methodologies to other rate-based/value-based structures that instead utilize intergovernmental transfers to fund the county non-federal share. The shift will: 1) Establish rates for reimbursement that are not limited to cost and instead focus on the quality and value of services; 2) Create opportunities for improved coordination of care by simplifying options for contracts and payments between Medi-Cal managed care plans and counties, without limiting financial benefits for the county; and 3) Reduce State and county administrative burdens and allow counties to close their accounting records closer to the end of a fiscal year by eliminating the lengthy and labor-intensive cost-reconciliation process.
 - Revisions to Medical Necessity:
 - Separate the concept of eligibility for receiving specialty mental health or substance use disorder services from the county and medical necessity for behavioral health services.
 - Allow counties to be paid for services to meet a beneficiary's mental health and substance use disorder needs prior to the mental health or

Jacey Cooper, DHCS: Yes, we have an option to look at a second opportunity if there is reason to think it will be successful. We have put constraints here in consideration of costs.

Deborah Pitts, University of Southern California Chan Division of Occupational Science and Occupational Therapy: That doesn't seem realistic to me given the population. There is no comment on workforce. I am interested in expansion of licensed professionals.

Mari Cantwell, DHCS: We are interested in discussing workforce and we are open to conversation about who are the right providers in behavioral health.

Kim Lewis, National Health Law Program: On the enhanced care model, I am confused who is required to get what services?

Jacey Cooper, DHCS: We want to ensure the most vulnerable receive enhanced care management so we didn't want to set a percentage and listed targeted populations that the MCO should focus on. They need to submit a plan for how they will provide services to the target populations, including contracting back to counties for complex care populations. We look forward to workgroup discussion to fine-tune this proposal.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers: On the crosswalk chart of what will go forward in 1115 vs 1915b, can you add freestanding acute psychiatric hospital facilities and recovery centers because that is a key part of the waiver. Can you speak to where care integration happens? Much of discussion is about system integration and that may make it easier on the ground, but I would like to see more on mandates to "own" care coordination.

Mari Cantwell, DHCS: Our expectation of health plans and counties is that care coordination is at the provider level, face-to-face, and in the community.

Vitka Eisen, HealthRIGHT 360: This does reflect many of the discussions we have been having over the time. I understand the focus on the jail population, but what about the prison population? How do we see to behavioral health needs of that population?

Jacey Cooper, DHCS: We do want to see to that population, as well. There are some pieces in place, but we need further conversation to refine and link the services correctly.

Gary Tsai, MD, Los Angeles County: An important context to remember is that, for ODS, managed care only happened two years ago. We want to fully leverage the flexibility of ODS, as well as consider how fast ODS systems can move. It has been an important priority of ODS to elevate the substance use system to a place that allows for integration with mental health and physical health. The two factors that allow for that growth are financing and workforce. An important part of financing is the cost reporting element. Workforce is critical too and in LA we are working with certifying bodies to increase the quantity and quality of the workforce that may strengthen CalAIM.

Carmela Coyle, California Hospital Association: This does seem directionally correct and we have not had time to review. Can this advisory group make time for a deeper opportunity for this group to hear about the proposal and to discuss before it goes to the workgroup process?

Michelle Cabrera, County Behavioral Health Directors Association of California: The call-out on populations in Medi-Cal for focus and priority is important. I think the technical elements of financing and medical necessity are important levers to move transformation of behavioral health systems. What are the unnecessary, self-inflicted wounds of our state that we can shift to prioritize community health movement that began decades ago? Medical necessity and financing are not sufficient alone to get where we want. How do we get to a workforce with capacity to work with jail and vulnerable children; how to invest in IT systems? We feel heard in this proposal.

Bill Walker, MD, Contra Costa Health Services: I want to acknowledge the breadth of proposals and detail and point out the lack of numbers. It is a bold conceptual proposal, but I want to raise the reality of how budget constraints and availability of IGTs will affect this. On timing, the full integration pilots are set for 2024; the integration of behavioral health and substance use in 2026?

Mari Cantwell, DHCS: We expect to have funding discussions over next months and engage the legislature to inform discussion with counties. I think this is a post January conversation when we have a sense of what funding is available. By June or July, we need a final package with funding included. On the dates, the two concepts are related and different. The Full Integration is focused on MCO and the administrative integration is for places without a Full Integration Plan, so we can move to single contracts for mental health and substance use, where the systems are separate.

Vanessa Cuevas-Romero, Sacramento Native American Health Center: In my professional and lived experience, individuals from diverse backgrounds want a combination of traditional and western models of services that match their cultural practices. How could this include traditional practitioners? The state of Washington allows this. Can we have a special workgroup to discuss these needs?

Mari Cantwell, DHCS: I appreciate you raising this, we can discuss.

Catherine Blakemore, Disability Rights California: Yes, a culturally competent system is critical. I would like to see a focus on the differences for rural or small counties. There is currently not capacity or managed care networks in those counties. Also, there is no reference to individuals in state hospitals and no path for people to leave state hospitals. I appreciate ways CalAIM connects to the Master Plan on Aging, but it is not clear how that happens.

Linnea Koopmans, Local Health Plans of California: The crosswalk is very helpful. For those proposals in CalAIM that are not in an existing waiver, is there a crosswalk for

those? I want to request that the issue of data sharing between MCOs and counties should be addressed as critical to success with these proposals.

Mari Cantwell, DHCS: Yes, on the crosswalk. On data, we think the best way to do data sharing is for the state to make data available to everyone.

Catherine Teare, California Health Care Foundation: It's exciting to see behavioral health at the center. On the shift from diagnosis eligibility to a functional eligibility, how does this relate to ongoing responsibilities for MCOs to provide mental health services?

Brenda Grealish, DHCS: Yes, the change relates to this and there is confusion. We want to open the discussion to identify the best systems and identify tools to guide services.

Rosemary Veniegas, California Community Foundation: I want to emphasize the need to focus and offer resources for youth. For the workgroup, we should connect workgroup members to youth and others to speak to them about this.

Kiran Savage-Sangwan, CA Pan-Ethnic Health Network: I want to underscore the need for cultural competency. How does this relate to trauma screening? Is there thought to having those who screen positive for trauma services be one of the populations for enhanced care management?

Mari Cantwell, DHCS: That is helpful, and we should include that discussion.

Sarah Arnquist, Beacon Health Options: The paperwork issue comes up all the time as a workforce issue and it also creates barriers to alignment of networks. I would like to see a grid of the required paperwork and the corresponding statute to inform discussion of network alignment.

MJ Diaz, SEIU: Our members are excited to engage in the system change discussion, as well as providing services. The workforce conversation of how to meet needs in both clinical and community settings is part of our strategic plan. We need to have conversations about the challenge of workforce investments.

Jim Kooler, California Friday Night Live Partnership: The focus is on individuals and I would like to discuss a focus on risk/protective factors that are community based.

Ken Berrick, Seneca Family of Agencies: I echo the problem of documentation that is costly and wasteful. There are opportunities in Local Education Agency Medi-Cal billing to expand and restructure that and even have similar options for child welfare.

Mari Cantwell, DHCS: Yes, it is our intention to link all these things together.

Public Comment

Tamara Jimenez, Anaheim Lighthouse: Thank you to Dr Sherin. I have seen the amazing work over the last decade in Los Angeles County and I have confidence the new approach is going to work. Senator Beall has bills with a focus on parity and mental health and needs everyone's support. I hope you will let us know how to advocate for this with legislature.

Jeff Farber, Help Line Youth Counseling and Chair of Los Angeles Youth Services Policy Group: We are contracted to do Medi-Cal specialty mental health and substance use services for youth in Los Angeles. I encourage you to operationalize how to put youth first in designing substance use/mental health to increase access and retention. The current Drug Medi-Cal system is a one-size-fits-all-model. Youth have complex needs and require services that are customized for youth developmental life stages and experiences. We need to reduce the barriers for youth to successfully access treatment. For example, under specialty mental health, we have 60 days for assessment and in ODS we have only 14 days. The longer time allows us to see what the needs are, how the environmental factors affect them and build rapport. Vulnerable youth populations need to be seen in systems and places that make sense for them, like home or coffee house or community center. Right now, we can only serve them in specific locations, with specific staff at specific times. The youth we serve today are the adults of tomorrow. To successfully support youth, we need a developmentally appropriate approach to services that increases access, improves retention and treatment outcomes. We have to offer greater flexibility to engage youth and their caregivers and develop treatment plans that address their developmental challenges.

Jane Adcock, California Behavioral Health Planning Council: The Council wants to invite DHCS to partner with us. You've identified areas you want to engage with stakeholders. This advisory committee has broad representation, but the voice of individuals with lived experience is needed in a number of areas. We invite you to partner with us to hold public meetings to discuss the issues.

Pam Hawkins, United Parents: We are a grassroots organization developed and run by parents. I want to reiterate the comments on youth. Social determinants of health are great for adults, but for youth, it is about reducing risk and increasing protective factors. The more that you look at early intervention and prevention services, the better the system will be.

Jodie Langs, West Coast Children's Clinics: I have an EPSDT medical necessity criteria-related question. Has there been discussion about adding eligibility criteria beyond diagnosis to respond to functional impairment for kids whose level of distress doesn't manifest in a diagnosis, but that we could offer early intervention if we expand the criteria?

Mari Cantwell, DHCS: Yes, that is where we want to go and look forward to refine the approach.

Darlene Walker, Options for Recovery: I am here because there is a population that goes unnoticed. I work primarily with pregnant and parenting youth and women. Pre-DMC there

was focus and hope; post-DMC there are limitations. For example, pregnant women require about 30 hours of case management; youth need 50 hours of case management in a month. We are currently down to 10 hours. This population has major needs. I don't want this population to get lost. Please consider a systematic flow for youth, so they don't have to go county to county to get services. It needs to be designed to work for youth, so they stay out of system. In addition, there is no reimbursement for engagement or outreach. Youth don't come knocking on the door – we have to go get them for services.

Kathleen Brown, City of Fremont, Alameda County and former member Youth Advisory Group: In every agency in our county, we don't have enough workforce and need help with additional quality clinical workforce for SUD. The Youth Advisory Group had an Assessment Workgroup that began work on a statewide assessment for youth programs. We would love to help with that work.

Jeff Davis, California Afterschool Network: We are talking partnership, early intervention, and how to reach kids. California has a system of 4,500 school-based, before-school, after-school, and 1,300 summer learning programs that could be an effective vehicle. These are school-based funded programs run through the County Office of Education. It seems there are parallel structures and siloes that could be knit together in terms of EPSDT, early intervention, and access to services in these high need communities. I hope this is something we continue to explore.

Kathy Jett, Jett Consulting: I want to put another voice in on the perinatal issue. I know Dr. Pfeifer is working on this and I suggest reaching out to DSS and Corrections. We hear there is a breakdown in pathways to services and programs and we are beginning to lose them, so there is urgency.

Stacey Hiramoto, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO): I want to support Vanessa's comment for a committee on cultural competence. If we don't address this, the disparities will grow.

Lishaun Francis, Children Now: Given number of comments on children and youth, and the fact that kids show up with behavioral health needs in a variety of systems, I hope we have a subcommittee specifically on kids within BH-SAC. There are different rules under EPSDT and different conversations related to mild to moderate and we need a separate discussion that is later joined with the broader conversation.

BH-SAC Member Ideas for Future Meeting Topics

BH-SAC Members

Mandy Taylor, California LGBTQ Health and Human Services Network, a program of Health Access Foundation: Next meeting, we should talk about where cultural competence, community defined best practices, diverse geographies/populations, SDOH, are being addressed. This might be either a separate discussion or integrated into all workgroups.

Ken Berrick, Seneca Family of Agencies: How do we link with other efforts and integrate with other efforts like Child Welfare Council and Education reform, so that flows into our recommendations?

Rosemary Veniegas, California Community Foundation: I suggest a discussion of housing and homelessness and we would be happy to help with resource and a speaker.

Chris Stoner-Mertz, California Alliance of Child and Family Services: I want to echo the need to have a discussion to dig deeper into the proposal before the next quarterly meeting.

Stephanie Welch, Department of Corrections and Rehabilitation: I suggest a discussion focused on populations transitioning from prison and state hospitals because the needs are different from local jails and they are a complex population to serve. I want to echo Ken's comment that we work with other efforts like probation and parole to lift up what is happening in different systems and tap those resources and workforce. I could do a presentation.

Mari Cantwell, DHCS: if you have suggestions about speakers or others, let us know.

Vanessa Cuevas-Romero, Sacramento Native American Health Center: I want to hear more about trauma screening and training. I am concerned about the potential for tools to cause more harm.

Steve Fields, Progress Foundation: There have been suggestions for a workforce discussion. Sometimes the workforce discussion is about more workforce. I think we need a discussion of who can do this work best – a more complex discussion about a reframed workforce, not just more workforce. It may not mean more cost, but a reordering of the relationship between licensed professionals and those with lived experience. This proposal is an opportunity because moves to a more social context and we need a workforce for that.

Jim Kooler, California Friday Night Live Partnership: I did a survey from the prevention field about what is important to them and I have information to present from that. There were 21 responses related to eight questions on topics such as cross system collaboration, under-age drinking and marijuana use, Prop 64, the recovery-based framework, incorporating youth opioid use and using data to tell the story. Key themes and responses, such as prevention in the continuum, defining youth systems of care, workforce, reimbursement and the full survey results are available at: <https://www.dhcs.ca.gov/services/Documents/KoolerLetter-Ideas-for-BH-SAC.pdf>

Michelle Cabrera, County Behavioral Health Directors Association of California: It would be good for the group to hear more about the Families First Prevention Services Act in child welfare because it has implications for behavioral health.

Kim Lewis, National Health Law Program: I like the suggestion for another meeting. Another overarching theme is need for better and real time data.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers: The feedback here and from the public include recommendations that don't typically fall into the Medi-Cal world. We need to spend more time on two issues: moving away from diagnosis as way to get into the door and the "in lieu of" opportunities. I want to underscore the loss of adolescent programs on both substance and mental health, as well as perinatal programs around the state.

Jessica Cruz, NAMI California: I would suggest for the upcoming meeting that we have a person with lived experience and a family member share their perspective. Putting the voices of those impacted by our policy decisions at the forefront will help set the tone for the meeting.

Next Steps and Final Comments; Adjourn
Richard Figueroa, DHCS

Thanks to staff for developing the proposal. We appreciate the input and requests for additional discussion and meetings. We need to take this back to fit the suggestions into the current plan for workgroups and input.

2020 BH-SAC Meeting Dates:

- February 12, 2020 1:30 p.m. – 4:30 p.m.
- May 27, 2020 9:30 a.m. – 12:30 p.m.
- July 16, 2020 1:30 p.m. – 4:30 p.m.
- October 28, 2020 9:30 a.m. – 12:30 p.m.