State of California

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

Minutes of Meeting
August 29, 2019

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

866-817-6533; Code 1189021

Members Participating:

Khatera Tamplen, Chair
Lauren Becker, J.D.
Stuart Buttlaire, Ph.D., MBA
Gilmore Chung, M.D. (via teleconference)
Adriana Furuzawa, LMFT, MBA
Kate Hardy, Psy.D.
Thomas Insel, M.D.
Yana Jacobs, LMFT
Karen Larsen, LMFT
Maggie Merritt
Tony Tullys, MPA
Paula Wadell, M.D.

Members Absent:

Gladys Mitchell

Staff Present:

Toby Ewing, Ph.D., Executive Director
Filomena Yeroshek, Chief Counsel
Norma Pate, Deputy Director, Program, Legislation, and Technology
Brian Sala, Ph.D., Deputy Director, Evaluation and Program Operations
Tom Orrock, Chief, Commission Operations and Grants

[Note: Agenda Item 6 was taken out of order. These minutes reflect this Agenda Item as listed on the agenda and not as taken in chronological order.]

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 10:06 a.m. and

welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

Chair Tamplen reviewed the meeting protocols.

Chair Tamplen asked for a moment of silence in honor of Rusty Selix, who recently passed away. Committee Members shared their memories and gratitude for Mr. Selix's work and accomplishments in the mental health field.

2: Family Member Perspective

The Commission made a commitment to begin Commission meetings with an individual with lived experience sharing their story. Chair Tamplen invited Ezio Lucido to share his story of recovery and resilience.

Ezio Lucido shared the story of living with and caring for an older brother, Jerry, who was diagnosed with early-onset schizophrenia at age 12, was institutionalized, did not respond well to current medical treatments, became dependent on medication, and was blamed for his illness. Because of his mother's unwavering support, Jerry has continued his journey of recovery with his family. Mr. Lucido stated, when he was a teen, he asked Jerry what he wanted his life to accomplish; Jerry told him he wanted kids like him to have a better future.

Mr. Lucido stated he started a film company to build an independent voice in his garage when he was 17 years old to help support his family and to help provide Jerry with the care he needed. Creating this film company gave his family the potential to be evidence that challenges can be overcome in a transformative manner that extends beyond them, to teach the public the value of sharing both the rewards and consequences of the family's collective-wellbeing, and to inspire the world to meet challenges in mental health from a default approach of compassion.

Mr. Lucido stated today his family has a successful business that employs other individuals with mental health challenges and, while Jerry struggles, he also triumphs. Mr. Lucido stated Jerry is the most resilient person he knows. He stated his brother continues to work with him in the business to continue his life mission. Soon, the goal of making a film of the Lucido family journey will be reached. Mr. Lucido introduced Jerry and his mother, who were with him in the audience. He stated their presence in the meeting today is a testimony to the power of support without compromise. They are an inspiration. He stated his family lives by their motto: compassion is genius.

Questions and Discussion

Committee Member Merritt asked for further details about the Lucido's film studio.

Mr. Lucido stated the studio is in Vacaville and the films his family have produced have been seen by hundreds of millions of individuals worldwide. He stated he has been writing Jerry's story for 22 years and just finished last week. He stated he started the studio because that independent voice is important in mental health.

Committee Member Jacobs asked Mr. Lucido, looking back, what he would have liked to have seen done for his brother when his brother first began having difficulties in school.

Mr. Lucido stated he would have liked to have seen more alternatives. For example, instead of going from zero to a hundred, having the option to try zero to ten and seeing how that might have worked out. Balanced tools for his parents would have also been helpful. Information is important; he would have liked more information to better understand the risks being taken. Mr. Lucido stated there was a default position of fear; he stated his hope that culture and society might come to understand mental health as not the end of a person's being. This would have helped his parents come to a healthier conclusion on how to proceed.

3: Approval of the June 14, 2019, Meeting Minutes

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

The MHSOAC EPI Plus Advisory Committee approves the June 14, 2019, Meeting Minutes.

Motion carried 10 yes, 0 no, and 2 abstain, per roll call vote as follows:

The following Committee Members voted "Yes": Committee Members Becker, Buttlaire, Chung, Furuzawa, Hardy, Insel, Jacobs, Merritt, Tullys, and Waddell.

The following Committee Members abstained: Committee Member Larsen and Chair Tamplen.

4: Budget Presentation on the MHSOAC Early Intervention of Psychosis Program

Presenter:

- Norma Pate, Deputy Director, MHSOAC

Chair Tamplen stated the Committee will hear a presentation on available funding for early psychosis. She asked staff to present this agenda item.

Norma Pate, Deputy Director, MHSOAC provided an overview, with a slide presentation, of the Early Psychosis and Mood Disorder Detection and Intervention Fund and the Budget Act of 2019.

Questions and Discussion

Chair Tamplen asked when the Request for Proposals (RFP) process will begin.

Deputy Director Pate stated there is no timeline at this point. An outline must first be developed and adopted by the full Commission.

Executive Director Ewing added that the goal is to encumber the funds prior to June 30, 2020.

Committee Member Buttlaire asked how the $500,000 was determined.

Deputy Director Pate stated it was a percentage. The administrative cost is approximately 15 percent of the total program cost.

Committee Member Buttlaire asked what best-practice programs cost.

Executive Director Ewing stated the $500,000 is for administrative costs for the Commission to implement the program – to hire staff, do outreach and marketing, and provide technical assistance. The bulk of the funds would go to the community mental health system.

Committee Member Buttlaire asked what the total amount of funding for the program will be.

Executive Director Ewing stated he does not know. The Commission has the option to make that an issue in the RFP or to stay silent on it.

Committee Member Insel asked if there is a requirement for a county match.

Deputy Director Pate stated there is an option to leverage funds but that will be determined by the Committee. The language is about leveraging funds or public or private donations, so it could be either/or.

Committee Member Insel asked how private funds would work.

Executive Director Ewing stated the details are being sorted out. There is confusion in the original documents about whether the $20 million will fund the AB 1315 program, but it is clear in the Final Change Book language. This is important because, if the $20 million is in the AB 1315 fund, it triggers the access to the $500,000 for implementation. If it is not in the AB 1315 fund, it does not trigger the $500,000 but there are other provisions in the enabling language that allow for implementation.

Executive Director Ewing stated large donations are not anticipated at the moment but, if a check is written to the EPI Plus Program and is sent it to the Commission, it will be deposited into the State Fund and added to the $20 million.

Committee Member Insel stated the need to figure out the mechanism so the $20 million can be expanded to make it even more attractive to counties.

Committee Member Jacobs asked if the funding is a one-time grant for counties.

Deputy Director Pate stated the funding can be spread out over three years. The funds issued can have a three-year grant term with the one-time funding.

Committee Member Jacobs stated the need for the Committee to think about guidelines for how counties can do pilot projects over a three-year period.

Deputy Director Pate stated adjustments can be made to that by leveraging other funding from the county to make it a five-year project with the last two years coming from the county or other funding.

Executive Director Ewing stated Dr. Tara Niendam will present on the history of the current effort that is in place later in the agenda. He asked that this fund not be

considered as pilot money, but to think about it in terms of leveraging many other potential resources.

Committee Member Tullys suggested looking at it as an opportunity to implement an evidence-based practice that will prevent serious mental illness. This funding is like using many grant dollars, where the funds are used to pilot a program, learning from that, and then building it into the service delivery system. There is an opportunity from the county perspective to discuss what is currently in place and how this fund can help them implement a version of this in their communities. This should be framed as an important opportunity for children and youth in the state; the funding will work its way out.

Public Comment

No members of the public addressed the Committee.

5: Learning Health Care Network, First Episode Psychosis Programs in California, and Opportunities for Public/Private Partnerships

Presenters:

- Tara Niendam, Ph.D., Executive Director, UC Davis Early Psychosis Programs
- Brandon Staglin, President, One Mind

Chair Tamplen stated the Committee will hear about the Learning Health Care Network and efforts to assist counties, including opportunities for public/private partnership. She invited the presenters for this agenda item to come to the presentation table.

Tara Niendam, Ph.D., Executive Director, UC Davis Early Psychosis Programs, provided an overview, with a slide presentation, of the landscape, treatment standards, EPI-CAL Learning Health Care Network, and state-level approach to training and technical assistance of the early psychosis services across California.

Brandon Staglin, President, One Mind, continued the slide presentation and discussed the One Mind Applications for Serious Psychiatric Illness Recovery (ASPIRe) Program of Sonoma County.

Questions and Discussion

Committee Member Hardy highlighted the most recently-published European guidelines on treatment that speaks to the need for careful assessment, which is a challenge with this population. She stated how to accurately assess individuals at clinical high risk and train a workforce that may not be well-versed in this to those levels is a tough question.

Dr. Niendam agreed that the assessment piece is key and knowing when to make subtle changes in treatment and medication. The workforce needs to be well-trained to pick up on subtle changes in symptoms or functioning. The majority of the workforce has not been trained that way.

Committee Member Insel stated in the Recovery After an Initial Schizophrenia Episode (RA1SE) study, the duration of untreated psychosis was a key issue on whether children got better or not. He noted that children with long durations of untreated psychosis, more than 74 weeks, most of chilren were in treatment but they were not being diagnosed or treated correctly. He agreed that there are training and quality issues that must be acknowledged.

Executive Director Ewing stated the language in the law says the purpose is to expand and improve existing treatments. One of the points of consideration that the Committee can discuss is how to set aside a portion of these funds to create programs following evidence-based practices using the language of the statute, but in other instances, strengthening what is in place today. That takes much of the fiscal sustainability issue off the table because it is about using existing dollars better. He asked for guidance from the Committee on the tradeoffs of creating better practice than what is currently available through things such as staff training, fidelity to models, research and analysis versus creating program where none exists - ideally it should be both, and how to allocate the limited resources.

Committee Member Jacobs stated it is a good point because investing money into retraining staff and educating them in a new way would be long-lasting. Giving staff those tools may lower staff turnaround.

Committee Member Buttlaire stated one of the advantages of funding existing programs is there is a baseline in terms of costs, outcomes, and expansion. Return on investment must be proved in order for this program to be effective.

Chair Tamplen suggested considering opportunities to expand learning collaboratives and first episode psychosis programs, opportunities to invest in and strengthen existing programs, and opportunities to create public/private partnerships.

Executive Director Ewing asked if there was guidance in terms of why the programs stopped at one year versus two to three years.

Dr. Niendam stated there was not.

Executive Director Ewing asked if a wide variation was seen in duration and approach because of the lack of guidelines.

Dr. Niendam stated that is correct within the state of California. She noted that guidance is now available through entities such as the Substance Abuse and Mental Health Services Administration (SAMHSA) but, when many of these programs were being developed, it was organic and there was a drive to fit programs to stakeholder needs and desires.

Executive Director Ewing stated he was still curious why the programs stopped at one year.

Dr. Niendam stated she could only speak for Sacramento County. Those programs were time-limited to two years as part of the RFP. It was a typical length for programs at the time and was built into the funding structure. Studies worldwide now show that these

programs should be five-year programs. The guidelines are shifting as data is gathered and lessons are learned.

Committee Member Furuzawa stated, in her experience, most of the programs were developed with technical assistance or existing methodologies that were in practice. They would typically seek to follow some criteria, such as being within two years of onset and, at the same time, there is the need for services and each county faces their own reality. In many cases, even though a program would have established criteria based on the model followed, there were also adaptations to the needs of the population to be served. She stated program staff would often educate the community mental health system of why it was important to adhere to certain models and criteria.

Committee Member Furuzawa stated, in terms of the duration of services, most programs started with a set plan in mind, which may have been guided by funding, but despite the best plans and estimates, it is becoming understood that maybe two years is not the answer and maybe five years is not the answer. Initiatives are now setting aside after-care programs to provide guidance to families or graduates of early psychosis programs for as long as required.

Committee Member Furuzawa stated something must be created that is long-lasting for California, that will touch all the different systems of care, and will support individuals who may be entering treatment today, but that will also have long-last effects for individuals who may receive these types of services later in life.

Committee Member Buttlaire asked about data on the drop-out rates for the various lengths of the program.

Dr. Niendam stated there is no data on that as yet but the EPI-CAL Network will have a much better sense of that. She stated the need to include client and family choice to be served elsewhere. Some individuals may not fit with this program and may choose to stay with their current provider.

Committee Member Hardy stated this discussion speaks to statewide and state-specific recommendations based on the latest data. This is a great forum to discuss the guidance being put in place around the duration of untreated psychosis and length of services provided.

Committee Member Tullys stated more research and evidence of opportunities of what works for people has come out. One of the opportunities for this Committee is to develop a focus and understanding of strong evidence-based clinical practices. She stated there not only has to be training, but there has to be an understanding that the field is changing and that, while being supportive and caring clinicians who are providing that level of care, understanding of the clinical and recovery pieces need to be ramped up and put together. There is an opportunity to understand that this new knowledge will require a different mindset and, more than training, it will be about the outcomes collected and compared. There are opportunities but also challenges for the Committee to do messaging across the state about being willing for clinicians to embrace these new studies.

Dr. Niendam agreed with the need for a culture change and the need to learn how to engage the various groups in the discussion of that culture change. Understanding must be built on where individuals feel they need to grow versus where they feel solid and how to support them in growth.

Committee Member Tullys stated the need to introduce into those educational platforms where the world is going in behavior health. Graduates do not have enough understanding.

Chair Tamplen agreed and stated the peer approach and the importance of that partnership with peer specialists is not getting into the schools where individuals are learning about this field. Top-down engagement pushes individuals away from wanting to engage.

Committee Member Becker referred to Table 2, Coverage of Coordinated Specialty Care Components under Public and Private Fee-for-Service Programs, on pages 14 and 15 of the white paper titled *Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care*, put out by the RA1SE Project, which was included in the meeting packet. She stated, although there are services listed that are not covered or inconsistently covered, there are items that are billable and that already have billing codes. She then referred to Dr. Neindam's article where it states there are six facilities that receive funding from private insurance and asked if there is qualitative data similar to the RA1SE chart.

Dr. Niendam stated there is.

Committee Member Becker asked if anything can be done such as lobbying to get more services covered.

Dr. Niendam stated this speaks to Committee Member Insel's point about how to bring systems in and work with them collaboratively around addressing this common issue because the codes are already there. She noted that there are more codes than listed on the white paper. She stated individuals sometimes do not use the codes.

Committee Member Becker stated ensuring that individuals can bill for services is the point where good programs can be built, with the help of this Committee, and counties can flourish beyond this Committee, especially counties that do not currently have services.

Mr. Staglin stated it is important to develop insurance coverage for these programs for greater accessibility. He stated One Mind hosts an annual event called the One Mind at Work Global Forum, which is taking place in September of this year. There will be a summit of major health care corporations the day before the forum, including insurers, to discuss the needs to change behavioral health practices and current provision models. One of the topics will be affording specialty care and how to implement that and make that a part of the culture that they subscribe to and believe in. He asked Committee Members to share suggestions with him offline for things to bring up at that meeting.

Committee Member Hardy asked if agencies and counties gravitate to different treatment models based on demographics.

Dr. Niendam stated that data was not collected. There have been multiple adaptations to treatment models but much more is needed in this area.

Executive Director Ewing stated Dr. Niendam and Mr. Staglin have been involved with the Innovation Collaborative. He asked them for a foundational description of what that is and there the collaborative is in the process.

Executive Director Ewing addressed the comment about the need for the system to move towards a learning system, and for that learning to then be pushed upstream into training and professional development for individuals entering the field as well as the individuals coming into the system. He stated the Commission made a small investment into Dr. Niendam's work. Dr. Niendam was able to bring together a group of counties with support from the Staglin family One Mind Foundation and some federal funding. This is the first effort for the state to try to facilitate a learning health care system targeting early psychosis work. He stated the hope, if this is successful, for the opportunity to point that approach to other topics in the mental health system. There is an opportunity to build off of what is already in place.

Dr. Niendam continued her slide presentation and reviewed the EPI-CAL Learning Network Collaborative.

Committee Member Insel asked if the EPI-CAL network in counties are clinics and if they are labeled coordinated specialty care.

Dr. Niendam stated they are programs that already exist that will provide team-based care. That could be within a larger outpatient setting community-based organization, which has a subset team within a larger organization, or it could be a separate facility. Currently, all the programs she is working with are already established, though Los Angeles County will have five programs across the county and includes new programs. She stated how this will be done in the future is an excellent question.

Committee Member Buttlaire asked if part of the model is school-based with the training of teachers to help identify. That is where the early intervention identification has to happen.

Dr. Niendam stated educating the community is part of the foundational core of coordinated specialty care and schools are an important part of that community. Although a few first-episode diagnoses have come out of schools, the majority of it is clinical high risk. It is important to keep children in school but also to keep their symptoms from getting worse. School-based outreach and integration of components of care such as screening is important.

Committee Member Buttlaire asked if substance abuse is being included as part of the identification and getting children in early. That is often the first sign that a child is beginning to have trouble.

Dr. Niendam stated substance use treatment should be part of the coordinated special care model but there has not yet been a broad research base on that. She stated she was part of a work group for SAMHSA on implementation of substance use treatment in coordinated specialty care. The report should be coming out soon.

Chair Tamplen stated the need to emphasize care standards – community-based services, the family being heavily involved and support, and the child not excluded from that.

Committee Member Jacobs asked about the data being collected and the difficulties of getting qualitative data from clients and family members who have been through the program.

Dr. Niendam stated that data is being gathered from clients and family members throughout the process.

Public Comment

Adrian Bernard, Co-Founder, Second Story Peer Respite House, has seen the shift of transformation that happens as peers interface with system providers. The speaker asked how peers are involved in this program, how peers are training the staff, and how lived experience is informing great transformation. The speaker stated feedback not received over the years is that a clinical gaze only may not be enough to transform the entire system.

Mr. Staglin stated the RFP that One Mind sent out to start the program in Sonoma County specifically states that family and peer support services advocates are sought to be members of the program. Dr. Neindam's programs in Sacramento, Napa, and Solano Counties also include peers.

Lorraine Zeller, Mental Health America of Northern California (NorCal MHA) ACCESS Ambassador, works in a facility that is connected to a clinic. Over the years, there has been a more positive interface with the clinicians. The speaker agreed that both clinical and recovery components are needed. The speaker encouraged the Committee to include the careful use of medication in the RFP.

TJ McKillop, Alchemy Mental Health Project Manager, VOICES Youth Center, asked if there will be a setup for youth centers like VOICES, such as a consultancy pathway to determine the best model for them. The speaker stated VOICES Youth Center is already doing make-shift coordinated specialty care by partnering with Sonoma County Behavioral Health. The speaker noted that the training piece has been a barrier to implement anything innovative.

TJ McKillop asked about planned innovations such as peer respite center models, which are greatly needed for youth and for the homeless. The speaker stated the most effective pathway for youth at the drop-in center has been through peer advocacy. The most effective person on the team at all times is the peer advocate. The speaker implored the Committee to strongly emphasize peer advocacy.

Steve Leoni, consumer and advocate, spoke at the last meeting about honoring the tradition of innovation in the state such as full-service partnerships (FSPs). The speaker stated there is an overlap between the individuals in the early psychosis programs and the FSPs. The speaker suggested using data from the FSPs to help inform the early psychosis programs because some of data might also apply to early psychosis.

Steve Leoni attended the Access California and NorCal MHA mental health conference in Los Angeles last week where Mark Ragins, M.D., a founding member of the Village, which is the model for FSPs, gave a special presentation on recovery and outcomes. Dr. Ragins's PowerPoint presentation will be made available next week.

Geoff McClendon (phonetic) spoke about reciprocity and portability of clinical care. There is an enormous vacuum between clinical care and getting back home, which logically leads to the family. The speaker stated there cannot just be family involvement; there must be intensive family involvement because, when 911 is dialed in the middle of the night and the police and fire departments show up, they do not know how to help.

Dr. Niendam reinforced the call for peer and family involvement. Peers and family members are involved in every layer of the program. She stated she liked the idea of including a role for youth centers and respite care in improving the system of care.

[Note: Agenda Item 6 was taken out of order and was heard after the lunch break.]

6: Setting the Vision for a Statewide Approach to Early Detection and Intervention

Presenter:

- Tom Insel, M.D., Committee Member

Chair Tamplen stated the Committee will hear a presentation on how new funding can support a statewide vision to reduce the duration of untreated psychosis, support recovery, and improve outcomes. She invited the presenter for this agenda item to come to the presentation table.

Tom Insel, M.D., Steinberg Institute, Committee Member, continued his slide presentation from the last meeting by presenting parts two and three – opportunities for California for 2019 – 2024 and a vision for 2024. He suggested that this Committee make a short-term goal to help demonstrate impact in the next 12 to 14 months in order to claim that the $20 million was a good investment. There is much this Committee can do but it cannot do everything.

Committee Member Insel stated the Governor's Office is interested in focusing on three populations for transforming behavioral health: homeless individuals, incarcerated individuals, and children at risk. There will be budget initiatives and goals set in place. This Committee can help by developing a series of technical assistance tools to help with that. It is important for this Committee to do something in the short-term to point to early successes by specifying the standards, training the workforce, engaging the private sector, and getting a number of clinics throughout the state that are already deeply engaged to the point where they have full fidelity within the next two years. It is important to measure, monitor, and demonstrate improvement.

Questions and Discussion

Committee Member Buttlaire asked if there have been studies looking at the relationship between adverse childhood experiences (ACEs) and first episode psychosis (FEP).

Dr. Niemdan stated ACEs are broadly associated with poorer physical, functional, and clinical outcomes. She noted that there are even poorer outcomes with FEP, along with increased risk for transition to psychosis and clinic high risk. ACEs are an important factor, which is why the foster care and juvenile justice populations have an enriched sample of individuals who are at risk for serious mental illness.

Chair Tamplen stated the need to ensure that the interventions do not create ACEs.

Committee Member Becker asked about development of certification programs that will enable individuals to staff these programs.

Committee Member Insel stated he has not thought through training individuals specifically for FEP programs, but there is interest and many counties are working with their community colleges to begin educational pathways to community mental health.

Committee Member Hardy stated King's College in London has an Early Intervention in Psychosis Master's program. There is integrated training countrywide that incorporates early intervention principles of recovery and wellness, which funnels students into the Master's program, if they choose to specialize.

Committee Member Hardy stated it would be a great opportunity to create a parallel educational program for individuals to work in the field while going through higher education courses.

Committee Member Insel stated there is interest in creating a new workforce modeled on what has been done in the UK, but this will take leadership and a national commitment.

Public Comment

Geoff McClendon (phonetic) stated he served under Governor Brown's Civil Service Innovation with Secretary Marybel Batjer, where the community colleges received $250 million to provide an innovative platform for certification for new types of workers. It is called the New World of Work. This would be an exceptional area for this Committee to exchange with the chancellor at the community colleges to combine AB 1315 funds with theirs particularly in regards to peer workers.

Lorraine Zeller, Mental Health Peer Support Worker, Santa Clara Valley Medical Center, added to the discussion on expanding, retaining, and educating the workforce. The speaker stated, on October 19th, there will be a Community Education Day for Psychosis in Redwood City. On October 13th, there will be an all-day training on compassion-focused therapy for psychosis for family members and peers at Stanford. The speaker left brochures advertising these events on the table.

Committee Member Hardy stated the compassion-focused therapy training is full. The host is currently searching for a larger room to accommodate more attendees. She noted that there is also a clinician training for compassion-focused therapy for psychosis that she will circulate.

Mr. Staglin agreed with the goals presented to reduce suicide, increase employment, and to reduce hospitalization and incarceration by 2024 of the work at the MHSOAC and, in particular, this Committee and the work that can be done for EPI Plus. He stated one of the challenges is to overcome the skepticism as to the benefits of caring for individuals with early psychosis as a priority for mental health systems to engage in. He asked for suggestions on how to approach skeptics to help persuade them of the importance of this kind of care.

Committee Member Insel stated it is a longer conversation that can be pursued offline. He stated it is critical to remind people that, in every other area of medicine, progress has come from moving upstream. He stated it is an obvious improvement to reach individuals before they get into crisis. It does not make sense that individuals have to end up in emergency rooms, locked inpatient units, or jail in order to get care.

Steve Leoni addressed “refreshing” the Mental Health Services Act (MHSA). The speaker stated, although they did not dispute that it can be better, there is concern that, in the attempt to change things, something important may be lost. There has been little communication with stakeholders and advocates about what is being considered. The speaker requested better transparency with this.

Steve Leoni stated, in the spirit of using what is already available, the California Behavioral Health Planning Council (CBHPC) is charged with the segment of the MHSA for workforce, education, and training (WET). The MHSA, unfortunately, was written in such a way that the WET funding ran out. The Office of Statewide Health Planning and Development (OSHPD) is charged with continuing to come up with new ideas and new plans, even if the funding runs out. The CBHPC is hearing from the Legislature that they do not think there is a problem with workforce in California. The CBHPC and OSHPD have already been engaged in a year-long process looking at what is needed in workforce and education. The speaker encouraged utilizing resources that are already available.

Adrian Bernard asked what can be done to create flat-rate billing for mental health patients.

Committee Member Insel stated there are cross-cutting issues that keep coming up in every county but, clearly, the workforce issue is an urgent problem. The workforce could possibly be increased by 35 percent in 24 hours just by reducing the administrative burden for all of the individuals who are on the frontlines. It is not that difficult; it is done in many other places. Whole person care is paid for on a per-person, per-month basis or some other basis. There are many models for how to pay for care. What is done in California through the county specialty mental health sector, the certified public expenditure (CPE) model, is the most laborious and the last satisfying for anyone. It is about what is done if what is cared about is reducing fraud, not about what is done if what is cared about is providing the most care to the individuals who need it.

Committee Member Insel stated this is on the list of things to figure out how to change. There are eight states doing certified community behavioral health centers that have a prospective payment model as described by Adrian Bernard. Most of the reports coming

back indicate that providers love that they can spend the most of their time doing what they most care about and not becoming well-paid clerical personnel.

LUNCH BREAK

7: Priorities for the Allocation of Funds for Early Intervention of Psychosis

Presenters:

- Khatera Tamplen, Chair
- Toby Ewing, Ph.D., Executive Director, MHSOAC

Chair Tamplen stated the Committee will discuss opportunities for the distribution of funds available for early intervention of psychosis including, but not limited to, the following:

1. Requirements regarding matching funds
2. Small county/Large county set aside
3. Competitive versus non-competitive procurement
4. Essential program components
5. Special challenges to consider when determining minimum requirements for applicants

Chair Tamplen asked Executive Director Ewing to guide the Committee through the discussion.

Executive Director Ewing stated today's agenda was meant to give Committee Members a general sense of the amount of funding available and what can be done with it, to provide an update on the status of building out the learning health care network, and to inspire and point the Committee in a direction to think about how to use available resources to move from where we are to where we want to be.

Executive Director Ewing asked for input on three facets: the role of the Commission to support success, facilitating resources, and funding counties. Commission staff is looking for guidance on how to move forward. Beyond that, there is a much broader conversation around fund raising and other activities to support this initiative.

Committee Members offered comments and recommendations as follows:

Role of the Commission

Identify key outcomes

Increase high school graduation

Reduce criminal justice involvement

Decrease suicides

Reduce 5150s

Engage the EPI Plus community

- Community, peers, and family

Outreach and Awareness

- Identify models such as New York and work at the federal level to create greater awareness

Convene a statewide conference as a launch platform for the new Coordinating Center (see the Facilitating Resources section, below)

Create awareness of trauma in delivery of care and address it

Cost research and staffing model

<u>Facilitating Resources</u>

Provide technical assistance

- Training to the model
- Training to the practices
- Training to operate the program within fidelity

Training/consultation

- Address the tension between the consistency of training and high fidelity
- Create a consultation model on early psychosis practice overall

Evaluation

- Develop capacity to use data
- Build learning collaboratives

Create a Coordinating Center

- Be the go-to place for consultation
- Convene around data as it grows to provide feedback

Bridge to specialty care

- Education and awareness of primary care providers
  - Learn how to refer
  - Learn how to improve access for specialty care

Communication/marketing strategy to general public that addresses stigma

- What is early psychosis
- What are effective services
- Utilize a compassionate approach

Value of high-fidelity model

<u>Funding Counties</u>

- Select representative large and small counties and regions to fund pilots and train them to fidelity
- Create two RFPs
    - Extend EPI-CAL
    - Open opportunity
        - Create a learning health system around programs that already show fidelity
        - Cost research
- Follow evidence-based practices
- Create uniform strategies
- Use coordinated specialty care model at high fidelity
- Incentivize innovation funding
- Incentivize peer model
- Focus on at-risk populations
- Design one program
    - Demonstrate engagement with community resources
    - Design, set standards, and funds (subject to review)
        - Determine how broadly to define the word “psychosis”
    - Beyond brick-and-mortar clinics
    - Unified data requirements
- Leverage and scale existing learning health system
- Target age range
    - Prioritize target
        - High risk
        - Juvenile justice
        - Homeless outreach
- Review the Head Space, Clubhouse, and other models and related research to help describe the desired elements in the program prior to drafting the RFP
    - Consider what is missing from existing models such as addressing substance use disorders and how to address and treat trauma.
    - Ask counties to address these two pieces.
- Set clear goals
    - Specific populations

Particular program

Identified outcomes

Fund a model with fidelity

Evaluate

Set criteria to inspire counties to do things in new ways

Strengthen the state’s view of these programs

Strengthen existing programs

Ensure people get needed training for assessment

Create strong centers to show return on investment and outcomes

Provide clear guidance on how counties can participate to ensure success

New challenges (SUD, trauma, cannabis)

Training

Common data elements

How to address challenges identified

Enable add-ons to the coordinated specialty care model

First episode and beyond

Clinical high risk and first episode in a step-down model

Mood disorders combined with first episode

Define clear avenues of what the programs would look like

Increase flexibility

Sustainability strategy

Recognize referral systems

Hospitals, CBOs, jails

Grow respite housing model

Parking Lot

Engage private sector

Engage philanthropy

Explore reimbursement models

Reform 5150 holds

Clarify the phrase “cannot hold for psychosis”

Fundraising strategies

Social media/marketing

ADJOURN

There being no further business, the meeting was adjourned at 4:01 p.m.