Client and Family Leadership Committee (CFLC) Teleconference Meeting Summary
Date: Thursday, April 15, 2021 | Time: 1:00 p.m. – 3:00 p.m.

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

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Committee Members:	Staff:	Other Attendees:
Khatera Tamplen, Chair Hufsa Ahmad Rayshell Chambers Emery Cowan Claribette Del Rosario Kylene Hashimoto Richard Krzyzanowski Rose Lopez Kontrena McPheter BeaJae North Larisa Owen Jason Robison Sharon Yates	Toby Ewing Kayla Landry Matthew Lieberman Tom Orrock Norma Pate Filomena Yeroshek	Christina Tarah Gamboa-Eastman Mayumi Hata Samantha Martinez Steve McNally Elizabeth R. Stone

Committee members absent: Donella Hyrkas Cecrle, Kellie Jack, Susan Wynd Novotny, Jules Plumadore, and Tina Wooton

Welcome and Opening Remarks

Commissioner Khatera Tamplen, Committee Chair, called the meeting to order at approximately 1:00 p.m. and welcomed everyone. She reviewed the agenda and meeting protocols.

Tom Orrock, Chief of Stakeholder Engagement and Commission Grants, called the roll and confirmed the presence of a quorum.

Agenda Item 1: Action – Approval of Meeting Minutes

Chair Tamplen asked for a motion to approve the meeting minutes from the March 18, 2021, CFLC meeting.

Committee Member Krzyzanowski made a motion to approve the minutes as presented. The motion was seconded by Committee Member Yates.

Vote recorded with participating members as follows:

- Approve: Committee Members Ahmad, Chambers, Cowan, Del Rosario, Krzyzanowski, Lopez, McPheter, North, Owen, Robison, and Yates, and Chair Tamplen.
- Abstain: Committee Member Hashimoto

Agenda Item 2: Presentation – Assembly Bill 988

Presenter:

- Norma Pate, Deputy Director

Chair Tamplen stated the Committee will hear a presentation on Assembly Bill (AB) 988 (Bauer-Kahan), The Miles Hall Lifeline Act, and will explore opportunities to employ peer providers in the 988 Crisis Hotline Centers. She asked the representative from the Steinberg Institute, sponsor of the bill, to present this agenda item.

Tarah Gamboa-Eastman, Legislative Advocate, Steinberg Institute, provided an overview of AB 988. She stated 988 is the new three-digit alternative to 911 for mental health crisis response. There are three core components to this system: 24/7 access to counselors who call, text, and chat, someone to respond in the field via mobile crisis response teams, which includes trained health professionals including peers who respond as an alternative to law enforcement during moments of crisis, and crisis residential and peer respites, safe and therapeutic places for individuals to stabilize and to be connected on their wellness journey. She noted that peers are explicitly called on within the mobile crisis section. Peers are a core component throughout the crisis continuum.

<u>Discussion</u>

Committee Member Krzyzanowski asked about the language "trained mental health professionals and peers" versus "trained mental health professionals including peers."

Ms. Gamboa-Eastman stated the Steinberg Institute sees peers as equals to psychiatrists and social workers and equally as important in the provision of mental health services. The language in that particular instance specifically called out peers because they can so often be forgotten. The language includes peers as part of the team.

Committee Member Hashimoto asked for clarification on the reporting requirements.

Ms. Gamboa-Eastman stated there are many reporting requirements such as outcomes and funding. The State Department will consolidate the data metrics into one annual master report to the Legislature and others.

Committee Member Ahmad stated concern that the suicide hotline is only in English and Spanish and the text line is only in English. Many communities have no access to suicide prevention resources. She suggested an expansion of the languages offered as part of the suicide hotline.

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Ms. Gamboa-Eastman stated the bill requires that all services be provided in universal language access. This is still being refined.

Committee Member Robison stated the World Health Organization's report on preventing suicide emphasizes the importance of social support. Although the bill mentions peer services and peer respite once, it does not mention what those practices are and if they maximize the caller's social support, which is done through peer listening and disclosing by the person that answers the call and by referring callers to community-based self-help support groups.

Ms. Gamboa-Eastman stated building in follow-up care and community is a critical piece of the bill.

Committee Member Robison stated evidence-based best practices for social support is self-help support groups. Community-based mental health organizations often do not maximize social support. Clinical care is not social support.

Committee Member Cowan stated, even if law enforcement will not be involved, it is important to know that they will be there. She stated anything that can be done to ensure that they are trained in crisis intervention team (CIT) or other peer models around co-responding is important.

Ms. Gamboa-Eastman stated the goal is to move as much as possible under mental health professionals, including peers, but there is also a place for law enforcement. The language around deploying law enforcement "only when there is an explicit threat to public safety" is to ensure that mental health professionals are at the helm. This is also why there is language included in the bill that states "any professional that touches the 988 system must have training in crisis intervention."

Public Comment

Christina asked about education for peers and if peers must be licensed in order to be a part of the team.

Ms. Gamboa-Eastman stated this bill must be implemented by July of 2022. Peers will be included from the onset, whether peer licensing is in place or not. The idea is that the peers ultimately will be certified so they can be reimbursed through Medi-Cal and private insurance.

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Agenda Item 3: Presentation – California Advancing and Innovating Medi-Cal (CalAIM)

Presenter:

- Mayumi Hata, Chief, County/Provider Operations and Monitoring Branch, Department of Health Care Services

Chair Tamplen stated the Committee will hear a presentation on the background and goals of CalAIM, a service delivery framework developed by the Department of Health Care Services (DHCS) to be implemented January 1, 2022.

Mayumi Hata, Chief, County/Provider Operations and Monitoring Branch, DHCS, provided an overview, with a slide presentation, of the updates in the DHCS behavioral health structure and leadership, and goals and areas of focus of the Behavioral Health CalAIM initiative. She stated CalAIM is a multi-year initiative by the DHCS to improve quality of life and health outcomes by implementing board delivery system, program, and payment reform across the Medi-Cal program. More information on the CalAIM program can be found on the DHCS website.

Discussion

Chair Tamplen stated it is good to know that revisions to the term "medical necessity" is forthcoming and that managed care plans will play a large role in these services. She asked for additional information about the term "in lieu of services" and the services that will be part of that category.

Ms. Hata stated it is still in the beginning stages of bringing managed care and counties to use the same screenings and look through the same lens during the initial screening for the beneficiary so that services provided will not change.

Committee Member Krzyzanowski asked about stakeholder input and participation. He asked what that looks like in terms of strategies and structures, such as the creation of an advisory group or reaching out to specific communities to get input.

Ms. Hata stated a committee, comprised of a variety of representatives and the public, met several times to provide input prior to the COVID-19 pandemic.

Chair Tamplen thanked Ms. Hata for her presentation and stated the Committee will look forward to updates on the progress of the CalAIM initiative throughout this upcoming year.

Public Comment

No members of the public addressed the Committee.

Agenda Item 4: Discussion – Strategies to Promote Peer Services

Chair Tamplen stated the Committee will discuss specific strategies to promote peer services in mental health. The Committee may consider strategies related to research opportunities, toolkits and/or handbooks, creation of a council on mental health peer providers, statewide conferences, billing practices, or a mental health services ombudsman.

Chair Tamplen stated the goal of this discussion is for the Committee to record ideas, work on definitions and descriptions of each idea, and submit a report with priorities and recommendations to the Commission for review. This will set the foundation for the Commission to lead efforts in the years beyond to help these ideas come to fruition. She asked Committee Members for ideas on strategies to promote peer services.

Discussion

- Include ongoing trainings that contribute to peer certification.
- Include additional trainings beyond the core curriculum such as bringing in subject matter experts to present on best practices in certain populations.
- Systems transformation cannot happen without systems training to help the other side understand who peers are and about the best practices for collaboration.

  - Intentionally engage and train individuals in the medical system to get buy-in to include peers at the table in a meaningful, shared-decision kind of process for inclusion, diversity, and equity. If managed care does not hire, support, and train peers across the system, it will become yet another segregated component of specialty mental health.
- Trainings need to include survival tools to help peers look out for themselves and the community within these systems, such as the following:
  - How to protect themselves from prejudice.
  - How to get the support and the reasonable accommodation they need so they can do their work.
  - How to work the system amidst imbalances and injustices that may possibly be directed at peer professionals.
  - Incorporate trainings on the Americans with Disabilities Act (ADA).
- Unions can be helpful for conflict resolution and worker rights.
- Provide a living wage with advancement opportunities for the peer workforce.
- Drop the peer label in the future.
- Begin to work with the private mental health system.
- Revise the California Strategic Plan on Reducing Mental Health Stigma and Discrimination, which has not been revised in over a decade.
- Hold regional forums as opposed to statewide or local forums.
- Hold learning forums with local medical directors, mental health staff, law enforcement, and other stakeholders to discuss how to help the community.
- Give peers as many toolkits and handbooks as possible.
- Remote counties will have different needs than urban counties.
- Concern about billing practices, how peer advocates will be paid, and if they will be designated as an employee or an independent contractor. There is flexibility so they can get paid both ways.
- Once peers are certified, how will they be managed?
- Having an ombudsman is important to monitor how peers are being managed.
- Although a great idea, there is concern about the 988 number. How will persons who call in and are underage be managed without parents becoming upset.
- Have something for all counties that codify peer services beyond Medi-Cal. Most peer services are not billed through Medi-Cal but are included in the Mental Health Services Act (MHSA) services.

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    - Peer services are not considered a medical necessity; they are to establish community and social support. Having programs that follow core competencies and best practices and value peer support are important.
- Create standards to ensure that everyone is connected to self-help support groups because that is the one thing that establishes social support when the peer is not working or when the clinic or recovery center is closed. The best practice to lead those groups are individuals with lived experience.
- Create a standard for counties to use peers with demographic specialties such as transition-age youth (TAY), adult, older adult, parent partner, family, and also in environmental and context specialties. Every homeless, crisis, and reintegration intervention needs to have individuals with lived experience. Those are specialties that are important.
- Ensure that everyone who is supervising peer services is trained in evidence-based best practices for peer services.
    - Build on the OSHPD training on the supervision of the peer workforce in Los Angeles to ensure that there are standards for supervision.
- Ensure that individuals who are hired to do peer support services are not co-opted to do other services. Guard against peer drift.
- Define what is meant by peer services.
- Support community-based organizations with funding and trainings because they work in communities and can connect with their community members who reach out for professional help more readily.
- Specify the target group.
- Cross-system work is essential for collaboration. Language matters and systems do not know each other's language.
- Career ladders, titles, and job descriptions are important.
- Include screening tools for outcomes and results to know what works such as the North Carolina Screening Assessment, which include domains such as housing, substance abuse, domestic violence, mental health, and physical health that can be done by a peer.
- Are there other MHSA innovation programs that have done peer work that can be learned from?

Executive Director Ewing stated there is tremendous opportunity to identify models or strategies that have worked around peers in California, even in parallel fields. This opportunity around peers and peer certification lends itself to benefit from lessons learned in many domains. Time needs to be spent reviewing these models and strategies and thinking about how to facilitate the lessons learned. This agenda item is meant as a discussion on how to create the infrastructure to support that learning.

- Think about how to handle situations where the client is a friend of the peer worker. One of the things that happened to peers joining the workforce in the late '80s and early '90s is that they lost their friendships with individuals who were peers. Once they worked for the system, they lost their whole community. The peer worker could not help friends because there was a rule against that.
- Fresno State had a six-month peer community certification.
- Training is good but it does not cover other things that come up out in the field such as learning to work with other perspectives, cultures, and silos. There has been no support for peer workers in this area but support is important for success. Paid internships are a way to give peers experience out in the field.
- Focus on recruitment and marketing.
- Expertise in peer services lies predominantly with peer-run organizations rather than with counties. California counties are far behind the national standard in best practices for peer services. The state needs to learn from these experts in peer-run organizations.
- Peers do not screen; peers welcome in and support the goals of individuals coming into the services. This is much different from an assessment. There are other ways for counties to get that information.
- Think more broadly about outcomes. It is important for this program to demonstrate outcomes, including increased social support, if the person is developing a sense of meaning and purpose, thriving, meeting their goals, and are happy.
- A presentation at the last meeting acknowledged that individuals in California are not getting the behavioral health services that they want and there is no mechanism in California to determine the services that are wanted. Peers are a way to do that.
- Los Angeles County did four peer innovation programs that were studied by UC San Diego – two peer-run respites and a peer-centered full-service partnership. Data is available on these projects, which showed significant improvement.
- Define peer support services and call out and identify the history behind peer-run organizations in the Committee's report.
- Include concurrent internships with the training to begin to bridge the gap between the classroom training and experientially what they see out in the field.
    - Consider what can be done organizationally to continue to provide support to bridge that gap once peers are in the workplace facing those challenges.
- Realize the power of this model that is being created. The model of mutual support between individuals with shared experience can go far beyond the world of mental and behavioral health.

<u>Public Comment</u>

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Samantha Martinez, Peer Crisis Counselor, stated their position is temporary; there needs to be a stabilization of that in order to continue with these resources. There needs to be an outreach component because there can be great resources and lived experience but, if peers are not allowed to reach out or connect to organizations, all that help will come to nothing. The step into the community is done is through individuals with lived experience. This is important.

Samantha Martinez suggested making Committee meetings more equitable by changing the meeting time so more members of the working public can attend.

Steve McNally, citizen and family member, stated there are many great ideas being shared but asked about the specific role of this Committee. The speaker stated once the DHCS has their stakeholder meetings, they define what this project will look like. Counties are in control of local funding and peers have always been a hot topic. While peers have always been able to be funded, they have never been funded or supported at the local level. The speaker agreed with some of the questions asked about the real acceptance level at the local level.

Steve McNally stated there are over 1,000 items in the Commission a about peers, starting prior to 2004. The speaker suggested looking at some of those presentations as background. The speaker stated they were unsure how much will need to be sold and how much will be a slam dunk. If it is a slam dunk, the funding would have been allocated and not left open.

Steve McNally stated counties that have peers have one or two. The speaker stated it could be determined that peers are so important that a peer should be assigned to each clinician team. The speaker suggested teaching the team leader, who is probably not used to being a team leader – counselor, psychiatrist, case manager – on how to best use peers.

Steve McNally stated there are many allies to be gained from going outside of the narrow focus of “mental health peer.” He suggested finding managed care or other large systems that care about peers and understand peers either through 12 Steps or other groups or have their own family experiences, and get them to match leveraged dollars one-to-one because counties may not support this.

Steve McNally agreed with the comment on the language issue. California has a requirement to provide information in multiple languages. The speaker stated this project might be a good way to try to reinforce what is on paper that does not happen in reality.

Elizabeth R. Stone stated Optum Health under United Health Care has numerous peer programs.

Wrap Up and Adjourn

Chair Tamplen asked Committee Members to send Mr. Orrock their data on the effectiveness of the peer innovation programs that Committee Members, their organizations, or their counties have done. She stated the next meeting is scheduled for June 17th at 1:00 p.m.

Chair Tamplen adjourned the meeting at approximately 3:00 p.m.

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