State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION
AB 1315 EPI Plus Advisory Committee Meeting

Minutes of Meeting
January 21, 2020

MHSOAC
Darrell Steinberg Conference Room
1325 J Street, Suite 1700
Sacramento, CA 95814

Additional Public Location

2000 Embarcadero Cove, Suite 400
Oakland, CA 94606

866-817-6533; Code 1189021

Members Participating:

Khatera Tamplen, Chair
(via teleconference)
Lauren Becker, J.D.
Stuart Buttlaire, Ph.D., MBA
Adriana Furuzawa, LMFT, MBA
Thomas Insel, M.D.
Yana Jacobs, LMFT
Maggie Merritt
Paula Wadell, M.D.

Members Absent:

Gladys Mitchell
Gilmore Chung, M.D.
Kate Hardy, Psy.D.
Karen Larsen, LMFT
Toni Tullys, MPA

Staff Present:

Toby Ewing, Ph.D., Executive Director
Filomena Yeroshek, Chief Counsel
Tom Orrock, Chief of Stakeholder
Engagement and Grants

1: Welcome, Introductions, and Roll Call

Chair Khatera Tamplen called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) Assembly Bill (AB) 1315 Early Psychosis Intervention Plus (EPI Plus) Advisory Committee to order at 10:04 a.m. and welcomed everyone. She thanked Executive Director Ewing for helping her run the meeting today since she was participating via teleconference. Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

Chair Tamplen reviewed the meeting protocols.

2: <u>Approval of the August 29, 2019, Meeting Minutes</u>

Action: Committee Member Insel made a motion, seconded by Committee Member Merritt, that:

- *The MHSOAC EPI Plus AC approves the August 29, 2019, Meeting Minutes.*

Motion carried 8 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Committee Members voted "Yes": Committee Members Becker, Buttlaire, Furuzawa, Insel, Jacobs, Merritt, and Waddell, and Chair Tamplen.

DISCUSSION

3: <u>Strategies for the Allocation of Funds for Early Psychosis Intervention</u>

Presenter:

- Toby Ewing, Ph.D., Executive Director, MHSOAC

Executive Director Ewing stated the Committee will discuss strategies for the allocation of $20 million to support efforts to detect mental illness as early as possible and reduce the duration of untreated psychosis and other mental illnesses. Funding strategies for training and technical assistance, capacity building, and development of new early psychosis treatment centers will be discussed.

Executive Director Ewing stated, at the last Advisory Committee meeting, the Committee informally discussed investing a portion of the $20 million allocated by the Legislature for early psychosis identification in Coordinated Specialty Care to incentivize the adoption of that model and a separate portion of funds for more innovative, creative approaches.

Executive Director Ewing stated the Commission has been working through this issue on another grant opportunity to adopt an integrative youth drop-in center model called Headspace. Tomorrow's Commission agenda includes a $15 million funding opportunity. Some of the tensions that came up in that conversation that are consistent with the tensions that this Advisory Committee is dealing with are the following questions:

- Are these funds to promote the adoption of Coordinated Specialty Care as a model or are these funds to promote innovative ways to reduce the duration of untreated psychosis?

- Should some of these funds be set aside for alternate approaches to early psychosis intervention?

Executive Director Ewing stated, if the advice is that Coordinated Specialty Care is an evidence-based practice and needs to be pushed and built off the infrastructure that has been built out with county innovation funds with the National Institute of Mental Health's (NIMH) support and support from the One Mind philanthropy, then it is a question of how to do that. The other pathway is to open this up and think creatively about the ways first episode psychosis services could be supported, including, but not limited to, the Coordinated Specialty Care model.

Executive Director Ewing asked for guidance on those two pathways rather than continuing to think about all the potential uses for the $20 million one-time funding. He stated staff must create a competitive proposal. The more concrete the guidance, the easier it will be for staff to deliver.

Committee Member Questions

Committee Member Insel stated the minutes of the last Advisory Committee meeting were helpful. He asked for clarification about the amount of funding and the process. He asked if counties are required to match whatever comes in in the way that AB 1315 is currently written, if counties are interested in doing this whether there is a match or not, and if there is an understanding that these funds are only for county specialty mental health care or if they can be opened up to other groups.

Executive Director Ewing stated the budget language made the funding available for the AB 1315 program, but the budget itself does not specify. He reviewed the budget language. The budget states the funds shall support the EPI Plus program and the EPI Plus program states "funds allocated by the Commission shall be made available to selected counties, or counties acting jointly, through a competitive selection process, or other entity for research, evaluation, technical assistance, and related purposes." He stated the primary recipient for programming is counties but a portion of the funds can be set aside for research, evaluation, technical assistance, and other purposes as determined by the Commission with advice and guidance from the Advisory Committee.

Committee Member Merritt asked about a funding cap for the amount that can be used for research.

Tom Orrock, Chief of Stakeholder Engagement and Grants, MHSOAC, stated the research cap is 10 percent.

Committee Member Insel asked about a funding match.

Executive Director Ewing stated the language states "the Commission shall take into account at least the following criteria and factors when selecting recipients ... a description of local funds, including the total amounts, that would be contributed toward the services and supports as required by the Commission through the competitive selection process, implementing guidelines, and regulations." He stated AB 1315 does not itemize that it must be a one-to-one match. The intent is to leverage the funding to strengthen the strategies but there is flexibility in what that local contribution looks like.

Committee Member Merritt asked for verification that this Advisory Committee will have the opportunity to review the applications by county and make recommendations to the Commission for funding distribution.

Executive Director Ewing stated he did not know. He stated the conversations held at UC Davis were about Coordinated Specialty Care. Much of the conversation has been about this model and how to roll it out. The work that the counties are investing in through county innovation funds has been to build out that strategy. These funds can be used to reinforce and extend that strategy to a larger number of counties and it can be used to support innovative approaches as well.

Executive Director Ewing stated in the Headspace conversation over the past few weeks this question came up: is the Advisory Committee's advice and guidance to the Commission to extend the Coordinated Specialty Care model or is it to encourage creative approaches to reduce the duration of untreated psychosis, which may include but are not limited to the Coordinated Specialty Care model?

Committee Member Becker asked how counties and other entities are put on notice of the fact that these funds are available.

Executive Director Ewing stated the legislation requires a competitive process such as a Request for Proposals (RFP) or similar competitive procurement process. Typically, staff prepares an outline, which is reviewed and adopted by the Commission. Once approved, staff will distribute a solicitation. He stated there is language in the law that the proposal selection process will happen in-house to avoid conflicts of interest.

Committee Member Merritt stated the thrust of AB 1315 was to ensure that the majority of the funds went toward scaling up the Coordinated Specialty Care model, which is modeled by UC Davis.

Committee Member Wadell stated UC Davis gets many referrals and is not large enough to deal with the incidents in Sacramento County. She stated UC Davis gets referrals from psychiatrists who are unsure how to handle certain situations and ask UC Davis to take over the cases. UC Davis gets questions from therapists who are unsure how to approach this and how to be helpful. She stated training more individuals to feel comfortable will increase access in a more meaningful way. There is much work to be done in this area, but one of the most meaningful returns on this investment would be training and support so that the existing agencies feel better equipped to provide services.

Executive Director Ewing stated Committee Member Merritt's comment was that the enabling legislation was targeted towards reinforcing the use of the Coordinated Specialty Care model that is articulated through the UC Davis work and that counties are co-investing in with innovation funds. He asked Committee Member Wadell if her comment about the need for training and support was meant for that particular approach, for other alternative ways to pursue improved service delivery for first episode psychosis, or for within the Coordinated Specialty Care model.

Committee Member Wadell stated she was suggesting training and support within the Coordinated Specialty Care model.

Executive Director Ewing suggested focusing on the large issue and discussing how to best support that, whether it is the Coordinated Specialty Care model or the Coordinated Specialty Care model plus other pathways, recognizing that the funding is limited. He asked if the Advisory Committee should focus on the Coordinated Specialty Care model or a range of approaches to address first episode psychosis.

Committee Member Wadell stated there is innovation and flexibility that happens within the Coordinated Specialty Care model. It not only allows for creativity, it demands it on a daily basis. She stated supporting the Coordinated Specialty Care model will not restrict innovation.

Committee Member Jacobs stated she has not been encouraged by what she has heard. She asked how to hone in on investing in a model that is truly innovative and has flexibility. She stated she liked that Committee Member Wadell indicated that individuals are asking questions – this means there is room for discussion to find solutions. For individuals to admit that means they are ready to have a dialogue and to look at each client individually rather than already having the answers before even meeting the client. That is innovative.

Committee Member Jacobs stated she was unsure that every county that is doing what is called coordinated care is doing it like UC Davis. It is important not to award funding to entities that will continue to do business as usual. Names are often put on things without delving into what each entity is actually doing. She stated this is where she leans more toward putting the funding to new innovative projects rather than investing all the funds into the Coordinated Specialty Care model.

Executive Director Ewing stated the Commission engaged UC Davis a number of years ago to look at the array of efforts that were identified as early psychosis programming and they found wide variation. Part of the original AB 1315 authorizing language is about creating fidelity to the model. Part of the idea is to strengthen the fidelity to the model, even while understanding the application of the model to the population. He stated it would be cleaner for staff to understand the Advisory Committee's recommendation – to focus within the Coordinated Specialty Care model or alternative approaches.

Committee Member Jacobs suggested stating, in order to apply for this funding, entities must be enrolled, included in the evaluation done by UC Davis, and monitored to ensure that they are keeping their programs to the fidelity that has been designed for it, rather than using the funding to enhance what is currently in place and calling it Coordinated Specialty Care.

Committee Member Insel spoke in support of Committee Member Wadell's suggestion to stay focused on Coordinated Specialty Care; although, he agreed that there is data where many counties are saying they are doing this when they are not. He suggested making an investment to ensure that there is fidelity and that outcomes are being measured to learn what is and is not working. He suggested broadening the scope to include more individuals.

Committee Member Insel stated the need for a statewide training and technical assistance center. He cautioned against awarding all the funding to counties and not

having someone coordinating this in a way that looks at outcomes, ensures fidelity, and does the training. He stated training will be the largest barrier to getting this done because there is no workforce that has the skills required for Coordinated Specialty Care.

Committee Member Insel stated the Commission meeting on Thursday will discuss Headspace and youth at risk, which is relevant to Coordinated Specialty Care but different. Coordinated Specialty Care is to ensure that, once someone has had a psychotic episode, they do not have a second one. The other work is about ensuring that someone does not have a first episode or, if they are developing a psychosis, they get diagnosed and treated much earlier. It is incredibly important but is a different kind of investment and a different set of interventions. He stated he would love to see this come together by 2025. That is the vision but California is not ready to dilute this effort by trying to include other programs.

Executive Director Ewing stated he raised the issue because, when thinking about the procurement process, the authorizing language on the youth drop-in centers is written generically, just as this language about early psychosis programs is written generically. Staff needed to look back at the intent of the efforts of the Headspace model, similar to today's question – if early psychosis is about the Coordinated Specialty Care model.

Executive Director Ewing agreed that, over time, California needs to get to the point where the systems begin to connect but, as staff began to design the proposal for the Commission, they had to decide if they were encouraging any effort of youth drop-in or incentivizing the Headspace model, similar to today – if staff is encouraging any effort around early psychosis or incentivizing a Coordinated Specialty Care model that builds on the learning collaborative the counties are co-funding – to push that model further to scale or to open it up to alternate approaches.

Committee Member Insel spoke in support of what was done in New York – to push the Coordinated Specialty Care model to scale. There is already a model to work with. It is not the manual; it needs innovative ideas but it can at least be made the foundation of the work. He stated the importance of a target to shoot for and a model that is known. Individuals can build beyond that to do additional things. At the UC Davis Conference, the need was expressed to innovate around substance use disorder and other issues that this model does not yet attend to. This is the foundation upon which everyone can build.

Committee Member Furuzawa echoed the comments of Committee Members Insel and Wadell. Misinformation or a lack of information is seen today of what Coordinated Specialty Care is. There are other existing funding sources that are already in use to implement components of it, but nothing is happening the way it should because there is a structure that is already well-documented that can be adopted and adapted to needs. She stated the areas that need to be developed are now known.

Committee Member Furuzawa stated Coordinated Specialty Care has the same issue of high incidents and not enough resources to provide the care and support that young people and families need. She stated training and technical assistance is fundamental. She stated the need to contract appropriately with the counties while developing more

programs. She suggested honing in on what the Advisory Committee will propose. She stated AB 1315 describes the Coordinated Specialty Care model without using the term. She stated $20 million is a good start and there are other ways of sustaining this long-term with existing funding. She suggested calling it Coordinated Specialty Care and going from there.

Committee Member Becker stated the importance of sustainability no matter what programs and activities counties or other entities bring. She suggested looking at liability issues for Coordinated Specialty Care or other non-evidence-based forms of care. She suggested a California early psychosis intervention app to help individuals locate a center. She asked how to evaluate communications to the media on how psychosis is portrayed and destigmatized.

Committee Member Jacobs asked if there is a list of models with innovative programs that may qualify as a Coordinated Specialty Care team. There are existing models that should be part of this process such as the Open Dialogue model, which may qualify to be part of early psychosis treatment.

Executive Director Ewing stated it sounds like the Advisory Committee is leaning towards working within the Coordinated Specialty Care model with some concerns such as the level of flexibility that is allowed within the model.

Committee Member Insel stated there is flexibility in the way Coordinated Specialty Care is set up. The one piece that is not flexible is there must be shared decision-making.

Committee Member Furuzawa stated there is a list of models that may qualify as Coordinated Specialty Care. She stated the beauty of this process is the list sets up larger buckets. Individuals can innovate by choosing how to deliver those components, which have structured evidence-based or research-validated diagnostic assessments, recovery-oriented psychotherapy, a care management component, and supported employment and supported education. The blueprint is the components that must be present. Coordinated Specialty Care needs to be a combination of those components to give the desired results.

Committee Member Wadell agreed. She stated she has a list in her office of useful things that are helpful to counties because they provide organization and scaffolding, such as the number of clients each provider can see.

Committee Member Buttlaire stated he is struggling with this. He stated, when coming up with proposals, the elements are described that need to be included in the proposal. The details cannot be dictated; the applicants participating in an RFP provide the details. Typical cases and what is being done for individuals are fragmented. He stated he is struggling with how directive the Advisory Committee needs to be in terms of looking at this. Individuals need flexibility – they need to be able to provide the services to ensure that clients are getting better. This is a journey in understanding the kind of Coordinated Specialty Care that is needed and which organizations to help with. He agreed that training is necessary and that outcomes are not always being measured. He stated the need to include psychiatrists and peers in the RFP requirements, to review

what applicants have and what they need to get, and who is supporting them in getting there.

Executive Director Ewing stated staff struggles with that issue on every procurement like this that is done. $20 million is a tremendous amount of money, and yet it is not enough for the need. It is important to consider how to make the best use of it. He pointed out that the issues that have been raised are different within the Coordinated Specialty Care environment. If the Advisory Committee's advice is to open it up to alternative approaches, it will become incredibly more difficult.

Public Comment

Brandon Staglin, President, One Mind, stated quality medical treatment, including medication and dialogue with a psychiatrist; supported education and employment in the form of support to volunteer; to be engaged, active, and learning; and to include family support are core components of Coordinated Specialty Care and why the speaker is a proponent of Coordinated Specialty Care today.

Brandon Staglin stated AB 1315 includes language about the need for data collection across the centers that are providing this care and funded by AB 1315 to ensure they are providing the care in a way that is evidence-based and according to the modes of fidelity. The speaker suggested that part of the 10 percent set aside of AB 1315 funding for research can be used to test innovative things within the Coordinated Specialty Care clinics.

Committee Member Discussion

Committee Member Insel agreed with the comments on sustainability. He stated, since the process for revising the waiver for Medi-Cal, it might be important to ensure that, in addition to a code for private payers, public payers are also able to cover all the services within Coordinated Specialty Care. It may be easier within the Medi-Cal Healthier California for All initiative, previously known as California Advancing and Innovating Medi-Cal (CalAIM). Within that reform effort, it may able to be specified as a bundled payment that would in some way be covered so it will be reimbursed and there would be no question that the counties that agree to do this can sustain it after the funding runs out.

Executive Director Ewing stated there are a number of things that must be addressed that are above and beyond the funding, such as policies, practices, training, workforce, research, and evaluation. He asked how to best utilize these funds to strengthen the approach and sustain the efforts. It is exciting that some practices, engagement, and learning can be incentivized with this funding, but the bigger opportunities are the issues around sustainability, greater awareness of the model, and confidence on the part of payer/funders. He stated the hope that the Advisory Committee can come to an agreement on the advice for the use of the funding and lay out the Advisory Committee's agenda moving past the one-time $20 million allocation.

Committee Member Insel asked how the $20 million, which will be put into an RFP and awarded to the counties, will be coordinated. He asked if a percentage should be held back to be used for oversight, training, and monitoring for fidelity on a statewide level.

Executive Director Ewing stated there have been conversations around other procurements that are, from a practice perspective, not related but, from a procurement perspective, very similar. These conversations have happened with the Commission's Schools and Mental Health project, the Commission's youth drop-in center work, and the No Place Like Home initiative. In conversations the Commission has been having with counties around almost every area that the Commission is working on, some counties and their community partners are ready to invest in a model, but there are others that are interested but do not yet have the infrastructure or staffing in place to invest.

Executive Director Ewing stated the Commission often allocates funds to partners that are ready and sets aside a portion of funds for technical assistance and training to support them. Partners who are interested but not ready to invest are often interested in planning support or a different level of technical assistance just to get ready to invest in a model. As has been seen with those counties and partners who are currently funding these types of programs, there are other funding streams.

Executive Director Ewing stated staff has talked to the Legislature about technical assistance and training support to accelerate the shift from business as usual to a model if communities are to be incentivized. He stated, in almost everything the Commission has done, technical assistance and support must be provided and tailored for communities that may already be doing something but need to get better at it, or communities who are ready to go and need an incentive of matching funds. There are communities that are perhaps a year out, but they will never get there without assistance.

Executive Director Ewing agreed with the set-aside for technical assistance, but stated the Commission does not have the capacity or the subject matter expertise to provide oversight, training, and monitoring. This is historically contracted out.

Committee Member Merritt stated the language in the law states "the Commission may consult with a technical assistance entity, as described in paragraph (5) of subdivision (a) of Section 4061, initiate an interagency agreement with another public entity, including the University of California system, or contract for necessary technical assistance to implement this part."

Executive Director Ewing stated a portion of the $20 million is to be held for technical assistance.

Committee Member Insel asked if that is paid out of the $20 million allocation.

Committee Member Merritt stated it is.

Executive Director Ewing stated, if the Advisory Committee agrees that the focus needs to be on the Coordinated Specialty Care model, the next conversation is how to do that. There is a restriction in the law for 20 percent of the funding to be used for clinical research. This was written when the vision was that there would be private sector

donations coming into the fund. He distinguished between clinical research and evaluation research for other kinds of technical assistance, training, and support.

Executive Director Ewing asked how to think about the balance between grants that launch new programs or extend the reach of an existing program, or strengthen the fidelity to the model of an existing program, which are very different things, versus funding that is available to support planning and early engagement, learning, and understanding. In some cases, the technical assistance might be the same. The state often prioritizes these kinds of contracts for other state bodies, including the University of California, which is called out in the legislation, but it is not limited to the University of California.

Committee Member Buttlaire asked about current well-run programs and where locations where there are not any. He stated his hope that someone who is being detected early on in terms of their potential psychosis would have equal access to some kind of care throughout California. He suggested looking geographically at where California is in terms of providing good care so some priority can be given to places that are eager to create programs and could use technical assistance. He stated he worries about places that have nothing now. He stated he would like that to be one of the thoughts about programs.

Committee Member Insel suggested potentially making those regional rather than just county-based by creating a center of excellence that would encourage counties to join together. One way to do this is to ask what it should eventually look like. He stated success would be having a statewide network that interfaces with the national network Early Psychosis Intervention Network (EPINET) and provides coverage so no one has to drive more than two hours and everyone has access to something no matter where they live in the state.

Executive Director Ewing stated there is language in both pieces of legislation around issues of unmet needs. The Commission has had conversations, consistent with the AB 1315 conversation, to get to a point where everyone in California has access to that high-quality program through a variety of means and the legislation recognizes the need for a multi-county collaboration.

Executive Director Ewing stated it sounds like the Advisory Committee is moving in the direction of strengthening a Coordinated Specialty Care statewide network. He asked how much to set aside for technical assistance and training; how the technical assistance should be defined, such as around fidelity, regional collaboratives, and planning support; and what the threshold for leveraging other funding should be.

Committee Member Jacobs asked if there has been a survey to learn who is currently doing this work and who is not. The amount of funding to set aside cannot be determined until the gaps are defined.

Executive Director Ewing stated those have been presented at the last two meetings. The challenge is just because a county has a program does not mean it is adequately meeting the needs of its population.

Committee Member Jacobs suggested directing that every entity that is awarded must be enrolled and giving funding to UC Davis to monitor, since they already have the evaluation, know how to administer it, and are currently running it with several counties.

Committee Member Becker agreed and stated UCLA and UCSD also have established programs.

Executive Director Ewing stated the Universities of California coordinate with each other and Standard University is part of that collaboration in some ways.

Committee Member Jacobs stated entities that apply for the funding can all receive the same technical assistance and be under the same monitoring and evaluation process statewide for efficiency and consistency.

Executive Director Ewing asked if the funding that is set aside for technical assistance and training should be allocated through a competitive process. He stated it sounds like the Advisory Committee is suggesting the need for program dollars to support the expansion of the existing network – individuals who are either doing this work or doing more of it, individuals who are not doing this work now, communities that are not receiving the services of a Coordinated Specialty Care approach, and technical assistance.

Executive Director Ewing asked for suggestions about the amount to invest in doubling down on existing systems, if the Advisory Committee agrees to support the expansion of the existing network, because it is about expanding a model that is in place. He stated it is very different to launch something from scratch.

Committee Member Wadell stated it is difficult to staff a program where none exists, when there is no one with experience to run that program. She stated it would make sense to first invest in bringing existing programs to fidelity and supporting them, because from them can come a trained workforce that can then spread. She stated training always comes at a higher cost than expected. It is difficult to provide training to providers because they have to block out their time to attend the trainings, when the expectation is that providers are billing 80 percent of their time. It is also a cost for the agency providing the training because, similarly, they are not engaged in billing during that time. She suggested that a large portion of the funds must be allocated toward training because from that comes a larger workforce and the opportunities for expansion.

Executive Director Ewing asked about a reasonable amount or percentage needed for training, support, and planning over the four-year cycle.

Committee Member Wadell asked Dr. Niendam to provide input on that.

Executive Director Ewing asked Dr. Niendam about the amount of the $20 million that should be set aside for a strategy that supports understanding of the Coordinated Specialty Care model, staff training, training coordination, and looking at data and outcomes.

Committee Member Insel asked Dr. Niendam about the amount of the funding that should go to the counties and the amount that should be used for statewide oversight and support.

Committee Member Jacobs stated half the counties in the state are already doing early psychosis programs. She asked Dr. Niendam about the number of those programs that are already in the UC Davis evaluation model because the Advisory Committee is talking about all participants being a part of the UC Davis evaluation model. In order to have fidelity, everyone must do the same thing.

Executive Director Ewing suggested, along with asking about the evaluation model, asking about the learning collaborative. All participants would be a part of the UC Davis evaluation model and the learning collaborative. Evaluation is just a piece of it.

Committee Member Buttlaire suggested asking individuals who are supposedly doing programs now what they would need in order to come into fidelity with the program. This would help the Advisory Committee think about programs that exist that may need additional resources to come online. This would mean that coordinated care would need to be defined in such a way that they could look at their system to evaluate what they would need.

Committee Member Insel stated this was done as part of the landscaping effort.

Public Comment

Tara Niendam, Ph.D., Executive Director, UC Davis Early Psychosis Programs, stated the need for her PowerPoint presentation from the August 29, 2019, Advisory Committee meeting, Early Psychosis Care in California: Current Landscape and Future Directions, to be included in the meeting packet for reference.

Dr. Niendam responded to Committee Member's questions. The speaker stated what counties would need to come into fidelity of the program varies county by county because some counties are able to create some components but are unable to carve out the other pieces, individuals, and training for supported education and employment, case management, or the linguistic skills for the physician time. The speaker stated physician time is a huge barrier to many of these programs.

Dr. Niendam stated it is unique depending upon where the programs are located, and the solutions might be unique, as well. Also, the complexity of the Coordinated Specialty Care model requires different solutions for different pieces.

Dr. Niendam addressed the questions on data and what is actually going on. These are very important questions because of the need to capitalize on the good work being done and the strengths that do exist in these communities and programs. The speaker stated the need to consider how to build on those and how to fill in the gaps.

Dr. Niendam stated there is work there about understanding the landscape in more detail, learning where the barriers and facilitators are, using a mix of the qualitative and quantitative data to create a plan, and bringing everyone into the California Collaborative Network to Promote Data Driven Care and Improve Outcomes in Early Psychosis (Learning Healthcare Network) to create an ongoing system of outcomes and fidelity monitoring.

Dr. Niendam stated many counties have reached out to UC Davis that wanted to join the Learning Healthcare Network; they have required support in navigating the process. The speaker stated there is currently a rich opportunity to invest at a state level to answer some of these excellent questions from the Advisory Committee and to develop a plan to move the state forward at a higher level. This will take a significant investment, both supporting the development of current programs and bringing new programs online in the right places and in the right ways that will support communities. The speaker stated they do not know how to best serve individual counties but communities want to be served and should have access.

Committee Member Insel suggested setting aside a possible 20 percent of the funds or a little more for a statewide effort of organization, training, and technical assistance. He referred to the California's Early Psychosis Opportunities and Challenges (map) handout and stated, in answer to Executive Director Ewing's question, rather than using the remaining funds to create new programs by 2024 in places that do not exist, there is plenty of work to do from the map just to get individuals who are trying to do this already a little further along.

Committee Member Insel stated it seems feasible to have approximately 15 programs across the state by 2024 all doing optimal care in the way that it has been defined, but there will need to be some part of it, at least 20 percent of it, going to organizing all that in a way that is thoughtful and providing the training. He noted that the workforce is the biggest barrier; it always has been. He suggested that that organizing group can set up telehealth for psychiatric support in three hubs around the state so all counties can benefit. He stated there are many things to work out but some substantial part of the funds needs to go to this statewide oversight effort around technical assistance and development.

Committee Member Insel stated, rather than using the rest of the funding to get another few counties into the collaborative, he would rather see the funding go to counties that are already working on this and have already voted that they want it but have not been able to put the whole thing together. He suggested doing this in ten counties or ten places, to end up with 15 to 20 programs across the state at the end of 2024. That would feel like success.

Dr. Niendam provided a sense of the scope. The speaker stated San Diego, Orange, and Los Angeles Counties and the counties from San Francisco Bay out to Sacramento are part of the program. The cost just to set up the Learning Healthcare Network in 12 sites in these two regions is $10 million. The speaker

stated it is a lot of people and a lot of training, but noted that those people are not being trained to do early psychosis care.

Dr. Niendam referred to the map handout and stated Committee Member Insel's suggestion to bring in all of the orange-colored counties on the diagram, which are the counties that already have early psychosis programs, and to bring them to fidelity, and to have the blue-colored counties, which are the counties where an early psychosis program is in development, turn orange so that everyone is on the same page will be costly to bring in the individuals who have the expertise to do that training.

Committee Member Jacobs stated the orange-colored counties may not still be orange and doing fidelity.

Dr. Niendam agreed.

Committee Member Becker asked about the ratio of each category of staff to patient.

Dr. Niendam stated the expected ratio is 20 clients to one clinician, which is a lot for an experienced clinician to manage. The speaker asked Committee Member Wadell about the ratio for physicians.

Committee Member Wadell stated the ratio for physicians is not more than 150 patients. It is typically done at per .2 FTE because most programs do not have full-time psychiatrists on staff. It is expected that a psychiatrist will see under 30 clients per day.

Committee Member Becker asked if there are nursing equivalents.

Committee Member Wadell stated it is not something done in her program.

Committee Member Furuzawa stated her program operates at no more than 100 unduplicated clients per year per full-time psychiatric nurse practitioner who is operating under the supervision of a licensed psychiatrist. She stated the caseload varies on the site and whether the supervising psychiatrist is also providing direct services or just providing supervision. The smaller site has an unduplicated client count of 70, even though the site is designed to serve no more than 40 unduplicated clients per year. She stated they have a .2 FTE licensed psychiatrist to see 40 clients. They see 70 because the site is in an area where there are no other resources.

Committee Member Becker asked about the licensure or education of the clinician.

Dr. Niendam stated the majority of clinicians are master's level, which is probably comparable across most of the programs. The challenge is the variety in training that the clinicians may have had. It takes more training if they need to be trained to do assessments.

Committee Member Becker asked if there is room in this model for associate- and bachelor-level degrees.

Dr. Niendam stated there is. They also have peer partners, family partners, and peer support specialists. There is room for those individuals; they help to round out the teams and do case management work, do community reintegration, run

groups, go out to the home, and provide support. There is a wonderful opportunity for a variety of individuals.

Committee Member Becker asked about the ratio of peer workers.

Dr. Niendam stated peer workers are usually half-time staff for 30 to 40 clients so they can be there every day. She stated she strongly believes that, if someone is hired, they should be given a living wage and benefits. She stated the peers in her program at UC Davis are at .6 and they get a good salary and full benefits.

Executive Director Ewing stated the intent is not to solve the issue or have a statewide program.

Executive Director Ewing summarized that Committee Member Insel suggested a 20 percent set-aside and a focus on strengthening current programs, and Committee Member Buttlaire commented that there are many regions throughout the state that have nothing and suggested a set-aside for maybe a planning phase support to address the needs in areas, particularly rural areas, that do not have the capacity and possibly never will, unless it is through a telemedicine-type approach.

Executive Director Ewing stated the Advisory Committee's suggestions were to have funds for technical assistance and training, funds to build out the infrastructure that is in place so it is more about pushing fidelity and not launching new programs, and a set-aside to recognize that there are areas of the state that need planning to help fill the needs of the community.

Committee Member Insel agreed with Executive Director Ewing's summary but stated that is the 2.0 version. There is not enough funding or experience to do all of that with the current allocation. He suggested using the funding for something that can be accomplished without doubt, and then creating a second initiative. The Governor's Office should be interested in starting a second initiative when the results of the first initiative are seen.

Committee Member Insel stated the map handout is useful because there are areas that clearly will need to build something that does not yet exist. He agreed with Committee Member Wadell that trying to build something when there is nothing to build from is a much bigger lift. He suggested using existing programs to do something that can be accomplished in a timely manner. With that success, it can be built from there with the second initiative.

Executive Director Ewing stated counties can be encouraged through innovation funds to invest in early state explorations. The Commission is having conversations on the commercial side about how they can intersect with some of these conversations in terms of their authority. This limited allocation is focused on the public side, but that does not mean that the Advisory Committee and the Commission as a whole cannot seek additional public and private investments.

Committee Member Insel stated he has visited many counties within the last six months to ask them how important this topic is to them. He stated he learned that, although it is important to counties, they are dealing with many urgent issues that are more important

to them right now. He suggested letting counties do what they need to do and then engaging them after the system is working better and the fidelity is built out.

Committee Member Jacobs stated one of the restrictions the state has is that individuals with Medi-Cal cannot go to a different county to get services. She stated many rural counties do not have large populations, so investing funding into building an early psychosis program does not make sense. She suggested that small, rural counties partner with a neighboring county that does have the funding, and that the residents of the small, rural counties be allowed to flow over to the closest county that has the services that AB 1315 has funded.

> Dr. Niendam stated there is a model for that with foster children. They are able to be served in the county of residence as opposed to the county where they went into the system. There are other ways to do this such as entering into a contract with another county to provide services, such as providing services in Sacramento County but Yolo County pays for it. Allowing those cross-county line collaborations is a good suggestion as long as it is not a great distance for individuals to go to reach the services. Dr. Niendam asked, in those instances, if the service can go across county lines to the client.

Committee Member Buttlaire built on Committee Member Jacobs's thoughts as well as an earlier comment by Committee Member Insel, which is the idea of greater centers of excellence. He stated part of the incentive funding would be for those programs that are doing a good job, and then reaching out to other places that do not have the programs and, through this program, give them more funding so they can reach out to other counties to work with UC Davis or others to provide the services. This needs to be expanded, if possible, by supporting good programs or programs in development, but also having them think about other counties.

Committee Member Insel agreed. He stated, even in the RFP, they should be framed as centers of excellence that are regional and not just county-based. There is a current conversation about reorganizing mental health care in California on a regional basis and this is a great example. He stated there is not a need for 58 counties to do this but there is a need to ensure that every county has access to it. If the language can explicitly be crafted in the RFP that says that these funds are to be used on a regional basis, it starts the change that everyone wants to see.

> Brandon Staglin stated Napa, Solano, and Sonoma Counties are currently forming a regional network as a region of the North Bay Area, where the Coordinated Specialty Care model is being administered under the oversight of UC Davis with support from Kaiser. The speaker stated there is synergy between those counties and the economies of scale coming there that are not only from a single nonprofit administering the care, but also the idea of including an in-house training person trained by UC Davis who would service the entire region is being discussed. A plan is currently being developed to save money and train more individuals more efficiently.
>
> Brandon Staglin stated it is important that the funding be used as efficiently as possible to show the efficacy of what can be done now by investing in training

and technical assistance to help counties and programs that are doing this care to do it more efficiently and effectively by tracking their outcomes through a Learning Health Care Network, and also by enabling a few counties that are already starting programs to build out those programs in a way that is efficient and effective by being part of the statewide collaborative. The speaker stated, by showing results within the short-term, results for the longer-term can be advocated for.

Brandon Staglin stated One Mind is ready to participate in this. One Mind is connected with the Governor's Office and with others throughout the state in partnership with organizations such as the Steinberg Institute to advocate for additional funding for this in the near future. The speaker agreed with the Advisory Committee to focus on results that can be improved on now to demonstrate the model for more results later.

Executive Director Ewing referred to the Early Psychosis Intervention Plus Summary of Advisory Committee Action document, which was included in the meeting packet. He reviewed the Potential Allocation Priorities on page four of the document as follows:

1. Support the Creation of a Statewide Training and Technical Assistance Center.
2. Build the Capacity of Existing EPI Programs.
3. Fund New EPI Programs.
4. Explore Public/Private Partnership Opportunities.

Executive Director Ewing stated the discussion today indicates that the Advisory Committee would like to save Priorities 3 and 4 for a future phase and to focus on Priorities 1 and 2. He asked if the Advisory Committee Members agreed with his summary.

Committee Member Buttlaire suggesting moving the second bullet on Priority 3, incentivize multi-county collaborative efforts, to Priority 2.

Committee Member Insel stated he was comfortable with the bullets under Priority 1. The bullets under Priority 2 do a disservice to what was heard in the conversations today. He stated what he took from the comments today was that the goal should be to "Ensure that the Existing Early Psychosis Intervention Programs are Reaching Fidelity to the Coordinated Specialty Care Model."

Committee Member Insel stated, beyond that, there may be a need to innovate around these issues such as substance use disorder treatment, trauma screening of children and youth, and other things, but that seems to be the add-on. The core of it for building capacity ought to be to at least reach the foundation of being able to deliver Coordinated Specialty Care in each of those sites that apply. He stated the need to simplify it. Most of the bullets could go under a single bullet with the potential to innovate on all of these issues that are not currently in the Coordinated Specialty Care model and need to be dealt with at some point.

Executive Director Ewing asked if this should be part of the procurement or for next steps.

Committee Member Insel stated anyone who wants to optimize Coordinated Specialty Care in new ways can be invited to be a part of this. The vision is to have approximately 15 programs across the state that are all developing high-quality care for this population, sharing the data, using the same outcomes, and creating a Learning Healthcare Network. The vision is to expand so that that is happening more broadly.

Committee Member Insel stated, in the procurement, it is fine to invite individuals to do more than that if they so choose. That would be a plus, along with having a regional approach. He suggested clarifying what the core of this is – to reach that level of fidelity so that everyone is delivering at least a basis of care that is known to work.

Executive Director Ewing asked Dr. Niendam, based on the work UC Davis did a few years ago and more recently, how many programs are currently in place and in alignment with the model.

> Dr. Niendam estimated that 15 to 20 programs are in alignment with the Coordinated Specialty Care model. There are good programs with good outcomes that do not necessarily have high fidelity to the Coordinated Specialty Care model because the funding is not available to them to do it. They do the best they can with what they have.
>
> Dr. Niendam stated the private payers cannot be taken out of the conversation. They are serving a huge number of Californians.

Committee Member Furuzawa suggested making the last bullet under Priority 1, disseminate a strategy for engagement of private insurers, the first bullet under Priority 1 and specifically including commercial insurance. She stated that should be a part of the technical assistance at this point because of the changes to the Medi-Cal Healthier California for All initiative, previously known as California Advancing and Innovating Medi-Cal (CalAIM). Reimbursement models will become crucial for publicly-funded mental health services in California. It is important for sustainability to begin considering that earlier on and to build it into the technical assistance.

Executive Director Ewing stated, while it is important to build in a sustainability piece in terms of the programming or support that is provided through this funding, this issue is a much broader issue above and beyond the $20 million that has been allocated. At the least, a day must be dedicated to that issue alone, talking with commercial partners and understanding the opportunities for the state to move in that direction. He suggested not burdening the procurement with that task. There is a research piece to that, understanding the incentive, education, training, and awareness, and the Medi-Cal Healthier California for All conversation.

Executive Director Ewing stated, although it is a significant issue that must be considered to be successful for all Californians, it is bigger than what can be done with the $20 million allocation, with the exception that there may be things that entities who are awarded these funds can do to leverage commercial insurance.

Committee Member Insel suggested adding a bullet under Priority 2 to say one of the features that would be encouraged is partnership with the philanthropic sector as a way to build out sustainability. He agreed with Committee Member Furuzawa that that

process itself is likely to make these new centers much more sustainable and able to serve more individuals. He agreed with including that into the RFP that this is a model worth looking at as counties are thinking about what they can do.

Committee Member Merritt stated the language in the law under AB 1315 includes many things that applicants need to describe: the need, a description of their programmatic components, a clear description of the funds they would use to match, and "a description of the sustainability of program services and supports in future years." She stated there is a great deal of information in the law; it does not need to be rewritten.

Executive Director Ewing stated, during the lunch break, staff will try to capture the comments and suggestions made by the Advisory Committee during the morning session and will share the summary with Advisory Committee Members in the afternoon session. He stated the structure of the afternoon session will include the following:

- A discussion on some of the pieces that are not yet on the table.
- A discussion about what can be incentivized in terms of the procurement.
- A discussion about what needs more work outside of the procurement.

Executive Director Ewing noted that some items will be both in the procurement and outside of it. He dismissed everyone for the lunch break.

LUNCH BREAK

DISCUSSION

4: <u>Continued Discussion of Strategies for the Allocation of Funds</u>

Presenter:

- Toby Ewing, Ph.D., Executive Director, MHSOAC

Executive Director Ewing stated the continued Advisory Committee discussion will include strategies including potential funding for statewide training and technical assistance, building the capacity of existing early psychosis programs and funding new early psychosis programs, and opportunities for public and private partnerships.

Executive Director Ewing stated a copy of Welfare and Institutions Code, Sections 5835 through 5835.5 was distributed to Advisory Committee Members for their reference. He summarized the comments and suggestions made by Advisory Committee Members during the morning session to consider in structuring the procurement:

1. **Create a set-aside for training, technical assistance, capacity building, and research and evaluation.**
   - Consider a set-aside amount of possibly 20 percent

<u>Issues for Advisory Committee Members to provide guidance on</u>:

The law is clear that the procurement for program dollars needs to be done competitively, but the competitive language does not apply for funding that is used for technical assistance.

- Advisory Committee Members discussed the capacity to support centers of excellence or regional centers.
    - If funding is set-aside for training and technical assistance, is the idea that it is only for grantees or is it technical assistance that is available for individuals who are not necessarily a grant recipient?
        - For context, the discussion earlier was to get to 15 centers. The Advisory Committee might advise staff to set a target number of grants to be provided.
        - If the consensus is to do technical assistance, the opportunity is missed to provide support to individuals who are not grant recipients but could benefit from the technical assistance.
- A related issue to that is the evaluation piece.
    - The evaluation that is required is specific to the grantees, but there is also the issue of whether the entity that is doing technical assistance and training is evaluating their own work.

Executive Director Ewing asked for feedback on this first issue. He stated the evaluation question will be dealt with separately:

- If a set-aside is done, what does that number look like?
- Is the set-aside specific to grant recipients or it is open?
- If it is open, there is a need to think about ensuring that grant recipients have first claim.

<u>Committee Member Questions and Discussion</u>

Committee Member Jacobs stated she was confused about how this is being presented. She asked who the grant recipients would be.

Executive Director Ewing stated the language in the law states the grantees could be counties. The Commission has $20 million. $5 million is set aside for training, technical assistance, and support. There needs to be agreement on data standards, learning on how to do billing, and developing potentially multi-county collaboratives with a telemedicine component.

Executive Director Ewing asked if this contractor will be asked to do those services for only county grantees or if funding is set aside for technical assistance. There may be providers who are not grantees but they would benefit from that technical assistance. If the technical assistance is open to non-grantees, that suggests that additional funds should be set aside to allow those funds to be leveraged against programming that is paid for with other dollars. The traditional model is that only grantees are eligible for technical assistance.

Committee Member Jacobs stated it is about the fidelity scale. She suggested that they do not all have to be grantees, but anyone who benefits from this funding should be in line with the fidelity scale.

Executive Director Ewing stated one way to support that fidelity for non-grantees could be through technical assistance and support. He stated Committee Member Jacobs is suggesting it should be opened up. That way, entities who want to move toward fidelity and are not a grantee can get some support for that.

Committee Member Becker asked what an entity who is getting just the set-aside would look like. She asked who the funding would go to.

Executive Director Ewing stated the language references the University of California. The law does not require a competitive procurement here, but it could be a competitive procurement. It could go to someone who is running a program or someone who is not running a program but has the expertise.

Committee Member Becker asked if this is for individuals who will be giving the trainings.

Executive Director Ewing stated these are providers. They will be providing training, technical assistance, and supporting capacity building on the part of programs.

Committee Member Merritt stated she was also confused. She asked if the individuals who did not receive funds from this competitive process, who were included on the map handout, and who have an early psychosis identification program could benefit from technical assistance, even though they were not awarded additional funds.

Executive Director Ewing stated they could. He stated the Commission could set funding aside for training and technical assistance for only individuals who receive a grant award or for anyone who is operating a Coordinated Specialty Care model to further the consistency of that approach. They could have received a grant but they do not need a grant to be eligible for care.

Committee Member Merritt stated, in the words of Committee Member Insel, that might be the 2.0 version. She stated, with $20 million, it should be much more focused due to the limited one-time funding. She suggested making the training, technical assistance, and support available only to grant recipients until more funding becomes available.

Committee Member Wadell stated she struggles with this because it is difficult to understand the full scale and the costs. She stated the need to think about what is practical and realistic due to the fact that there is already a model.

Executive Director Ewing stated it is easier to provide services only for grantees because then there is a stronger sense of what the project is – it is not open-ended. It makes it more concrete to keep the training, technical assistance, and support to grantees only.

Committee Member Merritt stated the law states “the Commission shall ensure that awards result in cost-effective and evidence-based services that comprehensively address identified needs of the target population, including transition-aged youth and young adults, in counties and regions selected for funding.” She stated, in order to

ensure that the awards result in cost-effective and evidence-based services, those counties that are awarded funding must receive a generous amount of technical assistance. She stated word will spread; once these counties are up and running and showing great results, other counties will become interested.

Committee Member Buttlaire suggested separating education and training from technical assistance, capacity building, research, and evaluation. Education and training could be a wider group of individuals to try to get them engaged and interested. He stated the effort that goes into technical assistance is really building capacity and working with programs to get them functioning and should be separate. It takes much more effort to ensure they are keeping the fidelity. Getting individuals interested in developing the program starts with education and training.

Executive Director Ewing asked Committee Member Buttlaire for more detail about his comment that the education and training piece is different from technical assistance and capacity building.

Committee Member Buttlaire stated it starts with education and getting people interested, tuned in, participating, and understanding the value. Not everyone knows about early psychosis identification and what goes into this kind of a system of care. He suggested developing training modules or other types of education and training. There should be some focus on that that is not only for grantees.

Committee Member Buttlaire suggested UC Davis as the provider of the education and training. Technical assistance is digging in with individuals who are providing the service, ensuring they are doing it with fidelity, checking in with them to ensure that it is happening properly, ensuring that they are building capacity, and getting people in and providing the kind of care they need.

Executive Director Ewing stated there is an argument about the Learning Healthcare Network and a research piece there, particularly supporting the ability of programs to use their own data and to understand it. But the evaluation raises a red flag. He asked if funds should be set aside separately for evaluation. Typically, third-party evaluations are more valid than self-evaluations.

Committee Member Jacobs suggested a separate evaluation and research component, but she could also see, within the UC system, that there are partnerships right there that are already on board. She stated UC Davis, UC San Diego, UCLA, and Stanford can all participate and different universities can take on different components of this technical assistance piece under that umbrella.

Executive Director Ewing stated it does not have to be a completely external partner. It can be an internal partner with some independence.

Committee Member Furuzawa stated she only sees a problem with evaluation in this context if the provider of technical assistance, capacity building, and the other elements is also one of the grantees. What she is seeing, including the feasibility studies for Coordinated Specialty Care, is that usually whoever takes on this technical assistance and capacity building does all of the components, but they are not one of the bodies being evaluated. They are evaluating the services.

Executive Director Ewing stated it sounds like the Advisory Committee is saying that it is helpful if it is a third-party evaluation but it does not have to be a third-party evaluation.

Public Comment

Dr. Niendam suggested that the RFP could stipulate an evaluation plan that includes external entities who would be on a committee to look at the data and evaluation plan. That is what is typically done in services, research, or clinical trials.

2. Emphasize sustainability and finance.

Executive Director Ewing stated he also heard the Advisory Committee say to put a heavy emphasis on sustainability and finance.

3. Common Evaluation.

Executive Director Ewing stated common evaluation came up consistently in the Advisory Committee discussion.

4. Match Requirement.

Executive Director Ewing stated there is a match requirement but the law does not specify the amount. He asked what that match requirement should look like. He stated the tension often seen is that the individuals who are most interested and often ready to go might not have a lot of unallocated funds. If funds are prioritized for individuals who have existing programs, programs that are in development and building off of what is available might be less difficult to provide a match requirement because individuals have already made commitments.

Executive Director Ewing stated there is often language that the supplement not supplant. The question is whether existing dollars count toward the match or the match has to be new dollars. If it is a new-dollar match, it can become a barrier to participation for some counties versus making an existing contribution. Their contribution is not being taken away so it is not supplanting but the overall investment is also not being grown beyond the state dollars.

Committee Member Questions and Discussion

Committee Member Jacobs stated, if they are in development and they have set aside money, she could imagine a county saying that they will put this up as an in-kind match such as putting up three FTEs and asking for more funding to make three more FTEs to make a full team. That would be seen as an in-kind match building upon an existing program without asking the county to add new dollars separate from the grant they are requesting.

Executive Director Ewing stated that is viable. The question is if it is more of a one-to-one or a two-to-one match.

Committee Member Merritt stated it was originally a 50/50 match when writing this law but that received pushback because not every county can do that and they would be left out. She stated the thought was then to take the county's ability to match what they put in their application as one component. They would be listing out their need and a

description of the program components, what they will do with regard to outreach, and funds that they would match. If their need is great but their capacity to match is small, then the grant selection team would have to make a decision about the ability to match versus the need.

Executive Director Ewing stated he was hearing Committee Member Merritt say it is a weighted match.

Committee Member Merritt agreed.

Executive Director Ewing stated the way the procurement works is that the weighting and the criteria must be established ahead of time. He stated this procurement can be weighted and the Advisory Committee can use its judgment of how much it will be weighted.

Committee Member Merritt asked how many of the components are weighted.

Executive Director Ewing stated it can get difficult; staff does not typically discuss it in a public forum because it can create a bias. He stated, if the Advisory Committee's advice is to recognize the match requirement and is not specific but suggests a percentage of points, that percentage will be determined behind closed doors.

Committee Member Buttlaire agreed with Committee Member Jacobs's suggestion to consider existing resources toward the match.

5. Incentivize Regional Collaboration.

Executive Director Ewing stated the Advisory Committee also discussed incentivizing regional collaboration.

6. Focus on the Coordinated Specialty Care model.

Executive Director Ewing stated the Advisory Committee needs to think about how to define the Coordinated Specialty Care model so there is a balance of fidelity versus innovation within the model.

7. Target the number of grants versus funds available option.

Executive Director Ewing stated the Commission has done procurements with a certain amount of funding to be divided equally between grantees and others where funding was divided based on small, medium, and large counties. $20 million is not enough funding to divide by small, medium, and large counties, so the options could be to award a certain amount of funding to be divided equally between grantees.

Executive Director Ewing stated the Commission has also done procurements where the top three winning applications are awarded the first-, second-, and third-best funding. This incentivizes the quality of the application but runs the risk of supporting only a single program. The Commission is moving away from that because it is trying to build a learning community.

<u>Committee Member Questions and Discussion</u>

Committee Member Becker stated she agreed with Committee Member Insel's suggested number of 15 grant recipients.

Executive Director Ewing stated Committee Member Insel's intent was to get to 15 statewide programs in future years. He stated Committee Member Insel asked how many programs are currently in California and Dr. Niendam stated there are approximately six.

Committee Member Becker suggested 10 grant recipients.

Executive Director Ewing stated the award will be $1 million each for 15 grant recipients, assuming that the set-aside will be $5 million for training, technical assistance, and support.

Mr. Orrock asked to discuss the possibility of regional grants.

Executive Director Ewing stated another way to do this, rather than small, medium, and large counties, is to award grants by geographic region. The challenge is, looking at the map handout, that the distribution does not quite follow geographic regions. He stated sometimes the Commission does that to create regional collaboratives, which is awarded through weighting.

Committee Member Becker asked about the average need and the amount of funding that may be requested by counties.

> Brandon Staglin stated one of the documents handed out today references a cost per patient per year for treatment in the Coordinated Specialty Care Clinic of approximately $15,000. Depending on the size of the programs that are applying for funding, it would be approximately $450,000 for 30 patients per year.

Committee Member Jacobs stated the Advisory Committee was talking about expanding on the counties that were already either orange or blue on the map handout, meaning that they either already have an early psychosis program or are developing one, rather than starting from scratch with a county that has nothing. The orange and blue counties already have some infrastructure built. She stated this funding will help them to expand with more fidelity, evaluation, and technical assistance. She asked if a county can even apply if they are within the beige "no early psychosis program" areas on the map handout and start from scratch.

Executive Director Ewing stated he sensed that the Advisory Committee was opting to build off of the infrastructure that is already there. The challenge will be that it is not about improving the three best programs, it is getting to the point where there is a robust collection of programs that are pursuing the Coordinated Specialty Care model with a future target of 15 programs across the state.

Executive Director Ewing stated it is not about serving the number of individuals that are already being served a little better, it is increasing the capacity for these existing programs to serve more individuals due to increased efficiency or increased staffing.

Committee Member Jacobs stated maybe those counties that are getting more proficient can become the learning center for their region in future years. Funding should also being invested toward that ultimate goal.

Committee Member Becker stated there are counties that are heavily populated, even though parts are very rural, that do not have early psychosis programs. She suggested

thinking in terms of two to four larger grants and then smaller ones that are meant for the counties that are developing or have developed programs.

Executive Director Ewing stated those are considered expansion grants. He stated an expansion grant is where an individual is already doing something and the grant helps them get better at what they are already doing versus helping an individual to launch a program.

> Brandon Staglin suggested a way to determine the number of programs in counties that ought to be given grants for joining the Learning Healthcare Network to create a network of a certain size to get a critical mass for useable data to show efficacy, if there is efficacy, in different components of Coordinated Specialty Care or of the whole model. The speaker stated this will be fundamental to getting more funding coming in. That data and the cost-effectiveness data are the goals of the Learning Healthcare Network.
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> Brandon Staglin suggested doing a Statistical Power Analysis of the number of clients that need to be enrolled in programs across the whole network to see their outcomes, and then, from those outcomes for that number of patients, getting a meaningful statistical result that can show whether it is scientifically valid that it is effective or not. The speaker stated that could be the number that is needed to determine the number of programs that are needed to be involved and, thus, the number of grants to award.

Executive Director Ewing stated it is a good point to think about; unfortunately, there is no time to do that in advance of designing a procurement. He stated weighting could be done because there are multiple ways to get to the threshold for programs that are proposing a higher number of individuals – a larger program that serves a smaller number of individuals or a smaller number of programs that are serving larger numbers of individuals. It is important to have enough variation across programming so something can be said about the differential response.

Executive Director Ewing stated this is consistent with the legislation, which talks about a Needs Assessment. He stated the idea may be that entities with smaller numbers would participate in a regional effort because the marginal cost of setting up a program for smaller numbers does not make sense.

Executive Director Ewing stated the Advisory Committee provided guidance that the idea is to get to a critical mass of programs that are pursuing a Coordinated Specialty Care model that can be learned from and grow over time. He stated he wanted to move on to other issues, unless there is further discussion from the Advisory Committee Members.

Committee Member Becker asked about the chances of the Legislature allocating more funding if this is done well.

Executive Director Ewing stated the chances would be better if it is done well.

Executive Director Ewing stated he added commercial insurance support for the list of work to be done outside of the procurement. He stated part of the conversation in the morning session was how to drive more resources into the Coordinated Specialty Care

model. A budget allocation for commercial insurance support is one way to accomplish this. Another way to think about it is streamlining access to the commercial payer opportunity and making sure that Medi-Cal is being maximized. That issue is being touched on in a number of ways.

Committee Member Becker stated that is the sustainability for who is funded now, but if other counties are ready for this program in five years, this Advisory Committee may not keep going.

Executive Director Ewing stated the original intent of AB 1315 was that the Commission would actively be pursuing funding for this effort from all sources.

> Dr. Niendam discussed, based upon their experience of working with various counties to try to help them, considering how to come together to make something like this happen. The speaker stated there currently is not a place where counties can go to get that guidance and it is difficult and frustrating for counties. The speaker asked if the Advisory Committee sees this discussion coming after the procurement process because, otherwise, a call is being put out for applications to counties that may not know how to best respond. The counties that will respond will be the counties that already know what they are doing.
>
> Dr. Niendam stated, the way this is set up, these two things will happen at the same time and there will not be an opportunity for these grantees to benefit from technical assistance for even writing the grants or thinking about the best way to create regional collaboratives. The speaker was struck by the fact that there were multiple questions before the lunch break asking about what is happening out there and if the orange counties on the map handout are still orange or if they are now blue. The speaker asked how to build these grants in a way that will have the largest impact on the most individuals. The speaker stated the leadership piece needs to happen so the Commission will know the best place to invest the funding.

Committee Member Jacobs stated the Advisory Committee is saying the grant needs to incentivize. Whoever gets the funding has to get extra points by showing they will collaborate with a neighboring county, especially one of the counties that are blue or beige on the map handout. If they are not, their application will go to the bottom of the list because that is how to help neighbors. She stated the grant should be scored in such a way that counties will be incentivized to partner with these counties that need to get up to speed.

Executive Director Ewing agreed. He stated that clearly lends itself to a county saying to a neighboring county that they are interested and asking to partner with them. He stated, at this point in time, this does nothing for that. If it was opened up to entities that are not grantees, thinking that this funding is not the only opportunity, then there would be technical assistance and support, but the comments from the Advisory Committee are that that would be addressed in version 2.0.

Executive Director Ewing stated the comments from the Advisory Committee are to do improve the work that is already being done by rewarding entities that are doing that work with more support to move this forward. He stated the need to think about how to

lay the groundwork. Clearly, a regional approach would be the best approach for rural counties.

Executive Director Ewing asked if there are strong feelings about the number of grants to award.

Committee Member Buttlaire stated the need to be mindful of what it takes in order to get a program up and running, even for those that are there. If counties will be incentivized to work with their neighbors, that clearly will take more funds in order to do that and that needs to be encouraged. He stated he does not have a number of grant awards in mind.

Committee Member Jacobs suggested five grants at $2 million per grant, but stated a smaller county may only need $1 million, which would allow for 6 grantees. She suggested setting a maximum amount per grant to see how much funding counties are asking for.

Executive Director Ewing asked for verification that the number should be between five and ten grant awards.

Committee Member Jacobs agreed, because that will leave $10 million for training, technical assistance, support, research, and evaluation.

Executive Director Ewing asked if there is a cap on the amount of funding per grant.

Committee Member Jacobs suggested $2 million per grant. She stated she was just throwing out numbers even though she had nothing in front of her to base it on. She stated it is difficult.

Committee Member Buttlaire asked about the amount of funding it would take to serve 100 individuals.

> Brandon Staglin stated it would take $1.5 million.
>
> Dr. Niendam stated their organization has approximately 100 to 120 individuals and it takes approximately $1 million per year to run the program.

Committee Member Buttlaire stated a $2 million limit makes sense, and may even be too high.

Executive Director Ewing noted that the funding is for four years – $2 million would be $0.5 million per year.

Committee Member Buttlaire asked if funds will be matched for sister counties. Counties will be incentivized but, as these come in, he asked if they will be encouraged to work with neighboring counties.

Executive Director Ewing stated that is typically not done in this type of competitive procurement. The incentives must be anticipated up front. In California, sometimes the logical partner is not the partner next door for a variety of reasons. That is where the telemedicine and mobile components come in.

8. Open/encourage add-ons.

Executive Director Ewing stated he heard the Advisory Committee say to be open and encourage add-ons, like the focus on substance use disorder, certain populations, juvenile justice, and all criminal justice involvement. Many bullets were listed on the Summary of Advisory Committee Action document that came out of the conversations from the two previous Advisory Committee meetings and the conference.

Committee Member Questions and Discussion

Committee Member Merritt asked for more details. She stated, in the law, it is not talked about as adding on. Care for individuals with substance use disorder is incredibly important and needed but there are other funding streams, such as Medi-Cal and even the Mental Health Services Act (MHSA), that are being refreshed this year to include care for individuals with substance use disorder. She asked if Dr. Niendam's organization currently meets the needs of individuals with substance use disorder.

Executive Director Ewing stated the comments listed in the summary document were captured from prior meetings. He referred to page 4 of the Summary of Advisory Committee Action document. He stated there were discussions around building capacity of these existing programs to more effectively deal with individuals with co-occurring disorders, to build in more trauma screening for younger children, to do outreach to populations that are at high risk that might not know about the service or that might not be coming in, to document and promote the model, to consider the peer role, and to include the treatment of high-risk youth.

Executive Director Ewing stated the discussion in the morning session was about being open to that but not requiring it. This is not about taking on something completely new. He stated applicants might want to target a population that they are not currently serving.

Committee Member Furuzawa used trauma as an example. She stated individuals could build into their proposal how they would increase services for trauma and treat trauma. These are things that may not be in the blueprint of Coordinated Specialty Care, but could be included in the proposals. A space would be made for those kinds of add-ons to be included.

9. Clinical and Outcome Measures

Executive Director Ewing stated there is language in the law that says that one of the roles of the Advisory Committee is to help the Commission identify clinical and outcome measures that would be part of the evaluation.

Executive Director Ewing stated this does not need to be done today. There is a lot of language in the law about the kinds of things that these programs should focus on. When the law was written, more funding was anticipated than was later allocated. It is not reasonable to expect counties or partnerships to do everything on that list for the individuals they are serving, but those items are important. He stated the Advisory Committee can have a more detailed discussion in the future about what is happening in the Learning Healthcare Network now, what data is being used, and other issues on the list.

Committee Member Questions and Discussion

Committee Member Furuzawa stated the law already suggests a number of these clinical outcomes that are measured in this work, including increasing participation in school attendance, social interactions, physical health, personal bonding relationships, and active rehabilitation. She stated the advantage of using a blueprint is that it already exists.

Executive Director Ewing stated the challenge is the number of things listed in the law. Ultimately, the Advisory Committee will need to get more specific on how to operationalize that. He stated AB 1315 provides guidance already and a nice knowledge base and a great deal of work has already been done in terms of the data systems, but the Advisory Committee also talked about having a common evaluation. Having this significant comprehensive list in the law will create tensions with consistency and utility. He stated the Advisory Committee can discuss the procurement in terms of allowing this work but it does not necessarily need to be articulated what those metrics are on the front end.

Items not captured in the 9-item staff summary from the morning session.

Executive Director Ewing thanked Advisory Committee Members for clarifying and strengthening some of the points. He stated there was a list of three items mentioned by the Advisory Committee that will be set aside on a separate list:

- Workforce development
  - Above and beyond the workforce for the grantee programs.
- Commercial insurance support
  - There are a number of things to reinforce that.
- Document and promote the Coordinated Specialty Care model
  - Outreach and public awareness.

Executive Director Ewing stated other things can also go on that list. He stated there will be many details that staff will be unable to share because it is a competitive procurement. He asked if there was anything that was missed that happened in the discussion today or in past meetings that needs to be considered internal to the procurement.

Public Comment

Kevin Dredge, mental health advocate and lobbyist, stated they were curious on everything being discussed and asked if Senate Bill (SB) 803, mental health services: peer support, is still being discussed. The speaker stated SB 803 is a solution to many things being discussed today.

Executive Director Ewing stated the Advisory Committee is not discussing peer certification today, although there have been conversations that the model prioritizes peers in terms of a workforce and part of a support and recovery team effort. He stated

peer certification is more about setting standards for the role of peers and a financing mechanism for that. They would go hand-in-hand but they are separate conversations.

> Steve Leoni, consumer and advocate, stated they appreciate the idea of trying to reach individuals early on, but there is a client and family stakeholder process and stakeholders are not aware of what is going on here. The speaker was upset with the idea that perhaps stakeholders will be presented with something that has been decided before individuals affected by it hear about it. The speaker stated the need to consider how to speak to those individuals and listen to those individuals to reach a compromise or win them over or whatever it will take to make this work. The speaker stated the hope that stakeholders will not be left out of the process.

Executive Director Ewing asked if Steve Leoni meant the programming or the procurement process.

> Steve Leoni referred to the programming that comes out of that procurement process.

Executive Director Ewing asked Advisory Committee Members to address Steve Leoni's concerns about a strong peer voice in program design and care delivery. He stated, based on Advisory Committee discussion, it sounds like that will be a core piece. He stated Committee Member Insel had stated earlier in the meeting that there is flexibility in the system but one thing that is not flexible is the decision-making process and putting the peer at the center of that team approach.

> Steve Leoni agreed that there are discussions about choosing a direction to go, but the speaker stated they were referring to a community planning process that is not part of the clinical world but helps determine what these programs look like and what the resources are. Stakeholders are invested in that and should be consulted during the decision-making process.
>
> Brandon Staglin stated they understood Steve Leoni's concerns. The speaker stated one thing that came up during the discussion earlier today was that a major central component of this will be that all the programs that are participating in grants coming from this funding stream will be joining the Learning Healthcare Network throughout California. A major component of that is getting feedback from stakeholders on how to do that care better and what it is that they value in the care that they receive. This is part of the qualitative research that is at the very basic part of the Learning Healthcare Network, which will be built into this process being discussed today.
>
> Steve Leoni agreed, but stated it is subtly different and there needs to be a dialogue to better understand both sides. The gap is a little too large to discuss in today's meeting but the speaker wanted to present the issue for consideration.

Chair Tamplen stated this Advisory Committee has involved peers throughout the process and heard the impact that this kind of program and the struggles that individuals with psychosis experience has had on their lives and the details of programs

that have helped them achieve their recovery. She stated, in addition, this Advisory Committee is honing in on the county process of engaging local stakeholders.

> Steve Leoni agreed that the county process of engaging local stakeholders is also important. The speaker stated there will be buy-ins by various counties at different times. The speaker noted that there is a great deal of fear out there right now. People do not know what is happening. The refresh process remains something of a mystery and keeps changing. The speaker stated it feels like things are not just changing but perhaps a lot of what stakeholders have come to believe in in the last 15 years will be thrown away.

Chair Tamplen stated Steve Leoni is speaking of the shifting of MHSA dollars. She stated she understands that there is a great deal of discussion in the peer community of what will happen to the MHSA and the focus on prevention and early intervention versus community services and supports.

> Steve Leoni stated it is obvious that the message being discussed in the room today is the need to go upstream and to get to early psychosis, but still, it is reorienting the system away from treating those who are typically the worst. The system waits until individuals fail the worst before helping them. The speaker stated the importance of starting to help individuals early upstream. To do that, the Governor is talking about reorienting the system to pay more attention in terms of proportion to individuals far up the stream, at the beginning of things, rather than waiting until they fail. The two are moving in a coordinated direction. The speaker stated they are making this statement with an assumption that all the pieces will begin to fit together in a larger picture.

Chair Tamplen asked, in regards to the early psychosis intervention program, if there will be an age cut-off or if it is across the lifespan.

Executive Director Ewing stated he did not recall. Typically, early psychosis targets younger ages, but it is not unheard of for individuals to have a first psychotic episode throughout the lifespan. He asked Committee Member Wadell for her thoughts on age range.

Committee Member Wadell stated her organization serves individuals 12 to 30 years of age. Another program serves individuals up to 40 years of age. The majority of the individuals are in the 15- to 25-year age range. Many programs only go down to 16 years of age for a variety of reasons.

Committee Member Furuzawa stated her organization serves individuals 14 to 35 years of age and has gone down to 12 years of age.

Executive Director Ewing stated the intent language in the law references a higher-risk timeframe. It will require research.

Committee Member Merritt stated the law lists the core objectives of the competitive selection process as including improving access to effective services for transition-aged youth and young adults at high risk for, or experiencing, psychotic symptoms, including the prodromal phase, or psychotic disorders. She noted that the law does not specify an age range.

Committee Member Becker stated this proves Steve Leoni's point that this Advisory Committee is not here for that age group but the Commission goes more generally to those kinds of populations.

Executive Director Ewing stated Steve Leoni's point is much broader in terms of the changes that California is going through. He stated this is a $20 million state investment out of a $12 billion annual mental health system. There are many resources out there that this funding does not touch at all. He stated counties have to opt in. Arguably, it would be part of the community planning process, which can be highlighted in the procurement.

Executive Director Ewing stated what he heard from the providers in the room today is that there is some flexibility and that, even though the age range goes up to 40, the reality is the individuals who are showing up tend to be approximately 25 to 30 years of age.

Executive Director Ewing stated, also, part of this is the Commission is trying to, with a tiny piece of the mental health system, emphasize quality, access, and moving to scale. What is seen is there are many programs around the state but there is not consistency in the quality of care, the knowledge sharing, and the emphasis of outcomes. He stated the Commission would be supportive of these kinds of investments in other aspects of the mental health system.

Executive Director Ewing stated it is not that this is a program that is excluding individuals, it is one example of efforts to try to learn together and to go to scale. This is being done with schools and mental health, and is trying to be done with the criminal justice involved population and with suicide prevention, which, in rural counties, is predominantly an older population that is isolated.

Executive Director Ewing stated, also, a great deal of emphasis has been given to try to strengthen full-service partnerships. This strategy, from the Commission's perspective, is not exclusive to a population that is at risk for first episode psychosis, but what is being discussed today, although it is a great deal of money, is a relatively small investment recognizing the scale of the program designed to leverage this learning collaborative strategy. He stated, consistent with Steve Leoni's broader point, it needs to be done in a way that supports engagement and builds support and is driven by the concerns of the population being served.

> Steve Leoni stated they understand it is a small piece and that the refresh initiative is a separate discussion. The speaker stated what they were trying to say is that, at this point in time, this is the most concrete and advanced idea of moving in a direction towards prevention and early intervention. The speaker stated, also, about taking it to scale, it is not just taking it to scale within this topic, but taking it to scale across systems. The speaker noted that what is done and how it is done will have a heavy influence on what happens later through that refresh process.

Executive Director Ewing stated the refresh process is still conceptual. It is still more in the language phase than in the specifics phase. He stated he would argue that the work the Commission is trying to do on full-service partnerships will be more impactful

because the investment is $800 million per year, it is in every county, it is a mandatory program, and it is designed to serve the population that is referenced – the individuals who are at risk of homelessness, justice involvement, and hospitalization. He stated he is excited about the capacity to understand how to use this approach of state facilitating continuous learning and apply that strategy like schools and mental health, full-service partnerships, and criminal justice diversion because that is where the bulk of the people and the resources are.

> Steve Leoni stated they were largely with Executive Director Ewing on this. The speaker stated they are speaking to this now, in part because the broader refresh is up in the air and this seems to be something concrete moving in the same direction. It is worth paying attention to.
>
> Kevin Dredge stated what is being discussed is that in 58 counties there is a great deal of division and this division has something that is very important for everyone's safety – mental health. SB 803 will structure a consistent standard of operation in the procedures and give an outline of rules and regulations to each county that are consistent so that everyone can work on the same page. The speaker asked if this assessment was correct.

Committee Member Merritt stated, once signed by the Governor, SB 803 will create a certification process. She stated the author has moved back from the last year's version of the bill, and this first round is just developing a certification process and establishing that in California.

> Kevin Dredge asked if the language had been completely changed from the original SB 10 language.

Committee Member Merritt stated it is not completely different. The author is only moving forward with the certification piece.

> Kevin Dredge asked for verification that it will now not include the Medi-Cal and Medicare merging together and other aspects.

Committee Member Merritt agreed. It is only establishing the certification process for peers. She stated the Medi-Cal work is being done through the Governor's Office and the Department of Health Care Services (DHCS) and the Medi-Cal Healthier California for All initiative, previously known as California Advancing and Innovating Medi-Cal (CalAIM). This information can be found on the DHCS website. There are documents and other information on the website about how the administration is hoping to transform the Medi-Cal program.

Committee Member Becker asked if the three items on the separate list of work to be done outside of the procurement will be addressed in version 2.0 - workforce development, commercial insurance support, and document and promote the Coordinated Specialty Care model.

Executive Director Ewing stated this is not version 2.0 because version 2.0 is about funding that can be pursued. These items are other opportunities above and beyond current funding. These are issues and values the Advisory Committee Members have raised that are important to success but will not necessarily be addressed through the

$20 million procurement, but there also is no need to wait for the next allocation of funds. He asked if Committee Member Becker wanted to add another item to that separate list of work to be done outside of the procurement.

Committee Member Becker asked to add stigma reduction to the list to put the image of psychosis in the public realm to increase awareness and understanding.

Executive Director Ewing stated Committee Member Becker had raised the issue earlier today of how media treats schizophrenia and psychosis and how, above and beyond the Coordinated Specialty Care model, there should be a focus on anti-stigma work regarding psychosis.

Committee Member Becker agreed. She suggested also including stigma reduction work in fictional media and in the news.

> Brandon Staglin stated One Mind is doing a new program called One Mind All Media with exactly that intent, working with stakeholders to help the public understand the need to accept, respect, and have compassion for those with neurodiverse conditions including psychosis. The speaker stated the Commission is a sponsor of a PBS documentary series that One Mind is sponsoring as well on this topic.

Executive Director Ewing thanked everyone for their participation in today's meeting on behalf of the Commission. He stated next steps in terms of the procurement is staff will sketch an outline to be presented to the Commission for their February meeting. He stated it will be a high-level outline because it is a procurement. That sketch will be publicly distributed along with the other Commission meeting materials. He stated, at the February 27, 2020, Commission meeting, if the Commission authorizes the sketch, an RFP or Request for Applications (RFA) will be released relatively quickly to make this funding available.

Executive Director Ewing stated the Advisory Committee will meet at a future date to figure out what the common evaluation needs to look like in terms of these dollars so language can be built into the procurement that says there shall be an evaluation and grantees will participate. Staff will require guidance from the Advisory Committee on the balance between uniformity and greater detail.

Executive Director Ewing stated the Advisory Committee needs to be thinking about the broader issue because the intent of the original AB 1315 was not only to release funding but was to build out a larger strategy. He stated there is a great deal of work to do around Committee Member Becker's comments about stigma, understanding, and awareness, promoting the Coordinated Specialty Care model, and thinking about finance.

Executive Director Ewing stated the Commission, with the help of Committee Member Buttlaire, has been talking with Kaiser about how to do a collaborative research project to better understand the economics of the Coordinated Specialty Care model so that more financial support can be garnered from the commercial sector.

Executive Director Ewing stated staff had a good conversation with representatives of the California Public Employees' Retirement System (CalPERS) last week. CalPERS is

interested in engaging in some of these conversations as they recognize that they are a significant participant in shaping the mental health system in California on both the commercial side and on the employer side as a representative of large employers in California.

Chair Tamplen thanked Executive Director Ewing for facilitating the meeting and thanked everyone for their participation.

ADJOURN

There being no further business, the meeting was adjourned at 2:32 p.m.