# DEPARTMENT OF HEALTH CARE SERVICES
## Behavioral Health Stakeholder Advisory Committee (BH-SAC)
## October 28, 2020
## 9:30 a.m. – 12:30 p.m.

## MEETING SUMMARY

**Behavioral Health Stakeholder Advisory Members (BH-SAC) 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; Vitka Eisen, HealthRIGHT 360; Steve Fields, Progress Foundation; Sarah-Michael Gaston, Youth Forward; Sara Gavin, CommuniCare Health Centers; Britta Guerrero, Sacramento Native American Health Center; Veronica Kelley, San Bernardino County; Andy Imparato, Disability Rights California; Linnea Koopmans, Local Health Plans of California; Kim Lewis, National Health Law Program; Farrah McDaid Ting, California State Association of Counties; Frank Mecca, County Welfare Directors Association of California; Maggie Merritt, Steinberg Institute; Aimee Moulin, UC Davis/Co-Director, California Bridge Program; 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; 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 HealthCare Foundation; Gary Tsai, MD, Los Angeles County; Rosemary Veniegas, California Community Foundation; Bill Walker, MD, Contra Costa Health Services; Jevon Wilkes, California Coalition for Youth.

**BH-SAC Members Not Attending:** Robert McCarron, California Psychiatric Association; Jonathan Sherin, Los Angeles County Department of Mental Health; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers.

**DHCS/CHHS Attending**: Will Lightbourne, Jacey Cooper, Kelly Pfeifer, Jim Kooler, Norman Williams, Morgan Clair, and Stephanie Welch, Deputy Secretary for Behavioral Health at CHHS

**Other Attendees:** Karen Larsen, Director of Yolo County Health and Human Services.

**Public Attending**: There were 182 members of the public attending.

**Welcome, Introductions, and Today's Agenda**
***Will Lightbourne, DHCS Director***
Director Lightbourne welcomed members to the meeting. He introduced new member Andy Imparato, the CEO of Disability Rights California, who joins to take the place of Catherine

Blakemore following her retirement. Also joining is Stephanie Welch, the new Deputy Secretary for Behavioral Health at the California Health and Human Services Agency. Director Lightbourne reviewed the agenda for the day.

**Director's Update**
***Will Lightbourne and Jacey Cooper, DHCS***
Slides: https://www.dhcs.ca.gov/services/Documents/0102820-BH-SAC-Presentation.pdf

Director Lightbourne delivered opening remarks about the ongoing trauma being experienced by people across the state from the wildfires and the COVID-19 pandemic. He spoke about the stresses this has created on behavioral health systems, both formal and informal. He reviewed bills of interest from the legislative session signed by the Governor, including Senate Bill (SB) 803 on peer support specialist certification and SB 855 to update mental health parity. He noted that both of these bills will have significance for DHCS' work going forward.

Chief Deputy Director Jacey Cooper provided updates on COVID-19 and California Advancing and Innovating Medi-Cal (CalAIM). On October 2, 2020, California received federal approval of a 90-day extension of the public health emergency (PHE) through January 21, 2021. DHCS will continue to review the need for additional extensions. In September, Ms. Cooper wrote to Secretary Azar to request at least three to six months of notice prior to ending the PHE. This is the estimated time it will take to unwind all of the far-reaching measures and flexibilities DHCS has implemented during the PHE.

DHCS has obtained more than 50 programmatic flexibilities through the Centers for Medicare & Medicaid Services (CMS), many of which expire at the end of the PHE. The flexibilities impact Medi-Cal eligibility, health care service delivery (e.g., telehealth), provider reimbursement, and many other aspects of the program. For example:

- DHCS estimates that since the PHE began approximately 100,000 to 200,000 Medi-Cal beneficiaries per month continue to be covered, but may no longer be eligible. DHCS estimates it will take county eligibility offices six to twelve months to clear the Medi-Cal renewal backlog.

- Approximately 200 providers who enrolled in Medi-Cal under streamlined emergency rules will need to enroll through the complete process.

- DHCS must clear backlogs of all auditing, licensing, and onsite oversight visits that were delayed due to the PHE.

Ms. Cooper continued with updates related to the Home and Community-Based Alternatives (HCBA) waiver and Assisted Living Waiver (ALW) in the Central Valley. During the PHE, waiver applicants in an inpatient facility in regions of the state identified as COVID-19 "hot spots" are prioritized for intake processing, without having been in an institution for 60 days, and before all other sub-populations. CMS approved a DHCS waiver for this transition. In addition, a Medi-Cal managed care plan (MCP) memo was sent to request that MCPs in Central Valley counties participate in county-level collaboration meetings or work with local county partners to set up meetings with hospitals, nursing

facilities, and HCBS waivers/providers. DHCS is actively working with CMS to obtain approval of a Benefits Improvement and Protection Act (BIPA) waiver that would temporarily allow Program for All Inclusive Care for the Elderly (PACE) organizations, in partnership with discharge planners, more flexibility to contact potential PACE-eligible beneficiaries in DHCS-designated COVID-19 surge areas and propose PACE as an enrollment option to meet their needs. California received overall hot spot authority and can implement these same flexibilities in new hot spot areas as deemed by the DHCS Director. DHCS sends weekly stakeholder updates with all approved flexibilities, and Ms. Cooper reported that DHCS continues to provide weekly stakeholder updates and post provider and eligibility specific guidance, including:

- Updates to the Uninsured Group program to come into compliance based on CMS feedback. The new COVID-19 Uninsured Group program was implemented on August 28, 2020, and covers COVID-19 diagnostic testing, testing-related services, and treatment services, including hospitalization and all medically necessary care, at no cost to the individual, for up to 12 months or the end of the PHE, whichever comes later.
- California Children's Services (CCS) Medical Therapy Program (MTP) guidance that describes "Urgent Need" criteria under which in-person services may be provided in Medical Therapy Units (MTU).
- Updated guidance regarding COVID-19 virus and antibody testing, which includes frequently asked questions and resources from CDPH, CMS, and the CDC.
- New Behavioral Health Information Notices (BHIN) describing Drug Medi-Cal Organized Delivery System (DMC-ODS) interim reimbursement during the PHE, waiver flexibilities applicable to Driving Under the Influence (DUI) programs, and flexibilities across behavioral health delivery systems to ensure access.

Ms. Cooper provided an update on the Medi-Nurse Line and its utilization. It was developed to offer guidance to fee-for-service (FFS) Medi-Cal beneficiaries and uninsured Californians who suspect they may be infected with COVID-19. It offers clinical consultation and triage with nurses as well as covered clinical assessments, advice, test sites, and behavioral health and stop smoking resources. Nurses are available 24/7 for consultation and triage. The line also connects callers to qualified providers to see if they may be eligible for Medi-Cal and can enroll in either Presumptive Eligibility, uninsured eligibility, or full-scope Medi-Cal. The line has received more than 60,000 calls from 57 counties in 17 different languages (of the 19 available), including 87% uninsured and 13% FFS callers. Ms. Cooper provided utilization data including demographics, county location, and language.

Ms. Cooper also reported on CalAIM. On September 16, 2020, DHCS submitted a request to CMS to extend the 1115 waiver through December 31, 2021. CMS let DHCS know that the extension was determined to meet completeness requirements. The extension request has been posted on the Medicaid.gov website for a 30-day federal public comment period ending on November 1, 2020. DHCS will continue to work with CMS on the 1115 and 1915(b) waiver extension requests, and to develop applications for new waivers that would

begin on January 1, 2022. Ms. Cooper mentioned that DHCS is hoping to receive feedback on the 1915(b) waiver soon and will submit it to CMS before the end of the year. DHCS will engage with stakeholders in early 2021 on the 1115 and the 1915(b) waivers.

**CalHOPE Update**
***Jim Kooler, PhD, DHCS***
Slides: https://www.dhcs.ca.gov/services/Documents/0102820-BH-SAC-Presentation.pdf

Dr. Kooler reviewed CalHOPE, a partnership with the Federal Emergency Management Agency (FEMA) and the Substance Abuse and Mental Health Services Administration (SAMHSA), which addresses the stress, anxiety, and depression related to natural disasters California has experienced in recent years. The Crisis Counseling Program (CCP) helps people find supports and resources, but it is not traditional mental health counseling. Originally, California was awarded $1.6 million for CalHOPE. California's award has been amended five times for a total of $3.6 million to raise awareness and normalize feelings of stress and anxiety during the COVID-19 pandemic, and to support referrals of individuals to the website (www.calhope.dhcs.ca.gov) and CalHOPE warm line - (833) 317-HOPE.

DHCS submitted an application in May to FEMA for $82 million to continue and expand CalHOPE. California anticipates there will be an award of $71 million from SAMHSA to expand services and increase media outreach and (support? Improve?) the website. The warm line will expand to 24/7, and $27 million will be invested in outreach to community-based programs for peers trained as crisis counselors to provide support. Because this is virtual, it is possible to focus on a particular population and serve them anywhere in the state. We anticipate that more than 550 peers will be hired and trained as a springboard movement of peers. In addition, DHCS will contract for tribal crisis counseling focused on the urban Native American populations and will invest in every county office of education to create social, emotional learning environments and best practices between remote learning and onsite learning. Dr. Kooler described a pyramid of services from universal approaches to highly targeted services designed to prevent a wave of despair from multiple disasters.

There are also two declarations of emergency in response to wildfires that are more traditional disaster approaches because we are able to identify those displaced due to the fires. The first, the Immediate Services Program, is for 13 counties. The Regular Services Program will extend those services for 10 additional counties. In all, this will likely represent $90 million of support across the state. DHCS has partnered with the following to expand the reach of CalHOPE: Univision, Access TV, Radio Bilingue, ABC-TV, California Surgeon General, I-Heart Radio (Mental Health Minute), and San Francisco 49ers.

**Questions and Comments**

*Sarah Arnquist, Beacon Health Options*: I am interested in the long-term strategy and collaboration with the Department of Aging. They are also soliciting proposals for a crisis intervention hotline and warm line for non-emergency emotional support calls for older adults and persons with disabilities. In addition, the Department of Social Services planned hotlines for families involved in the child welfare system. Has the state given thought to the multiple crisis hotlines, given the national movement to create a single phone number as an alternative to 911 for people with a behavioral health crisis?

*Jim Kooler, DHCS*: We are in conversation with the Department of Aging about how their Friendship Line may interface with CalHOPE. It is specifically targeted to seniors, so we want to ensure there is a good interface. It is intended for pre-crisis stress-related issues as opposed to immediate crisis. There is discussion over no wrong door versus the remembered door. We are looking for the best way to get support to people no matter where they enter.

*Michelle Doty Cabrera, County Behavioral Health Directors Association of California*: It is important to note that FEMA funding is built on a federal framework that assumes all crisis response happens in person. Historically, County Behavioral Health partnered with the state to apply for FEMA funds post crisis or disaster. The county supplements FEMA funds to meet both immediate response and long-term response. The county is last to leave the site of these events. Due to COVID-19, the in-person traditional models do not work. FEMA funding is a critical source of emergency response funding for post disaster, behavioral health support. We are excited to build that out with a new model that acknowledges the COVID-19 reality.

*Jim Kooler, DHCS*: FEMA is struggling with this. They are comfortable with a point in time emergency, defined by geography and in person. The PHE is not any of that. We are breaking new ground with the model we will be implementing.

*Jim Kooler, DHCS:* In terms of addressing substance use disorder issues, we make a handoff to connect them to someone who can help. Crisis counselors do not address long-term assistance. Any county-based organizations interested in hosting groups of four to five crisis counselors and a supervisor will be able to apply for funding.

**Child Welfare Council and Behavioral Health**
***Ken Berrick and Karen Larsen***
Slides: https://www.dhcs.ca.gov/services/Documents/0102820-BH-SAC-Presentation.pdf
Recommendations: https://www.dhcs.ca.gov/provgovpart/Documents/Behavioral-Health-Committee-Policy-Recommendations-DraftSeptember-2020.pdf

Ken Berrick, CEO of Seneca Family of Agencies and Karen Larsen, Yolo County Director of Health and Human Services, presented information on the culmination of an effort by the Child Welfare Council Behavioral Health Committee to develop policy recommendations.

The Child Welfare Council was established by the Child Welfare Leadership and Accountability Act in 2006, with responsibility to improve cross-system collaboration to meet the needs of children and youth involved with child welfare and juvenile probation. The Behavioral Health Committee includes county behavioral health departments, managed care organizations, behavioral health providers, state agencies, legal advocacy organizations, parent advocates, and advocates with lived experience navigating the child welfare system. It is tasked with advising the full Child Welfare Council and CHHS on:

- Preventing unnecessary entries into the child welfare system.
- Providing alternatives to Child Protective Services (CPS) reporting when

there is not an imminent danger.
- Effectively supporting the behavioral health needs of children and families involved in child welfare/juvenile probation.

The Behavioral Health Committee recommendations include:
- More effectively support the behavioral health needs of children and families who are involved in the child welfare system.
- Improve access to behavioral health care for families at risk of formal adjudication, and prevent unnecessary contact.

Ms. Larsen reviewed the specific recommendations included in the report that intend to strengthen and address access issues that emerge from a fragmented system. Specific recommendations to accomplish this include:
- Align medical necessity determination for Specialty Mental Health Services (SMHS) with the federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) statute.
    - Remove diagnosis criteria for child Medi-Cal beneficiaries requiring SMHS.
- Eligibility determinations for SMHS:
    - Substantiated report of abuse or neglect
    - Threshold Child and Adolescent Needs and Strengths score
    - Threshold Adverse Childhood Experiences (ACEs) score
- Strengthen referrals from the child welfare system to the behavioral health system.
    - Statewide referral protocol
    - Out of county placements
    - Behavioral health and primary care

Mr. Berrick discussed the continuum of services and supports that should be seamless and available. The continuum should include prevention/early intervention, community supports, tiered therapeutic placement options, aftercare, and a continuum of crisis services. Services across the full continuum should be available for each population base of 500,000 to 750,000. There may need to be multiple continuums in large and densely populated counties and regional collaboration in small or rural counties. This is intended to address inequity in service access based on zip code. Mr. Berrick then offered a detailed description of the services that would be included in each element of the continuum. The council recognized it cannot incorporate every prevention support that children and families rely on, such as preschool, and that these additional services are critical to prevention. He described each level of the continuum and emphasized they are intended to offer diversion points through services that prevent a child from requiring more intensive intervention.

Ms. Larsen reviewed the outcomes and accountability mechanisms for measuring progress. We will need augmented data collection and data aggregated by race and ethnicity to track whether the reforms are working. It is an equity issue that we are not capturing this currently. The council envisioned 1) co-created statewide goals for the behavioral health system and corresponding outcome metrics; 2) expanded infrastructure to collect, synthesize, and monitor that outcome data; and 3) a robust, continuous quality improvement framework. This is intended as a visioning document and implementation requires reforms though statute and regulations, workforce, technology, fiscal support, and engagement of youth and parents at every step of decision-making.

**Questions and Comments**

*Hector Ramirez, Consumer Los Angeles County*: On the issue of disability data, we are seeing disability manifest in a variety of forms, especially with COVID-19. For those working in this area, I would like to see us start to track the requests so we can prepare for new trends and disability accommodations. On one other note, if DHCS is working on the peer support certification process, my recommendation is to reach out to the Behavioral Health Planning Council because they have been doing work on this issue for many years and have a significant amount of stakeholder knowledge. It could help to speed up the process by building on best practices.

*Kelly Pfeifer, DHCS:* Thank you. We will be developing a stakeholder process for the peer support process and absolutely will rely on the Behavioral Health Planning Council.

*Rosemary Veniegas, California Community Foundation*: Thank you to Karen and Ken and the Child Welfare Council for the report and recommendations. Many of the recommendations also apply to youth seeking substance use services. What opportunities do you see for integrating the full continuum of behavioral health and substance use services?

*Ken Berrick, Seneca Family of Agencies:* We received feedback along the way that it needed to be integrated through every service. It is clear in the text of the recommendations, although perhaps we did not highlight it our remarks. Gratitude to the advocates on the committee who pointed out that needed to be a clearly delineated part of continuum. For example, the crisis continuum would have to be informed by substance use knowledge rather than operate a freestanding program. We do not think it is useful to separate programs. They should be integrated across each component of the continuum.

*Karen Larsen, Yolo County Director of Health and Human Services*: As someone who provided substance abuse treatment for more than 20 years and did trauma screenings with every individual that came through those services, we rarely had someone come through substance use disorder treatment services who did not have a significant trauma history. And so, we must include substance use disorder treatment, not only for the parents and family members, but for the youth as they grow older and are trying to deal with the repercussions of their histories of trauma.

*Rosemary Veniegas, California Community Foundation*: Please let me know if there is any way I can assist with engaging stakeholders for your conversations.

Will Lightbourne, DHCS: Thank you everybody, and particularly thanks to Ken and Karen. I know this has been a true labor of love for them.

**Structural Racism and Behavioral Health Delivery System and Outcomes**
***Discussion Facilitated by DHCS and California Pan-Ethnic Health Network***
Slides: https://www.dhcs.ca.gov/services/Documents/0102820-BH-SAC-Presentation.pdf

Director Lightbourne framed the topic, reminding members that during his first BH-SAC meeting as Director of DHCS this past July, he emphasized that responding to the obvious disparities in health outcomes attributable to place of birth and race is one of the most pressing issues ahead for DHCS, CHHS, and the Administration. This is a start to that dialogue of the implications of those disparities and what to do about them. He thanked Kiran Savage-Sangwan from California Pan-Ethnic Health Network for her help in designing and facilitating the session. Today is an opportunity to hear from our stakeholders about the information we need to gather; where you think the problems and the opportunities lie. We are going to present some data to provide a foundation for the discussion and narrow the conversation to the health system and what is within our reach to improve. We know the data are imperfect.

COVID-19 has made disparities very visible. Population data obscures some of the impact. However, when we review the mortality rates per 100,000 from COVID-19 by race/ethnicity, it shows a stark picture. He reported that, for Whites, the death rate is 27 per 100,000; for Latinos, it is 42 per 100,000; for Asians, it is 27 per 100,000; for African-Americans, it is 48 per 100,000; for multi race, it is 7 per 100,000; for American Indian/Alaska Native, it is 28 per 100,000; and for Native Hawaiian and other Pacific Islander, it is 41 per 100,000. Clearly, the mortality rate, which is linked to circumstances where people live and get care, is very racially imbalanced.

Over a series of slides, Director Lightbourne reviewed penetration rates for SMHS and DMC services. There is a pattern that Asian/Pacific Islanders and Latinos are the least likely to receive consistent services. The issue of seeking service has to be factored into consideration of the effectiveness of systems. He reviewed health outcome data from MCPs that reveals American Indian, Alaska Native, and Black outcomes are significantly worse than Whites. He reviewed some data that offers specific examples, including postpartum care, blood pressure control, hospital readmissions, and immunization rates. Director Lightbourne then reviewed data from the California HealthCare Foundation documenting the extreme gap of life expectancy for Black Californians compared to other groups. Latinos are more likely to report being in fair or poor health. He acknowledged there are underlying policy issues that drive these disparities, including unequal schooling, violent policing, mass incarceration, historic red lining, under investment in affordable housing, racialized capitalism, and immigration policies, and these lead to the social determinants of health. Social determinants of health can potentially be improved through health delivery systems. Other issues and conditions must be addressed by a range of government and social policy beyond health. Finally, he offered a list of current and future efforts by DHCS related to address this topic.

Kiran Savage-Sangwan offered introductory remarks and thanked DHCS for acknowledging the topic. She emphasized that the discussion is about structural racism. We are talking about systems, policies, and institutional practices. This is not about individual actions or behaviors of consumers or those who work in health systems, but the system structures, institutions, and policies that continue to perpetuate conditions that lead to disparate and inequitable outcomes based on race.

Perhaps one of our discussion points today will be how does what we measure, what we

report, how we talk about data, how we define our data, and who decides what to measure contribute to our understanding of where disparities may lie. There are starting points and models for what we can do more of in both behavioral health and health care. How do we define outcomes in a way that is consumer and client centered? How do we structure services so they are available in the community, so people do not have to come into a health care system, but it meets them in the community? There are questions about what we need to stop doing or do differently. And what do we need to do more of that we are doing well in behavioral health?

**Questions and comments**

*Jei Africa, Marin County Health Services Agency*: This topic is a lifelong interest of mine professionally and personally. If we really are going to have a fruitful conversation about racism and how it impacts mental health or behavioral health, we must look at the roots of how we understand behavioral health in our system. My suggestion about looking at issues of equity is that we look at oppression as a pathogen; racism is often times associated with poor mental health outcomes; racial discrimination affects mental health; and race-based trauma should be considered as part of our conversation. ACE screening and ACEs do not capture race-based stress that people experience, specifically in communities of color or the LGBTQ population. I also think that implicit bias in our system has been institutionalized and internalized in our policies and practices of how we approach these issues as individuals. For me, that has a lot to do with the leadership. I am interested in helping lead or co-lead this work with you.

*Hector Ramirez, Consumer Los Angeles County*: I am Mexican and American; I am gay; I am disabled. Like many of us here, I have many intersections. These data shows racism that has been happening for years and now is magnified. As a person with a disability, there are stresses in my environment that contribute to the way I have adapted. The stress of living in a land occupied by people you are not part of or welcomed by. I think that having DHCS raise this will help to elevate the conversation. I know that sense of inequality is manifesting in my peers with disabilities. It is important to address the big elephant in the room. Even though our current president says not to talk about critical race theory, we have to because we are a nation of diverse people. It is important to reevaluate the way that we are mainstreaming specific aspects. For example, we just finished an LA County External Quality Review session. I was surprised to see that what is on paper does not reflect the community, especially for the Latino community. I know the level of data is not as rich as it could be, and I appreciate it is getting better, but I also know we have work to do because it does not reflect the reality of what is happening. I really welcome this conversation.

*Veronica Kelley, San Bernardino County:* I am an Asian American woman who is a behavioral health director, so having this discussion is food for my soul. I appreciate that we have this on the agenda. We are talking about systemic racism, and the whole system that we all operate in is very paternalistic. We say to people to follow our rules and you will be able to get what you want. That is in the entire structure, how we do contracting, who gets services, and what we have to do to get paid for services? What we could do is share our system's rules with our community. Many counties are doing that to figure out the gray

areas in our bureaucracy. We have to share our real rules instead of keeping them secret. County behavioral health cannot be the only one at this table. I do not know if MCPs have the same requirements for culture as county behavioral health has had since 1994. We need a plan for how we are going to address inequities from a cultural perspective in our communities. I would suggest that we do an actual plan with teeth in it versus a retrospective plan. Our partners at the table can learn from some of the things that the county has been doing for years.

*Steve Fields, Progress Foundation*: This is a conversation we are having in multiple arenas, and it is welcome. What we do not look at in the behavioral health field is the disparity of people of color in our inpatient units, emergency rooms, and institutional environments. We often think that if someone is getting treatment, it is a step forward, but the fact is that community behavioral health systems do not have early intervention -, early alternatives for voluntary treatment. We have to look at ourselves as perpetuating poor outcomes and the incredible recidivism in our systems of care. We have the capacity to develop other kinds of services to be utilized at a lower level of distress. There are too many systems that utilize hospitalization as a response when there are many options to prevent institutionalization. In the early days of Proposition 63 funding, I was part of a group putting together a proposal for specific, culturally responsive residential treatment alternatives for Black clients of the behavioral health system. The state would not accept the proposal because the charts showed that they were an overserved population. The data for hospitalizations of Black San Franciscans was off the charts, so they already get services. That is a kind of institutionalized racism. The result is residents are hospitalized for seven, eight days, and go right back to the communities that are destitute of services and create the conditions that then exacerbate a mental illness or a substance use. It is time for the behavioral health system to look at its own system of care, and instead of embracing involuntary treatment methodologies every time we can't figure out what to do, we should develop a system of care that is relevant to people's needs and avoids having to use the most drastic responses when we know we could prevent it.

*Michelle Doty Cabrera, County Behavioral Health Directors Association of California*: There are limitations when we look solely at Medi-Cal data. Many of the ways that counties do outreach engagement, prevention work, and community defined practices has been supported and funded outside of Medi-Cal, in part because of Medi-Cal rules at the state or federal levels. Steve's point about the disproportionality at the acute levels is well taken. What is hidden when folks are treated with bias, not just in terms of their race and ethnicity, but that intersectional identity that Hector and others spoke to and which leads to unfair criminalization of people with serious mental illness and substance use disorders. I would ask that next time, we incorporate data from Medi-Cal managed care, the mild to moderate benefit, disaggregated by race and ethnicity.

*Jacey Cooper, DHCS*: We agree with you 100 percent on the mild to moderate data. We will be making that information public as we finalize it.

*Aimee Moulin, UC Davis/ Co-Director, California Bridge Program:* Involvement in the criminal justice system is really about gaps and missing health care services. Criminal justice involvement means folks are functionally receiving health care services through the criminal justice system. I have been thinking about how we can engage people equitably,

engage individuals who really need health care. I have spent much of the last two years trying to expand access to treatment to people who are engaged in the criminal justice system. What I want to think about is how can you not be involved in the criminal justice system and be involved in health care systems instead? I think we should focus on that.

*Rosemary Veniegas, California Community Foundation*: I want to echo those comments. Because of our charge as the BH-SAC, how we think about diversion from justice or other systems involvement to health involvement is critical to reverse poor outcomes and increase positive outcomes, especially for youth of color who would be involved in behavioral health services. For example, in Los Angeles County, early data from the DMC-ODS program showed that of Latinx youth who access services, 81 percent used alcohol, 80 percent used meth, 65 percent used cocaine, 77 percent used marijuana, and 75 percent reported misusing prescription drugs. If we are talking about structural racism, we are talking about the war on drugs and how that has impacted youth of color and their caregivers and families. As this continues to impact our communities, people of color and youth of color will continue to comprise disproportionate numbers of those arrested or cited for possession of substances. Why is it that entry into justice becomes the first door to behavioral health services? How do we redirect and divert to the actual services that are needed? Reducing barriers to enrollment is critical. The Medi-Cal enrollment data show decreasing rates of youth enrolled pre-COVID and continuing through COVID. How do we address this structural barrier to entry into Medi-Cal, which is the first door for youth to access behavioral health services?

*Kim Lewis, National Health Law Program*: We often devolve into defending the status quo. We do not stand back and look at how structures are set up in a way that is racist and not designed for consumers. If we were going to build a system, we would not build it this way. It is fragmented and has been historically driven by fiscal concerns and a lack of accountability and responsibility for a population that we have not put at the center of care. That translates into all of the things people talked about. The collection of data, what we collect, and how we use it is not done equitably. What are we measuring that matters for people? We often throw around data on claims, access, and penetration rates, but we do not look at how people are moving through different systems. How is it working for them? How are they doing in school? Are they getting expelled? Are they getting suspended? Are they going into foster care or the criminal justice system as adults? We have to think about being less fragmented and design the system around the adult and family member consumers and child consumers. Whether it's in child welfare, juvenile justice, adult criminal justice system, or in the mental health, physical health, or managed care world, we must be accountable together and look at how we would design the system in a way that is going to be different and result in different outcomes. The worst outcomes are for people of color, and that is not okay. We must find a way to change and not just talk about it.

*Kiran Savage-Sangwan, California Pan-Ethnic Health Network*: It is important we are having this discussion here in this meeting. What we recognize as structural challenges sometimes revolve around who makes decisions. Behavioral health does so much work in stakeholder engagement, particularly at the county level. That is not equating to consumers and families and communities having a meaningful role in driving decision-making. That includes decisions about how we break down structural barriers, how we re-

imagine systems. A question I have for the group is how we might think about community engagement differently and think about it in terms of shared decision-making and power sharing. What could that look like?

*Mandy Taylor, California LGBTQ Health and Human Services Network*: In terms of community engagement and power dynamics, in order to get meaningful community engagement, we must dismantle some of the power dynamics that are inherent in the behavioral health system, even at the client and provider relationship. Oftentimes it is not the client choosing what type of care they want or need. It is the provider assessing them and making the decision for them about what types of services they can engage in. When there is a lack of self-determination, there is a lack of self-efficacy. Instead, the provider is set up as the person with power, and then that provider is answering to a director, who is answering to a county, who is answering to a Medi-Cal system that is founded on the same uneven power dynamic. I would like to see that dynamic changed for community engagement, in particular, for communities of color and other cultural communities. Instead of saying, we would like your opinion, and then we are going to make the decision, say here are the parameters of this program, and we would like for you as a community to tell us what you would like us to do within those parameters.

*Jevon Wilkes, California Coalition for Youth*: I am a black man. As a child, I did not ask for a diagnosis, but I got one anyway. I have been doing this advocacy work for the last 14 years, pouring my heart out, seeing young people come to the table and pour their heart out. We have left millions of dollars of federal matches on the table. Providers have taken the easy way out without amplifying the money that could be drawn down through Medi-Cal. Young people are looking for a way through this pandemic. Suicide ideation is increasing. There is a self-reflection and a system reflection that must happen. We are leaving youth a system of discombobulation, not communicating, not sharing data. We must reimagine a system where services are accessible and available to people.

*Vitka Eisen, HealthRIGHT 360* via chat: In addition to looking at broad macro structural change, we must look at micro changes. What practices do we engage in currently that have a disproportionate negative impact on communities of color. For example, referral prescribing practices for medication assisted treatment. Overuse of urine screening? Who gets administratively discharged?

*Rosemary Veniegas, California Community Foundation*: The opportunity to shift from a power dynamic to a peer dynamic is critical. We see elements in regional forums by CPEHN. How do we engage peers in the design, monitoring, evaluation, and maintenance of the systems intended to provide access? We see a model in the Affordable Care Act and the patient-centered outcomes research work, which requires that there be patients, advocates, and others who are direct beneficiaries of the interventions and programs. We also see the opportunity for structural change in the Child Welfare Council Committee recommendations on workforce development. If we have a peer dynamic in behavioral health services, through peer specialists and others with lived experience, then it creates less of that power dynamic and more of the person to person.

*Will Lightbourne, DHCS*: We will bring back a series of themes to our next meeting. In

practical terms, we might focus on CalAIM and procurement of the managed care plans, as well as changes inside DHCS. Perhaps we can put out a series of practice implications as co-owners of the behavioral health delivery system. There were interesting questions around the need to look at data elements that capture where people are getting served, where in the continuum they are getting served, and where there may be disproportionality or racism in that. We can also try to pull in data from Mental Health Service Act and related resources.

*Kiran Savage-Sangwan, California Pan-Ethnic Health Network*: I can summarize a few things I heard. How do we gather and use data in an equitable way? How do we improve the fragmentation in the system that perpetuates disparities? How do we start to shift, align, and integrate what we are doing? There were comments on the hierarchy of behavioral health and thinking differently about sharing decision-making and power. I heard thoughts on transparency or information sharing around the rules, the money, and the role that money plays in driving change. That makes me think about payment reform and the role of payment reform to advance equity. What do we need to change to hold ourselves and our systems accountable for the outcomes that we produce?

*Will Lightbourne, DHCS*: There were a number of comments about the criminal justice system being a default health care system. I hope to track where people are getting or not getting services and start to highlight that part of the continuum. That may help us move closer to actionable items. I am very grateful to everybody for the honest sharing. DHCS views this both as an external facing agenda through our authority as a financing and purchasing institution to combat racism in our community. We are also doing internal self-examination to look at ourselves as an institution and a culture to bring within us the same anti-racism agenda. Thank you very much.

**Annual Behavioral Health Open Forum**
***Kelly Pfeifer, MD, and Jim Kooler, PhD, DHCS***
**Slides:** ***https://www.dhcs.ca.gov/services/Documents/0102820-BH-SAC-Presentation.pdf***

Dr. Pfeifer offered introductory remarks as background. When the BH-SAC was formed, there were other work groups related to behavioral health that were folded into this group. There may be topics that other work groups addressed that have not been discussed here. Each BH-SAC agenda is developed with input from you and considering what the most critical issues are for your feedback. We have devoted a lot of time to CalAIM, the pandemic and response, structural racism, and improving care for children and youth. In addition, we want to flag topics, such as prevention, that have not yet been brought to this particular forum this year, but substantial work continues by DHCS staff and counties to implement programs, especially for youth, to address issues before they develop into mental health or substance use disorders. Narcotic treatment program providers and Driving Under the Influence (DUI) providers used to have their own workgroup, and we continue working with them outside of BH SAC, meeting frequently to address issues of concern, especially during the pandemic. This time on the agenda is for open dialogue to hear from you about any issues that may not have been addressed this year, but are important to highlight as the calendar year closes. We also want to invite people during the public comment section to offer remarks.

Dr. Kooler commented that this space is for issues that have not been part of the conversation so far. One of the concerns is that we have by necessity had a strong focus on the urgent and immediate over the year and have not had the opportunity to look to the horizon, to look upstream.

**Questions and Comments**

*Catherine Teare, California HealthCare Foundation*: I would like to request we take a comprehensive look at youth data. In particular, youth served through Medi-Cal minor consent program, which has been the recipient of some flexibilities. In line with the previous conversation, we must understand where youth are entering the system through MCPs as well as mental health plans and substance use disorder treatment services at the county level. In addition, we are concerned about the burden on youth and the epidemiological findings on suicidal ideation. I would like to discuss that as future topic.

*Barbara Aday-Garcia, California Association of DUI Treatment Programs*: DHCS absolutely responded to DUI programs to address concerns in a timely manner during the pandemic, even though we did not have the ongoing workgroup. I would like this workgroup to encompass DUI issues going forward.

*Kelly Pfeifer, DHCS*: We continue to meet with DUI providers monthly.

*Ken Berrick, Seneca Family of Agencies*: I appreciate the topic of equity. While we are doing that, there are pressing urgent changes we could make right now that would have a big impact. They are not exciting, but we could change the way we do documentation in compliance with federal law, and it would result in more services. I hope we can find a forum where we can grab some of this low hanging fruit to make us more effective.

*Kelly Pfeifer, DHCS*: We are deeply committed to this. I have learned changing documentation requirements is more difficult than it seems because much of it is deeply rooted in statute, regulations, and waivers. If you have quick changes to suggest, please send them to me via email.

*Kim Lewis, National Health Law Program*: CalAIM was paused this year, and now there is a new reality of COVID-19. There will be long lasting impacts on health, equity, and outcomes. I am wondering how DHCS is thinking about this and where to have a larger conversation about what needs to change or keep in place based on this reality. How might that impact decisions and policies? At DHCS and in the behavioral health world we need to deal with this new reality.

*Kelly Pfeifer, DHCS*: Absolutely. We are learning some sobering things about the long-term impact of COVID-19 for the people who get the disease and the long-term impact of the PHE.

*Rosemary Veniegas, California Community Foundation*: I am thinking about how real time eligibility determination, auto-renewals, and accelerated enrollment can be tools that will

allow us to anticipate the availability of a vaccine for COVID-19 and ensure that individuals who are Medi-Cal-eligible will be able to access vaccines. The more people are already covered by the time the vaccine is available, the more we can remove delays in access to vaccines.

*Hector Ramirez, Consumer Los Angeles County*: A possible topic is the impact of the current stressors on maternal health and women in general. There are concerning issues around stress and domestic violence that I want to highlight from the point of view of caregiver health.

*Michelle Doty Cabrera, County Behavioral Health Directors Association of California*: The impact of COVID-19 is an important topic. We are starting to see much higher numbers of youth in crisis this year as compared with earlier years. Some of our systems of reaching youth through schools have been impacted. We are looking for alternative ways to reach families, but a lot of those outreach and engagement activities fall outside of Medi-Cal, and yet the downstream impacts are significant and severe. There is emphasis on child welfare, but it will not capture the broader population needs for children and youth.

*Linnea Koopmans, Local Health Plans of California*: I would like to see this group have conversations on making telehealth flexibilities under the PHE part of permanent policy, and specifically looking at how it has increased access to mental health services. DHCS is currently evaluating that and other COVID flexibilities. This group can be helpful thinking through telehealth and mental health access.

*Chris Stoner-Mertz, California Alliance of Child and Family Services*: We are working with DHCS on how to create crisis residential services through opportunities, such as different licensing. I think we must make that a priority to build the continuum and be responsive to children's needs.

Comment via chat: Focus on reentry from the criminal justice system; look at structured therapeutic housing.

*Kelly Pfeifer, DHCS*: Thank you for helping to highlight these priorities as we think about the agenda for the coming year.

**Public Comment**

*Stacie Hiramoto, Racial & Ethnic Mental Health Disparities Coalition (REMHDCO):* I respectfully recommend that you consider allowing public comment after each section instead of at the end. My comments relate to the structural racism and behavioral health delivery system and outcome section. Usually the public comment period at the end is for comments not related to the agenda items. I think it is wonderful that you discussed structural racism, and there were very good comments. We have been meeting with DHCS, everyone from Vanessa Baird to Karen Baylor. We recommended that DHCS form an advisory committee on reducing disparities. Particularly in this time of urgency where we have the COVID-19 disparities, and two nights ago, another black man with an obvious

mental health issue was killed by police. I feel a real urgency. This advisory committee could be made up of community members with experience in reducing mental health disparities, people from underserved communities, and county ethnic services managers who should report directly to the Director of DHCS. Thank you.

*Marissa Vismara, California Primary Care Association*: I want to thank DHCS and the BH-SAC for the relationship during this time. And also to echo what was mentioned on telehealth flexibilities. As leaders in behavioral health during a global pandemic and societal call for race equity, this means telehealth. Health centers who serve Medi-Cal patients have seen their patient show-rates jump up to 95 percent on average because of the telehealth flexibilities, and patients report high levels of satisfaction. Virtual care is removing barriers and increasing access to behavioral and mental health services. Community health centers require these innovative tools to reach communities and provide timely care during and after the pandemic. So we ask that you continue your commitment to current telehealth flexibilities that are outside the current federal declaration authority, and specifically to continue and guarantee that telehealth flexibilities, including use of and payment for audio-only services, continue into the future and are not dependent on the PHE.

*Karen Vicari, CalVoices*: We are a statewide peer run advocacy organization. Mandy, Karen, and Rose all made some really good comments about shared power or client driven services and broad stakeholder engagement. I want to echo and agree with those. Along that line, I want to point out that this committee has no representatives from peer run organizations. I would recommend an organization that represents purely clients. Groups like ours work with people day in and day out all over the state. As we look to CalAIM, SB 803 will not be fully implemented for a couple of years, and I would like to see more reference to peer services when CalAIM comes back. We offer peer training at our organization, and there is a rush of people who want to get trained before the legislation takes effect because there's going to be a grandfather clause. My last comment is the digital divide. COVID-19 and telehealth have highlighted the lack of internet service and the lack of access to devices by our lowest income individuals. They are the ones who could benefit from telehealth because they are the same ones who do not have transportation to get to their appointments. I don't know if it's something that can be addressed in CalAIM, but I wanted to raise it as an issue we find very important right now. Thank you

*Katherine Elliott*: I really appreciate the Child Welfare Council ideas for eligibility for SMHS. I also really like the whole notion behind CalHOPE and increasing our nimbleness to respond to emergency situations. I want to ask you to consider developing a strategy for responding to the needs of Black men and boys in the wake of the highly publicized violence. I think that would be a reflection of the nimbleness that we are trying to pursue as an organization.

*Chris Miller*: I am from the Los Gatos/San Jose area of Silicon Valley. I spoke at the last meeting and I did receive some follow up notices from DHCS. I sat on the Interagency Prevention Advisory Council (IPAC),Suicide and Depression workgroup. That workgroup was focused on two primary areas, reducing student stress and the integration of spirituality and faith communities. I am excited to report that Governor Newsom signed

legislation to create the Office of Suicide Prevention within the California Department of Public Health, although it is contingent upon legislation providing money for that next step. If that happens, I look forward to working with you. I really enjoyed going to the Sacramento IPAC meetings, and I am still interested in engaging in that work. I feel like the reformatting of the process meant IPAC concluded and was embraced into this effort. I am here to help. I think there is a lot that can be done around faith communities, which was one of the efforts of the suicide and depression workgroup. There are three counties in the state, Los Angeles, Alameda, and San Mateo that have adopted county level policy statements related to the incorporation of spirituality into clinical work. Those policies are intended to promote openness and inclusiveness toward the spiritual and religious beliefs of all people on the road to recovery. Thank you.

*Basit Choudhary*: I am 24 years old, recently graduated from Sacramento State University with a bioscience degree. I am also an active youth leader in the Muslim community. As you may or may not know, there is an organization called Muslim American Society Social Services Foundation (MAS-SSF), which was formed in 2007. It is likely the only public organization in California that really caters to the Muslim community. It serves all backgrounds, but is focused on the Muslim community because there is not much representation regarding mental health support for this community. There is a lot of cultural stigma with seeking support services for mental health. I am a youth leader under the Muslim Transitional Age Youth Advocacy Program. This is funded through the Los Angeles County Mental Health Services Oversight and Accountability Commission. Our team learned about advocacy, talking with leadership, and leading a town hall. We saw youth leaders advocating for mental health support services in their communities, and we ourselves led a town hall a week ago. The purpose of our town hall was to de-stigmatize mental health for the Muslim community, and more importantly, to advocate for a wellness center in an underserved high school in the Sacramento region that would emphasize mental health support services and would be led by older youth for youth of all backgrounds. We want to give youth empowerment and include the youth voice in the decision-making process regarding mental health. Depression, anxiety, and suicide affect youth. Preventative measures are for youth and should include the youth voice. We would really like for cultural competency to be in play. As mentioned earlier in the meeting, peer-to-peer support sometimes can be even more effective than clinical counseling. We would like the opportunity to talk more about this project of opening a wellness center in Sacramento County. We would really like your next meeting to talk more about this. Thank you so much for this opportunity.

*Steve McNally*: My comments are about things I am interested in as a family member. For example, local engagement was referenced. As a collective behavioral health group, we could have spent $100 million on $2 billion received, pre-COVID, to do communications research. I think after all the money was spent, we still seem to be making decisions in an absence of data on capacity, needs, gaps, and quality. My family receives many county services. I don't have problems navigating the system, but that is very difficult for most people. There is a real need for federal fund participation. However, a lot of counties aren't getting very much. San Bernardino does an exquisite job, but that is not the case everywhere. There is a culture to validate and be defensive. Information is just information, and it's not good or bad. It's to improve the system. For all the money we spend, California

shows up fairly poorly on a lot of national reports. I would hope that organizations that have access to the appropriate people might publish countywide reports on federal fund participation and Medi-Cal penetrations, so we can find out where it's going, where it's good, and where we might be able to ask for help if we're in a locale that doesn't do it. Also, we get legislated solutions like No Place Like Home where we gave up 8 percent to get 4 percent back. I agree with John Shirin that we really need a continuum of care, and we need to be able to leverage all the money. Everyone seems to be off into their own areas. Thank you.

*Christina Aquilar*: It has been great to hear the entire meeting. I am part of the Muslim advocacy group and wanted to speak on behalf of the community. Many of our youth experience racial and religious discrimination in Sacramento and also are greatly affected by the pandemic and isolation. We want to make sure that our youth have access to mental health support and don't feel isolated from the world. In our Transition Age Youth group research into youth led wellness centers, unfortunately, we were only able to find one center on a private school campus. In our experience, both personally and in interviewing others, it's clear that our public high schools are seriously lacking mental health education and resources. We believe that having a youth-led wellness center would allow our youth to have a safe place to go to find resources and trained peer support who can relate to their struggles and needs. We want youth to be a part of the decision making process and to be a part of supporting our parents. We would appreciate time on your next meeting agenda to provide details on our vision for this, and to get support from your thinking. We recently held a virtual town hall meeting that highlighted our youth experiences and our vision for this wellness center that is available on our Facebook page. If you would like more information or to support us, I can reach out to you. Thank you so much for your time.

*Jeff Farber, Helpline Youth Counseling*: I am the chair of the Los Angeles County Youth Services Policy Group (YSPG), as well as the Executive Director of Helpline Youth Counseling. I really want to commend DHCS and the BH-SAC committee for your commitment to creating a more expansive, equitable, and integrated system of care, especially for young people and their families and caregivers. I reviewed the slides and the documents, and I urge you to take action on the Child Welfare Council's recommendation to ensure EPSDT access to SUD services as well as SMHS. A key element of strengthening access is to remove the diagnostic criteria for child Medi-Cal beneficiaries and align medical necessity determination SMHS with the EPSDT statute. The YSPG also urges the state to provide clarification and direction regarding EPSDT and accessing the benefit to counties to ensure greater accountability and access for SUD services. Finally, I am making a request that when we discuss behavioral health services, we make sure that it includes SUD services, as well as SMHS. A lot of times the comments are about behavioral health, and I want to see if we can redefine behavioral health to always include SUD services. I think you are doing an amazing job of moving things forward and creating a system that will provide greater access and opportunities for young people in California. Thank you.

**Next Steps and Final Comments; Adjourn**
***Will Lightbourne, DHCS***

Thank you to everyone participating in the call and to staff for supporting the meeting. The dates for 2021 quarterly meetings are:

- February 11, 2021 – 1:30 p.m. – 4:30 p.m.
- April 29, 2021 – 9:30 a.m. – 12:30 p.m.
- July 29, 2021 – 1:30 p.m. – 4:30 p.m.
- October 21, 2021 – 9:30 a.m. – 12:30 p.m.